

REPORT 10

PATTON STATE HOSPITAL

June 6-10, 2011

**THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA**

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Patton State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Patton State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Patton State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

Table of Contents

Acronyms used in Court Monitor reports:	iv
Introduction	12
C. Integrated Therapeutic and Rehabilitation Services Planning	22
1. Interdisciplinary Teams	24
2. Integrated Therapeutic and Rehabilitation Service Planning (WRP).....	35
D. Integrated Assessments	90
1. Psychiatric Assessments and Diagnoses.....	92
2. Psychological Assessments.....	110
3. Nursing Assessments	114
4. Rehabilitation Therapy Assessments	123
5. Nutrition Assessments	138
6. Social History Assessments	152
7. Court Assessments	158
E. Discharge Planning and Community Integration	161
F. Specific Therapeutic and Rehabilitation Services	177
1. Psychiatric Services.....	180
2. Psychological Services	210
3. Nursing Services	234
4. Rehabilitation Therapy Services	251
5. Nutrition Services	260
6. Pharmacy Services	267
7. General Medical Services.....	268

8. Infection Control	294
9. Dental Services	312
G. Documentation	323
H. Restraints, Seclusion, and PRN and Stat Medication	324
I. Protection from Harm	338
1. Incident Management	341
2. Performance Improvement	370
3. Environmental Conditions	399
J. First Amendment and Due Process	409

Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
ACLS	Advanced cardiac life support
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AED	Anti-epilepsy drug
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ART	Assault Reduction Taskforce
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
B & B	Bladder and Bowel
BCC	Behavioral Consultation Committee
BFA	Basic First Aid
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention

CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CMT	Clinical Management Team
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment/Court-Ordered Outpatient Treatment
COVR	Classification of Violence Risk
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CSW	Clinical Social Worker
CV	Curriculum vitae (i.e. resumé)
CVA	Cerebrovascular accident
CXR	Chest x-ray
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DJD	Degenerative joint disease
DPCIP	Discharge Planning and Community Integration Program
DMH	Department of Mental Health
DOJ	Department of Justice
DON	Director of Nursing
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered

DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis
EAP	Employee Assistance Program
ED	Executive Director
EKG	Electrocardiogram
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
ETU	Enhanced Treatment Unit
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FPA	Focused Psychological Assessment
FQRP	Forensic Quality Review Panel
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
FTS	Follow Through Staff
GAF	Global Assessment of Functioning [Score]
GI	Gastrointestinal
GIVI	Gastrointestinal viral illness
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HCMR	High Concern Medical Refuser

HEP	High Efficiency Particulate Air
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HOM	Hospital Oversight and Monitoring
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IER	Independent External Review
IM	Intramuscularly
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MAS	Medical Ancillary Services
MBSS	Modified barium swallow study
MDO	Mentally Disordered Offender
MFT	Marriage and Family Therapist
MH	Mental health

MI	Mental illness; myocardial infarction
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NAO	New admission orientation
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NFA	Neuropsychological Focused Assessment
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPH [insulin]	Neutral Protamine Hagedorn [insulin]
NPO	Nulla per Os (nothing by mouth)

NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIM	Potentially inappropriate medications
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POC	Plan of Correction
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee

PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PTFA	Physical therapy functional assessment
PWT	Program-Wide Trainer
QOD	Abbreviation for "every other day"
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SLU	Social Learning Unit
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale

S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
STA	Secure Treatment Area
START	Simple Triage and Rapid Treatment
STOP-A	Selected Treatment of Psychomotor Agitation (algorithm)
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
Tx	Treatment
UCR	Urgent Care Room
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
VRMC	Violence Risk Management Committee
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from June 6-10, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C.1, C.2, D.1 through D.7, E, F.1 through F.9, G, H, I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the EP, which was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond to the recommendations in any ways it chooses as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations were more focused on process deficiencies. As the facilities have made progress in each area, the recommendations are more typically directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included but were not limited to charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

The Court Monitor's compliance findings are a function of independent review and judgment, taking into consideration both quantitative and qualitative factors related to the requirements of the particular EP cell.

The Monitor's quantitative data is typically collected through chart reviews while on site. Sources of qualitative information include: a) chart reviews; b) staff interviews; c) observations of teams, programs and the environment of care; d) assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance; and e) assessment of trends and patterns of change rather than single and/or temporary occurrences that are inconsistent with these patterns and trends. The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

The CM may also evaluate his findings relative to data presented by the facility that results from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

In the ratings of compliance, the Monitor uses a scale of non-compliance, partial compliance and substantial compliance. A rating of non-compliance indicates lack of efforts and progress towards compliance. No ratings of non-compliance were assigned in this report. A rating of partial compliance falls short of the Court Monitor's threshold of compliance, but indicates progress and efforts towards

achieving compliance. A rating of substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

D. Findings

This section addresses the following specific areas and processes, some of which are not covered in the body of the compliance report.

1. Key Indicator Data

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for management in terms of summarizing general performance and assessing trends, but they cannot stand alone as a means of formulating judgment regarding facility performance and practices, including such judgments that are part of EP monitoring. The court monitor reviews the key indicators from a statistical point of view, taking into consideration relative clinical significance, but does not conduct independent validation of the data. At times the court monitor will comment upon changes that he believes require the facility's attention, but the absence of comment by the court monitor should not be construed as an indication that no attention, investigation or follow-up is necessary. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by PSH at the time of this review indicate stable performance in a number of domains over the past six months.

2. Monitoring, mentoring and self-evaluation

- a. PSH has maintained significant progress in self-assessment and data presentation.
- b. Regarding the process of self-assessment, this monitor has requested the following:
 - i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
 - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
 - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
 - A review of the facility's assessment of barriers towards compliance; and
 - A plan of correction.
 - ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
 - iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
- c. PSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.
- d. The existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.
- e. The CM will accept further reasonable reduction in the self-auditing samples if DMH, with input from the facilities and practitioners, determines that this reduction is needed to ensure that senior clinicians achieve adequate balance in time spent in auditing and time spent in clinical activities and oversight.

3. Implementation of the EP

- a. PSH has accelerated its progress in implementing the EP, led by an effective clinical leadership team and highly qualified and dedicated practitioners. The facility's progress is outlined in each corresponding section of this report.
- b. The facility has made progress in streamlining both the process and content of the WRP review with input from practitioners. This is an important step in achieving a reasonable balance between documentation and direct care and assisting the WRPTs in their efforts to focus on the most relevant current needs of the individuals.
- c. PSH has made significant progress in addressing previous findings regarding the formulation of treatment objectives that were measurable and observable but had little relevance to the actual needs of the individuals. During this review, most of the treatment objectives were clinically meaningful, more concise and well aligned with the current needs of the individuals.

- d. The facility has maintained effective cognitive remediation and substance use education programs that meet the needs of individuals who suffer from cognitive impairments and/or substance use disorders.
- e. The WRPs of individuals suffering from seizure disorders included objectives that were well-aligned with the current needs of individuals and that utilized appropriate learning outcomes.
- f. PSH has maintained progress in ensuring a well-functioning PSR Mall that meet the specific treatment/rehabilitation needs of the individuals.
- g. PSH has adequately implemented its current risk management procedure, including the following areas:
 - i. Timely and appropriate documentation of the incident;
 - ii. Review of the incident by the treating, covering or on-call psychiatrists within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individuals and/or others;
 - iii. Attention by the WRPT of the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;
 - iv. Tracking by risk management staff of the incidents that constitute triggers or thresholds requiring progressive levels of reviews; and
 - v. Review and recommendations by the Facility Review Committee of situations that require this level.
- h. PSH has initiated a new process of post-assault intensive case analysis in response to issues that were identified during the last review. The analysis addressed incidents of serious aggression that did not reach the threshold for sentinel events. The reviews, led by the Chief of Psychiatry, Rebecca Kornbluh, MD, identified a variety of systemic issues, some of which required immediate corrective actions. Some of the corrective actions have been initiated following a review by the Quality Council.
- i. PSH has made recent progress in addressing previous findings regarding the oversight system of the Quality Management System, particularly in the area of violence reduction. In this regard, the following comments are relevant:
 - i. There are numerous clinical and systemic factors that impact violence in any facility. During the course of the facility's implementation of the EP, significant progress has been made in resolving many of these factors, including but not limited to the provision of timely and appropriate disciplinary assessments and services that comport with generally accepted standards of care and the quality of interdisciplinary collaboration in the development and implementation of an effective treatment planning system that address both symptoms of mental illness and the functional impairments that underlie and accompany the illness.
 - ii. More recently, under the leadership of the Medical Director, George Christison, MD, the facility began the processes of review and analysis of violent incidents to determine systemic patterns and trends and to develop and implement corresponding corrective actions that are well-aligned with the facility's needs.
 - iii. The analyses in this and other facilities in the system are pointing to two main areas that require further work to ensure that the gains in clinical standards will not be undermined by systemic challenges. The first challenge is to ensure that individuals who require a level of custodial security that cannot be provided within a psychiatric hospital setting are placed

in settings that can provide this level of security. This of course should be based on objective criteria derived from generally accepted standards in the area of violence risk assessment. The current violence risk assessment, as part of the admission psychiatric assessments, is adequate as a clinical tool but further assessments will be needed to delineate the precise characteristics of individuals whose aggression is driven primarily by psychopathy and who require a higher level of security. Currently, there is a legislative venue for DMH to successfully address this matter and DMH has already recognized this matter in its Strategic Action Plan to reduce aggression. The second challenge is to implement more appropriate settings and/or treatment models within the hospitals to meet the needs of the most acutely ill individuals who are prone to severe impulsive and/or psychotic aggression and for whom psychiatric models are proven to be effective. In this regard, the facility's initiative to utilize, and train staff on the use of a medication algorithm suited to the most acutely ill individuals (STOP-A) is very timely and appropriate. To ensure due process protection, individuals in the second category must be clearly delineated from those in the first.

- iv. The facility's progress on meeting these two challenges is critical to achieving/maintaining substantial compliance with EP requirements in the section regarding Protection from Harm.
- v. The development of plans to reduce aggression (i.e. the DMH Strategic Action Plan and the corresponding action plans at the facility level) is necessary to achieve compliance; but it is not sufficient; only action is.

4. Staffing

The table below shows the staffing pattern at PSH as of April 30, 2011:

Patton State Hospital Vacancy Totals as of April 30, 2011				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0%
Assistant Director of Dietetics	5.00	5.00	0.00	0%
Audiologist I	1.00	1.00	0.00	0%
Chief Dentist	1.00	1.00	0.00	0%
Chief Physician & Surgeon	1.00	1.00	0.00	0%
Chief, Central Program Services	0.00	0.00	0.00	0%
Chief Psychologist	1.00	1.00	0.00	0%
Clinical Dietician/Pre-Reg. Clin Dietician	15.00	13.00	2.00	13%

Patton State Hospital Vacancy Totals as of April 30, 2011

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Clinical Laboratory Technologist	0.00	0.00	0.00	0%
Clinical Social Worker	105.50	93.50	12.00	11%
Coordinator of Nursing Services	1.00	1.00	0.00	0%
Coordinator of Volunteer Services	1.00	1.00	0.00	0%
Dental Assistant	4.00	4.00	0.00	0%
Dentist	2.00	2.00	0.00	0%
Dietetic Technician	4.00	3.00	1.00	25%
E.E.G. Technician	0.00	0.00	0.00	0%
Food Services Technician I and II	113.00	105.00	8.00	7%
Hospital Worker	0.00	0.00	0.00	0%
Health Record Technician I	8.00	8.00	0.00	0%
Health Record Techn II Spec	3.00	3.00	0.00	0%
Health Record Techn II Supv	1.00	1.00	0.00	0%
Health Record Techn III	1.00	1.00	0.00	0%
Health Services Specialist	24.00	19.00	5.00	21%
Institution Artist Facilitator	0.00	0.00	0.00	0%
Licensed Vocational Nurse	66.00	64.00	2.00	3%
Medical Technical Assistant	0.00	0.00	0.00	0%
Medical Transcriber	5.00	4.00	1.00	20%
Medical Transcriber Sup	0.00	0.00	0.00	0%
Sr Medical Transcriber	2.00	1.00	1.00	50%
Nurse Instructor	5.00	5.00	0.00	0%
Nurse Practitioner	5.00	5.00	0.00	0%
Nurse Coordinator	12.00	9.00	3.00	25%

Patton State Hospital Vacancy Totals as of April 30, 2011

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Office Technician	33.00	33.00	0.00	0%
Pathologist	0.00	0.00	0.00	0%
Pharmacist I	15.00	15.00	0.00	0%
Pharmacist II	1.00	1.00	0.00	0%
Pharmacist Services Manager	1.00	0.00	1.00	100%
Pharmacy Technician	11.00	10.00	1.00	9%
Physician & Surgeon	23.00	22.75	0.25	1%
Podiatrist	1.00	1.00	0.00	0%
Pre-Licensed Pharmacist	0.00	0.00	0.00	0%
Pre-Licensed Psychiatric Technician	1.00	1.00	0.00	0%
Program Assistant	8.00	8.00	0.00	0%
Program Consultant (RT,PSW)	0.00	0.00	0.00	0%
Program Director	10.00	8.00	2.00	20%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0%
Psychiatric Technician	701.00	657.00	44.00	6%
Psychiatric Technician Trainee	0.00	0.00	0.00	0%
Psychiatric Technician Assistant	35.00	34.00	1.00	3%
Psychiatric Technician Instructor	1.00	1.00	0.00	0%
Psychologist-HF, (Safety)	70.50	68.25	2.25	3%
Public Health Nurse II	2.00	2.00	0.00	0%
Radiological Technologist	1.00	1.00	0.00	0%
Registered Nurse	408.00	380.00	28.00	7%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0%
Rehabilitation Therapist	93.30	81.75	11.55	12%

Patton State Hospital Vacancy Totals as of April 30, 2011				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Special Investigator	9.00	8.00	1.00	11%
Special Investigator, Senior	0.00	0.00	0.00	0%
Speech Pathologist I	1.00	1.00	0.00	0%
Sr. Psychiatrist (Spvr)	13.20	13.00	0.20	2%
Sr. Psychologist (Spvr and Spec)	25.50	24.00	1.50	6%
Sr. Psych Tech (Safety)	80.00	80.00	0.00	0%
Sr. Radiological Technologist (Specialist)	1.00	1.00	0.00	0%
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor	3.00	1.00	2.00	67%
Staff Psychiatrist	95.40	80.00	15.40	16%
Supervising Psychiatric Social Worker	5.00	5.00	0.00	0%
Supervising Registered Nurse	3.00	2.00	1.00	33%
Supervising Rehabilitation Therapist	4.00	3.00	1.00	25%
Teacher-Adult Educ./Vocational Instructor	14.40	8.00	6.40	44%
Teaching Assistant	0.00	0.00	0.00	0%
Unit Supervisor	33.00	29.00	4.00	12%
Vocational Services Instructor (0.00	0.00	0.00	0%

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with staff, facility and State administrative and clinical leaders;

4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial compliance with any Section of the EP for eighteen consecutive months (four reviews), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Patton State Hospital December 5-9, 2011.
2. The Court Monitor's team is scheduled to tour Napa State Hospital July 25-29, 2011 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has strengthened and consolidated its WRP training/mentoring activities and begun implementation of a streamlined version of the WRPs. This work has resulted in improvements in the clinical meaningfulness of treatment/rehabilitation objectives and the WRPTs' ability to track the individuals' treatment/rehabilitation needs and progress towards discharge. In addition, this is a significant step to serve the practitioners' need to find a reasonable balance between documentation and direct care and to assist them in focusing on the main needs of their individuals. 2. PSH has maintained substantial compliance with the requirements of Section C.1. 3. PSH has achieved substantial compliance with all the requirements of Section C.2, including progress in ensuring that the WRP treatment/rehabilitation objectives adequately address the current needs of the individuals. 4. PSH has provided data showing positive clinical outcomes for individuals suffering from substance use disorders. 5. PSH has maintained strong cognitive remediation programs to address the needs of individuals with cognitive impairments. 6. PSH has made further progress in ensuring that the WRPs of individuals suffering from seizure disorders include objectives that are aligned with the current needs of individuals and that utilize appropriate learning outcomes. 7. PSH has increased the number of specialty Mall groups with the intent of reducing Mall group non-adherence and to provide group-specific curricula. 8. PSH's Supplemental Activity scope of activities and organizational structure and procedures have improved significantly 9. The quality of Mall groups observed, especially the Substance Abuse

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recovery Mall groups, has improved significantly.</p> <p>Areas of need include:</p> <ol style="list-style-type: none"><i>1. PSH should proceed with full and careful implementation of current WRP streamlining efforts.</i><i>2. PSH needs to ensure that the WRPTs are able to track, in a measurable manner, the individuals' progress in achieving the revised treatment/rehabilitation objectives.</i><i>3. PSH needs to use a consistent approach to addressing the technical formatting problem of documenting the individuals' "strength description" in the current WaRMSS.</i>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Daphne Erhart, PhD, Acting Wellness and Recovery Planning Chief 2. Gari-Lyn Richardson, Standards Compliance Director 3. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH update of WRP training and mentoring activities provided to the WRPTs during the review period 2. DMH Streamlined Quarterly and Annual WRP Guidelines-Pilot, February 2011 3. PSH WRP Streamlining Instructions 4. Outline of PSH training on WRP Streamlining 5. WRP Streamlining training slides 6. PSH Guidelines for Creating Objectives, April 28, 2011 7. PSH Clinical Chart Auditing Form summary data (November 2010 to April 2011) 8. PSH WRP Observation Monitoring summary data (November 2010 to April 2011) 9. PSH WRP Team Facilitator Observation Monitoring Form summary data (November 2010 to April 2011) 10. PSH data regarding staffing ratios on admissions and long-term units (November 2010 to April 2011) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 06) for review of JD 2. WRPC (Program I, unit 74) for review of EM 3. WRPC (Program I, unit EB04) for review of LG 4. WRPC (Program I, unit EB11) for review of NK 5. WRPC (Program III, unit 30) for review of MAK 6. WRPC (Program III, unit 31) for review of OVM

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>7. WRPC (Program III, unit 33) for review of TMM 8. WRPC (Program IV, unit 36) for review of RS 9. WRPC (Program V, unit N22) for review of SWD 10. WRPC (Program V, unit N23) for review of KG 11. WRPC (Program VII, unit 73) for review of DDR 12. WRPC (Program VIII, unit N20) for review of JC</p>
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Provide an update of WRP training and mentoring activities provided to the WRPTs during the review period. • Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners. <p>Findings:</p> <p>During this review period, the facility modified and consolidated the previously described training and mentoring activities. The goals were to address the use of a streamlined WRP/case formulation, improve the clinical meaningfulness of treatment objectives and facilitate periodic tracking of the individual's treatment/rehabilitation needs and the pathways towards discharge. To this end, all mentors and WRPTs received training/mentoring as follows:</p> <ol style="list-style-type: none"> 1. On February 15, 2011, Daphne Erhart, PhD, Acting Wellness and Recovery Planning Chief trained all discipline seniors, Program-wide trainers, and discipline chiefs as well as 90% of the conference coordinators (the coordinators who couldn't attend received 1:1 updates at a later date by their Program-wide trainers). This training emphasized WRP streamlining guidelines that included but were not limited to consolidation of the different components of the case formulation and the use of a monthly mechanism to review pertinent information to determine if a full monthly WRP is to be completed

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>within WaRMSS or an abbreviated review can be completed within a "Monthly Form."</p> <ol style="list-style-type: none"> 2. Seven follow-up trainings were held on March 2011 (one for each Program) to ensure that the information from the above training was fully learned. Program management was included in these trainings. These trainings were attended by all discipline seniors, Program-wide trainers and nursing mentors as well as 86% of Program directors and Pprogram assistants. 3. A follow-up training on "How to Write a Meaningful Objective" was provided to all mentors on April 27, 2011. During this training, mentors created objectives during the training to ensure they had acquired the needed skill. Materials were provided for teaching their teams how to write objectives that are individualized and helpful for the individual to move towards meeting their treatment goals and discharge. All discipline seniors, Pprogram-wide trainers and nursing mentors attended this training (with the exception of one rehabilitation therapist who was provided the information at a later date). 4. Extra trainings were provided as needed for any mentors or staff needing extra help or consultation during the months of February 2011 through May 2011. These were available in group settings or 1:1 consultation according to the staff member's need. 5. The facility continued conference mentoring and all 68 teams throughout the hospital were assigned a conference mentor (on February 15, 2011). Each mentor was responsible for 2-3 teams. Mentors consisted of all senior psychiatrists, senior psychologists, lead social workers, lead rehab therapists, and Program-wide trainers. Each mentor personally attended to their teams' conferences on a weekly basis for approximately two months (depending on the team's need). Mentoring focused on the information learned from the above trainings. 6. By May 20, 2011, the following was achieved: <ol style="list-style-type: none"> a. All WRPTs completed mentorship/training.
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>b. Mentors monitored their teams' development of individualized and clinically meaningful WRP objectives to help the individuals meet their treatment/rehabilitation goals.</p> <p>c. Sixty-six out of 68 teams modified treatment/rehabilitation objectives for their entire caseload and the two remaining teams modified at least half of their caseloads' objectives.</p> <p>Recommendation 3, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPCs held each month (November 2010 - April 2011):</p> <table border="1" data-bbox="980 743 1877 1081"> <tr> <td data-bbox="980 743 1075 894">1.</td> <td data-bbox="1075 743 1780 894"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1780 743 1877 894">98%</td> </tr> <tr> <td data-bbox="980 894 1075 1081">2.</td> <td data-bbox="1075 894 1780 1081"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1780 894 1877 1081">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>Other findings: The monitor and his experts attended 12 WRPCs. The meetings showed further progress in the overall process of the team meetings, including improved ability to focus on the main current needs of the individuals while adhering to the process steps of the WRPCs.</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	98%	2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	95%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	98%						
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the review period. 2. Ensure full implementation of the streamlined WRPs. 3. Continue to monitor this requirement. 									
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 98% based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 69% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 1227 1881 1416"> <tr> <td data-bbox="982 1227 1079 1268">1.</td> <td data-bbox="1079 1227 1787 1268"><i>The team psychiatrist was present.</i></td> <td data-bbox="1787 1227 1881 1268">92%</td> </tr> <tr> <td data-bbox="982 1268 1079 1341">2.</td> <td data-bbox="1079 1268 1787 1341"><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td data-bbox="1787 1268 1881 1341">100%</td> </tr> <tr> <td data-bbox="982 1341 1079 1416">3.</td> <td data-bbox="1079 1341 1787 1416"><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully</i></td> <td data-bbox="1787 1341 1881 1416">100%</td> </tr> </table>	1.	<i>The team psychiatrist was present.</i>	92%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully</i>	100%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td data-bbox="976 190 1081 230"></td> <td data-bbox="1081 190 1785 230"><i>updated.</i></td> <td data-bbox="1785 190 1879 230"></td> </tr> <tr> <td data-bbox="976 230 1081 305">4.</td> <td data-bbox="1081 230 1785 305"><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td data-bbox="1785 230 1879 305">95%</td> </tr> </table>		<i>updated.</i>		4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	95%
	<i>updated.</i>							
4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	95%						
C.1.c	Function in an interdisciplinary fashion.	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all the items.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <hr/> <p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 99% based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.d</p>	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, PSH reported a compliance rate of 98% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.1.e</p>	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 98% based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendation: Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 100% for the review period, based on a 19% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (November 2010 - April 2011):</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>5. <i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p>	<p>100%</p>																					
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																						
<p>C.1.h</p>	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented core WRPT member attendance data based on an average sample of 19% of quarterly and annual WRPCs held during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="982 1118 1745 1424"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>86%</td> <td>86%</td> </tr> <tr> <td>Psychiatrist</td> <td>90%</td> <td>92%</td> </tr> <tr> <td>Psychologist</td> <td>86%</td> <td>95%</td> </tr> <tr> <td>Social Worker</td> <td>90%</td> <td>93%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>89%</td> <td>97%</td> </tr> <tr> <td>Registered Nurse</td> <td>97%</td> <td>97%</td> </tr> </tbody> </table>			Previous review period	Current review period	Individual	86%	86%	Psychiatrist	90%	92%	Psychologist	86%	95%	Social Worker	90%	93%	Rehabilitation Therapist	89%	97%	Registered Nurse	97%	97%
	Previous review period	Current review period																						
Individual	86%	86%																						
Psychiatrist	90%	92%																						
Psychologist	86%	95%																						
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Rehabilitation Therapist	89%	97%																						
Registered Nurse	97%	97%																						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Psychiatric Technician	97%	97%	<p>The data showed attendance rates at higher than 90% for all professional disciplines, which represents progress since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																				
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data on average case load ratios:</p>			<table border="1"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:16</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:6</td> <td>1:6</td> </tr> <tr> <td>PTs</td> <td>1:3</td> <td>1:3</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:25</td> <td>1:25</td> </tr> <tr> <td>PhDs</td> <td>1:26</td> <td>1:25</td> </tr> <tr> <td>SWs</td> <td>1:25</td> <td>1:25</td> </tr> </tbody> </table>		Previous review period	Current review period	Admission Units			MDs	1:15	1:15	PhDs	1:16	1:15	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:6	1:6	PTs	1:3	1:3	Long-Term Units			MDs	1:25	1:25	PhDs	1:26	1:25	SWs	1:25	1:25
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		RTs	1:25	1:25	
		RNs	1:8	1:8	
		PTs	1:3	1:3	
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as C.1.a through C.1.f.</p> <p>Findings: Same as C.1.a through C.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as C.1.a through C.1.f.</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alejandro Fernandez, Senior Rehabilitation Therapist 2. Allison Rembulat, RT, PWT 3. Andrew Blaine, MD, Chief of Medical Staff 4. Bolos Acherohogue Luzviminda, RN 5. Chris Keierleber, Senior Rehabilitation Therapist 6. Connie Etter, RT, Assistant Chief, Enhancement Services, Supplemental Activity Assistant 7. Daphne Erhart, PsyD, Acting Wellness and Recovery Planning Chief 8. Daryl Oddell, PT 9. David Haimson, PhD, Chief of Psychology 10. Delores Otto-Moreno, Assistant Director of Nutrition Services 11. Denise Byerly, POST Coordinator 12. Erica Easterly, Psy.D, PWT 13. Erin Cross, RT, PWT (Program Wide Trainer) 14. Ethel Wanyana, RN 15. Gari-Lyn Richardson, Director, Standards Compliance 16. George Christison, MD, Medical Director 17. Glenna Briney, CSW 18. Grace Ferris, Assistant Director of Nutrition Services 19. Greg Siples, Chief of Rehabilitation Therapy 20. Helga Thordarson, PhD, Senior Supervising Psychologist 21. J.L. Guffey, RT 22. Jennifer Vuelas, PT 23. Joanne Person, PT 24. Jonathan Meyer, MD, Staff Psychiatrist, Director Substance Abuse Services 25. Jonathan Monroe, PT 26. Jose Arcualo, PT 27. Joseph Greene, LCSW, PWT

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>28. Julie Yang, Psy.D 29. Kathleen McIntire, Senior Rehabilitation Therapist 30. Kim Braxton, CSW 31. Kristina Hooper, Assistant Director of Nutrition Services 32. Lori Hely, P 33. Mark Richards, PT, By Choice Assistant Coordinator 34. Mark Williams, PhD, PBS Team member 35. Melanie Byde, PhD, Senior Psychologist, Mall Director 36. Melissa Hudson, Sr. PT 37. Micheal Guerrero, PT 38. Nguyen, Shana Chau, SMD 39. Paul Malko, US 40. Rebecca Griffin, Senior Rehabilitation Therapist 41. Rebecca Kornbluh, MD, Acting Chief of Psychiatry 42. Robert Koranda, Psy.D, PWT 43. Robbin Huff-Musgrove, PhD, Senior Psychologist 44. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 45. Stan Hydinger, Senior Rehabilitation Therapist 46. Steve Berman, PhD, By Choice Coordinator 47. Susan Meader, PT 48. Susan Velasquez, PhD, PSSC Coordinator 49. Tai Kim, Director of Nutrition Services 50. Utae Kamishiro, RT 51. Vivian Collins, Assistant Director of Nutrition Services</p> <p><u>Reviewed:</u></p> <p>1. The charts of 145 individuals: AA, AAD, AC, ADC, AFR, AKA, ARC, AS, BC, BDM, BH, BR, CA, CC, CCB, CCX, CG, CH, CJ, CJ, CM, CMB, DA, DB, DC, DEA, DEN, DH, DLT, DMJ, DRS, DRW, DWW, EA, EH, EKE, ERA, ET, EV, GC, GFV, GH, GJG, GRW, GS, HME, HW, IM, ISL, JAD, JAP, JBW, JC, JCW, JF, JFT, JG, JHB, JJG, JJJ, JL, JMM, JNC, JNL, JPW, JQ, JR, JRM, JS, JSD, JST, JU, JWA, KCP, KE, KJ, KM, LEL, LG, LR, LRR, MAS, MAW, MBJ, MEH, MHL, MT, NM, NMJ,</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>OC, OM, PCG, PG, PH, PT, RAH, RAO, RB, RCP, RG, RK, RLA, RLK, RMJ, RMT, RO, RP, RPE, RR, RRA, RRB, RRD, RSH, RSS, RW, RY, SB, SBP, SC, SDH, SDJ, SHK, SJ, SMK, SMM, SO, SP, SWS, TC, TCG, TFP, TG, TH, THH, TM, TRK, TS, VGR, VQ, VT, WB, WD, WDW, WGA and WK</p> <ol style="list-style-type: none"> 2. One WRP per team for the following 68 individuals: AB, AP, ASR, BRA, BT, CAB, CJS, CRR, DAS, DB, DDG, DEB, DGA, DNK, DRJ, DT, ECA, EK, EMM, EO, ET, FRD, FW, GA, GAF, GC, GIW, GLC, GS, HAL, HRB, ICH, JAE, JAM, JCM, JMU, JP, JTF, JU, LEF, LGM, LJP, LL, MB, MP, MTH, NAL, OB, PAB, RAG, RB, RDP, RLK, RMM, RMT, RRR, RS, RW, SAO, SGD, SH, SL, SNC, SR, SSS, ST, TBM and VEB 3. Current WRP with corresponding Focus 1 PSR Mall Progress Notes for the following five individuals: JMM, JS, NM, OC and PH 4. Single document outlining number and hours of cognitive remediation groups provided; current review period and prior review period 5. Master List of all Cognitive Remediation Groups 6. Neuropsychology Testing for JNL 7. Lesson Plans (2) for group <u>Cognitive Remediation</u> for DEA, JNL, MBJ, RMT, SO, VQ 8. Lesson Plan for group <u>RISE: Neuro-cognitive Training Assisted/Supported</u> for JBW and TCG 9. Lesson Plan for group <u>New Hope (Cognitive)</u> for WK 10. Lesson Plan for group <u>Circle of Many Colors</u> for AFR 11. Lesson Plan for group <u>Substance Recovery</u> for GFV and LR 12. Lesson Plan for group <u>CARE-MI Precontemplation/Contemplation</u> 13. Lesson Plan for group <u>CARE MI Contemplation/Preparation</u> 14. Master list of Substance Abuse groups scheduled for the evaluation week 15. Revised NSH Staging Questionnaire 16. East/Central and West Side Substance Abuse Proposals by Jonathan Meyer, MD 17. Proposal for Future Direction in Substance Abuse Treatment in the West Compound
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> 18. Proposal for Substance Abuse/Addiction Groups on the East and Central Compound 19. PSH WRP Observation Monitoring summary data (November 2010 to April 2011) 20. PSH Clinical Chart Auditing Form summary data (November 2010 to April 2011) 21. PSH Chart Auditing Form summary data (November 2010 to April 2011) 22. PSH Integration of Medical Conditions in WRP summary data (November 2010 to April 2011) 23. Summary data substance abuse process and clinical outcomes 24. PSH Consumer Satisfaction Survey summary data 25. PSH WRP Substance Abuse Auditing Form summary data (November to April 2010/2011) 26. PBS/BG implementation with Unit Staff 27. Curriculum and Lesson Plans for Mall group (Success Stories) 28. Curriculum and Lesson plans for Mall group (Exertion 3: Seasonal Sports) 29. Curriculum and Lesson Plans for Mall group (Line Dancing) 30. Lesson Plans and Handouts for Mall group (Health Relationships) 31. Lesson Plans and Worksheets for Mall group (Cultural Awareness and Identify) 32. List of individuals with Substance Abuse Diagnosis 33. List of individuals with high triggers 34. List of Supplemental Activities offered during this review period 35. Completed Mall Facilitator Observation Sheets 36. Supplemental Activity Monthly Calendar (May 2011) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Substance Abuse group <u>Beginning Relapse Prevention</u>, Action and Maintenance stages, facilitated by Georgiana Vinson, Registered Nurse 2. Substance Abuse group <u>Education & Recovery from Addiction</u>, Pre-
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>contemplative stage, facilitated by Lisa Logan, Clinical Social Worker and Anthony Fletcher, Rehabilitation Therapist</p> <ol style="list-style-type: none"> 3. Substance Abuse group <u>Co-occurring Disorders</u>, Action stage, facilitated by Kathy Freeman, Clinical Social Worker and Melissa Roskos, Rehabilitation Therapist 4. Mall Group: Cultural Awareness and Identity 5. Mall Group: Origami 6. Mall Group: Healthy Relationship: Boundaries and Respect 7. Therapeutic Community group activity (Unit 36) 8. Therapeutic Community group activity (Unit 32) 9. WRPC (Program III, Unit 33) for quarterly review of TMM 10. WRPC (Program I, Unit EB04) for quarterly review of LG 11. WRPC (Program III, Unit 31) for quarterly review of OVM
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 98% based on an average sample of 19% of the WRPCs held each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (November 2010 - April 2011). Based on an average sample of 36% of the A-WRPs, the facility reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals admitted during the review period (AFR, GFV, JG, JJJ, LR and RCP) and found compliance in five charts and noncompliance in one (RCP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Based on an average sample of 52% of the 7-day WRPs, the facility reported a mean compliance rate of 96% with this requirement. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals and found compliance in all cases (AFR, GFV, JG, JJJ, LR and RCP R).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="993 1081 1650 1312"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>34%</td> <td>96%</td> </tr> <tr> <td>Monthly</td> <td>14%</td> <td>96%</td> </tr> <tr> <td>Quarterly</td> <td>22%</td> <td>91%</td> </tr> <tr> <td>Annual</td> <td>21%</td> <td>93%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	34%	96%	Monthly	14%	96%	Quarterly	22%	91%	Annual	21%	93%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	34%	96%															
Monthly	14%	96%															
Quarterly	22%	91%															
Annual	21%	93%															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
C.2.c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 14% to 80% of the relevant population for each sub-indicator during the review period (November 2010 - April 2011).</p> <table border="1" data-bbox="991 857 1885 1383"> <tr> <td data-bbox="991 857 1087 1042">2.</td> <td data-bbox="1087 857 1789 1042"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1789 857 1885 1042">95%</td> </tr> <tr> <td data-bbox="991 1042 1087 1156">2.a</td> <td data-bbox="1087 1042 1789 1156"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1789 1042 1885 1156">92%</td> </tr> <tr> <td data-bbox="991 1156 1087 1269">2.b</td> <td data-bbox="1087 1156 1789 1269"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1789 1156 1885 1269">97%</td> </tr> <tr> <td data-bbox="991 1269 1087 1383">2.c</td> <td data-bbox="1087 1269 1789 1383"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1789 1269 1885 1383">96%</td> </tr> </table>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	95%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	92%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	97%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	96%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Comparative data indicated that PSH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p> <p>Recommendation 2, December 2010: Provide a summary of changes in the number, range and content of cognitive rehabilitation interventions during the review period.</p> <p>Findings: During this review period, the facility increased the number of cognitive remediation group offerings from 32 to 36. The courses and curricula remained unchanged from the previous review period.</p> <p>Other findings: This monitor reviewed the following:</p> <ol style="list-style-type: none"> 1. The charts of nine individuals suffering from the following cognitive disorders: <ol style="list-style-type: none"> a. Dementia Due to General Medical Condition with Behavioral Disturbance (VQ); b. Dementia Due to General Medical Condition without Behavioral Disturbance (JNL and SO); c. Mild Mental Retardation (MBJ, TCG and WK); d. Moderate Mental retardation (RMT); and e. Cognitive Disorder NOS (DEA and JBW); and 2. The charts of six individuals diagnosed with seizure disorders (AA, EH, GRW, MAS, TCG and WGA). <p>The reviews found general evidence that PSH has maintained progress in the following areas:</p> <ol style="list-style-type: none"> 1. Review of seizure activity and workup for the seizure disorder; 2. Review of cognitive functioning (for individuals with cognitive
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>impairments);</p> <ol style="list-style-type: none"> 3. The use of learning-based and clinically meaningful objectives to address the needs of individuals diagnosed with cognitive impairments and/or seizure disorders; 4. The performance of cognitive assessments/screening tests and/or neuropsychological testing to determine the level and scope of cognitive dysfunction and assist in the cognitive diagnosis; 5. Provision of formal and informal cognitive remediation interventions for individuals diagnosed with cognitive disorders. Examples include the following: <ol style="list-style-type: none"> a. Cognitive Remediation (DEA, JNL, MBJ, RMT, SO and VQ); b. RISE: Neurocognitive Training Assisted/Supported (JBW and TCG); and c. New Hope, Cognitive (WK). 6. Completion of timely neurological consultations to address the needs of individuals with seizure disorders; and 7. Caution in the use of long-term high-risk medications (e.g. anticholinergics and benzodiazepines) for individuals diagnosed with cognitive impairments. <p>The review found no evidence that neurological consultation addressed an individual's status relative to the continued use of high-risk anticonvulsant in presence of cognitive impairment (EH).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide a summary of changes in the number, range and content of cognitive rehabilitation interventions during the review period.
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	Compliance: Substantial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Ensure that current streamlining efforts facilitate linkage between case formulations and treatment objectives (i.e. treatment objectives adequately address the current status of the individual).</p> <p>Findings: PSH training material regarding WRP streamlining adequately addressed this recommendation.</p> <p>Recommendation 2, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH reported a compliance rate of 99% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained compliance rates of at least 90% from the previous review period for all of the requirements in C.2.d.i to C.2.d.vi.</p> <p>Other findings: This monitor reviewed one WRP per team (#68) at PSH for the following individuals: AB, AP, ASR, BRA, BT, CAB, CJS, CRR, DAS, DB, DDG, DEB,</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>DGA, DNK, DRJ, DT, ECA, EK, EMM, EO, ET, FRD, FW, GA, GAF, GC, GIW, GLC, GS, HAL, HRB, ICH, JAE, JAM, JCM, JMU, JP, JTF, JU, LEF, LGM, LJP, LL, MB, MP, MTH, NAL, OB, PAB, RAG, RB, RDP, RLK, RMM, RMT, RRR, RS, RW, SAO, SGD, SH, SL, SNC, SR, SSS, ST, TBM and VEB.</p> <p>This review found general evidence that PSH has maintained substantial compliance with this requirement of the EP and made sufficient progress in improving the linkage between the case formulation and the foci and objectives outlined in the WRP (see C.2.e and C.2.f.iii).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	Same as above.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	Same as above.
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	Same as above.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	Same as above.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the	Same as above.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>changes that will be necessary to achieve discharge.</p>	
<p>C.2.e</p>	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Same as in C.2.d.i. • Continue to monitor this requirement. <p>Findings: Using the DMH WRP Chart Auditing Form, PSH reported a compliance rate of 99% based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the records of 27 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.e. Twenty-five records were in substantial compliance (AAD, AKA, CA, CC, CCB, CH, CM, DC, DEN, DMJ, EH, GJG, JCW, JHB, KE, LEL, RB, RLA, RRA, RRD, SB, SBP, SMK, TS and VGR) and two records were not in compliance (SC and VT).</p> <p>This monitor also reviewed the records of 14 individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Twelve records were in substantial compliance (AAD, ARC, AS, DA, GC, HW, KE, PCG, SB, SDH, SP and TS) and two records were not in compliance (EH and ISL).</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Finally, this monitor reviewed the records of 14 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH assessed its compliance with the requirements in C.2.f.i through C.2.f.v based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 95%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ, LR and RCP) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH reported a compliance rate of 99% based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ, LR and RCP) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Same as in C.2.d.i. • Continue to monitor this requirement. <p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ, LR and RCP) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ,</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>LR and RCP) and found substantial compliance in four cases and partial compliance in two (AFR and GFV).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ, LR and RCP) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

provided as part of the 20 hours of active treatment per week;

Findings:

PSH presented the following data for the review period (November 2010 - April 2011):

Number of individuals by category		
	Mean scheduled hours	Mean attended hours
N	1571	1571
Hours:		
0-5	12	67
6-10	8	72
11-15	13	76
16-20	1538	1347

Mall Attendance		
	Previous period	Current period
Mean number of individuals		
0-5 hours	49	67
6-10 hours	52	72
11-15 hours	65	76
16-20+ hours	1,425	1347

This monitor reviewed the charts of 10 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found that there was good correspondence between the WRP scheduled hours and the MAPP scheduled hours.

The following table summarizes the monitor's findings:

Individual	WRP scheduled	MAPP	MAPP attended
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <thead> <tr> <th></th> <th>hours</th> <th>scheduled hours</th> <th>hours</th> </tr> </thead> <tbody> <tr> <td>ADC</td> <td>18</td> <td>18</td> <td>15</td> </tr> <tr> <td>BH</td> <td>20</td> <td>20</td> <td>N/A</td> </tr> <tr> <td>DB</td> <td>18</td> <td>18</td> <td>9</td> </tr> <tr> <td>JC</td> <td>20</td> <td>20</td> <td>4</td> </tr> <tr> <td>LG</td> <td>20</td> <td>20</td> <td>N/A</td> </tr> <tr> <td>OM</td> <td>19</td> <td>20</td> <td>N/A</td> </tr> <tr> <td>RG</td> <td>19</td> <td>0</td> <td>0</td> </tr> <tr> <td>RY</td> <td>20</td> <td>20</td> <td>7</td> </tr> <tr> <td>TM</td> <td>20</td> <td>20</td> <td>N/A</td> </tr> <tr> <td>WD</td> <td>18</td> <td>18</td> <td>13</td> </tr> </tbody> </table> <p>The N/A for MAPP attended hours indicates that the hours were not posted for entry. As the table above indicates, there appear to be issues to be remedied with regard to MAPP data on attended hours. However, the WRP scheduled hours and the MAPP scheduled hours were highly correlated except in the case of RG.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		hours	scheduled hours	hours	ADC	18	18	15	BH	20	20	N/A	DB	18	18	9	JC	20	20	4	LG	20	20	N/A	OM	19	20	N/A	RG	19	0	0	RY	20	20	7	TM	20	20	N/A	WD	18	18	13
	hours	scheduled hours	hours																																											
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JC	20	20	4																																											
LG	20	20	N/A																																											
OM	19	20	N/A																																											
RG	19	0	0																																											
RY	20	20	7																																											
TM	20	20	N/A																																											
WD	18	18	13																																											
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	There has been no change at PSH regarding off-site programming for civilly committed individuals. Civilly committed individuals are not programmed for off-site visits due to the difficulty in coordinating such events with the Hospital Police, who are required to accompany individuals on any off-site trip (California Welfare and Institutions Code, Section 4107(a)). When possible, PSH continues to transfer individuals with the potential for off-site visits to other State facilities with off-site options.																																												

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.f.viii</p>	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 21% of the quarterly and annual WRPs due each month for the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of seven individuals found substantial compliance in all seven (CJ, KJ, KM, MHL, RAO, RG and RLK). These seven individuals had been assigned to groups that pertained to their diagnoses, discharge criteria, life goals, and other preferences (e.g. leisure and recreation) and needs (e.g. medical issues).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.g</p>	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.g.i</p>	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AFR, GFV, JG, JJJ, LR and RCP) and found substantial compliance in all cases.</p> <p>This monitor also reviewed the records of 20 individuals receiving direct speech, occupational, and physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.g.ii</p>	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, the facility reported a</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compliance rate of 97% based on an average sample of 82% of individuals placed in seclusion and/or restraint each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraint during this review period. The review focused on the documentation in the Present Status section of the circumstances leading to the use of restrictive intervention. The assessment of treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences is now part of the monitor's review of psychiatric reassessments (see D.1.f.). The following tables outlines this review:</p> <table border="1" data-bbox="991 781 1879 1049"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td>JMM</td> <td>4/30/11</td> <td>5/5/11</td> </tr> <tr> <td>JS</td> <td>4/24/11</td> <td>5/4/11</td> </tr> <tr> <td>NM</td> <td>5/5/11</td> <td>5/9/11</td> </tr> <tr> <td>OC</td> <td>4/7/11</td> <td>5/31/11</td> </tr> <tr> <td>PH</td> <td>4/18/11</td> <td>5/31/11</td> </tr> </tbody> </table> <p>The review found substantial compliance in five cases and partial compliance in one (PH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	JMM	4/30/11	5/5/11	JS	4/24/11	5/4/11	NM	5/5/11	5/9/11	OC	4/7/11	5/31/11	PH	4/18/11	5/31/11
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JMM	4/30/11	5/5/11																		
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NM	5/5/11	5/9/11																		
OC	4/7/11	5/31/11																		
PH	4/18/11	5/31/11																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.g.iii</p>	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 98% based on an average sample of 19% of the quarterly and annual WRPCs held each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in all cases (AFR, GFV, JG, JJJ, LR and RCP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.g.iv</p>	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compliance rate of 98% based on an average sample of 19% of the quarterly and annual WRPCs. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor assessed the documentation (frequency, content and filing) of the Mall notes for all interventions specified for Focus I that addresses psychiatric disorders. The review found substantial compliance in three charts (AFR, JG and RCP) and partial compliance in three (GFV, JJJ and LR). .</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	Current findings on previous recommendation: Recommendation, December 2010: Continue to monitor this requirement.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that eight WRPs had integrated the relevant information from the discipline-specific assessments into the individuals' WRPs (CJ, KJ, KM, MAW, MHL, RAO, RG and WB) and one (RLK) had not.</p> <p>Other findings: This monitor reviewed the records of 27 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct speech, occupational and physical therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Audit Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011):</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">1.</td> <td style="width: 80%; padding: 5px;"><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td style="width: 15%; text-align: center; vertical-align: top;">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals found that nine WRPs contained objectives written in a measurable/observable manner (AFR, DA, GC, JG, JJJ, LR, MEH, RAO and SDH) and four did not (MAW, MHL, RG and RLK).</p> <p>A review of the records of five individuals found that the objectives in two of the WRPs in the charts were directly linked to a relevant focus of hospitalization (RAD and RG) and three were not (RLK, MHL, and MAW).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%
1.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See C.2.f.viii.</p> <p>Findings: See C.2.f.viii.</p> <p>Current recommendation: See C.2.f.viii.</p>			
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 22% of Mall group facilitators each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 415 1892 492"> <tr> <td data-bbox="993 415 1087 492">15.</td> <td data-bbox="1087 415 1793 492"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 415 1892 492">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of eight individuals found that all eight WRPs had specified the strengths of the individual in all active interventions reviewed (AFR, DA, GC, JG, JJJ, LR, MEH and SDH).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	99%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	99%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1305 1892 1421"> <tr> <td data-bbox="993 1305 1087 1421">8.</td> <td data-bbox="1087 1305 1793 1421"><i>The WRP includes all objectives from the individual's current stage of change (SOC) or readiness for rehabilitation, to the maintenance stage for each</i></td> <td data-bbox="1793 1305 1892 1421">99%</td> </tr> </table>	8.	<i>The WRP includes all objectives from the individual's current stage of change (SOC) or readiness for rehabilitation, to the maintenance stage for each</i>	99%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"><i>focus of hospitalization, as clinically appropriate</i></td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of 11 individuals found that the individual's vulnerabilities were documented in the case formulation section in all 11 WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (BR, CJ, ET, KJ, KM, MHL, PT, RAO, RG, RSS and WB).</p> <p>Current recommendation: Continue to monitor this requirement</p>	<i>focus of hospitalization, as clinically appropriate</i>	
<i>focus of hospitalization, as clinically appropriate</i>				
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Facilitator Mall Observation Monitoring Form, PSH assessed compliance based on an average sample of 7% of the Mall group facilitators each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that cognitive screening had been conducted or the reasons for not completing it as part of the Integrated Assessment: Psychology Section were indicated in all nine WRPs (CJ, KJ, KM, MAW, MHL, RAO, RG, RLK and WB).</p> <p>A review of documented cognitive levels of eight individuals (AFR, DA, GC, JG, JJJ, LR, MEH and SDH) and the Mall groups to which these eight</p>		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>individuals were assigned found that all eight were enrolled in Mall groups appropriate for their cognitive functioning levels.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																			
C.2.i.vii	<p>Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported the following data pertaining to Mall Facilitator Progress Note completion by program, based on a 20% random sample in November 2010:</p> <table border="1" data-bbox="991 784 1795 976"> <thead> <tr> <th></th> <th>P1</th> <th>P2</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3794</td> <td>3191</td> <td>2958</td> <td>3166</td> <td>3933</td> <td>3309</td> </tr> <tr> <td>n</td> <td>758</td> <td>638</td> <td>592</td> <td>633</td> <td>787</td> <td>661</td> </tr> <tr> <td>%S</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> </tr> <tr> <td>%C</td> <td>100</td> <td>98</td> <td>97</td> <td>96</td> <td>96</td> <td>100</td> </tr> </tbody> </table> <p>A review of the charts of five individuals found that all five contained progress notes (MAW, MHL, RAO, RGM and RLK). The information from the progress notes had been incorporated into the Present Status section of the individuals' WRPs.</p> <p>Other findings: This monitor reviewed the records of 27 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct speech, occupational and physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. Twenty-five records were in substantial compliance (AAD, AKA,</p>		P1	P2	P3	P4	P5	Mean	N	3794	3191	2958	3166	3933	3309	n	758	638	592	633	787	661	%S	20	20	20	20	20	20	%C	100	98	97	96	96	100
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%C	100	98	97	96	96	100																															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>CA, CC, CCB, CH, CM, DC, DEN, DMJ, EH, GJG, JCW, JHB, KE, RB, RLA, RRA, RRD, SB, SC, SMK, TS, VGR and VT) and two records were in partial compliance (LEL and SBP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH had always provided Mall services to meet this criterion. In addition, there are groups held during Mall group hours that do not meet the criteria of Mall groups (i.e. individualized learning-based objectives and interventions). These are the Therapeutic Community groups. These groups are held on the units, and are attended by all individuals on the particular unit (at times the individuals also meet in smaller groups). At these group meetings, the issues on the units relevant to the individual and/or the unit as a whole are discussed. This monitor observed one of the Therapeutic Community group meetings. The meetings was well attended, the individuals were very active asking and answering questions and addressing issues on their units both at the system level and the individual's level; and there was sufficient staff to address the safety issues in a large group. This group format and purpose appears to be of extreme interest and use to the individuals and should be continued. However, it should be organized such that it meets the PSR Mall criteria, or held outside of the 20-hour Mall group hours. The Mall Director is aware of the discrepancy and is working to resolve it.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH did not care for any bed-bound individuals during this review period.</p> <p>Current recommendation: Continue to monitor this requirement in the event this issue arises.</p>																																
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 894 1883 1159"> <thead> <tr> <th></th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>7733</td> <td>5278</td> <td>8121</td> <td>7756</td> <td>7724</td> <td>5998</td> <td>6087</td> </tr> <tr> <td>Groups cancelled</td> <td>64</td> <td>0</td> <td>3370</td> <td>1828</td> <td>1949</td> <td>1196</td> <td>1201</td> </tr> <tr> <td>Cancellation rate</td> <td>1%</td> <td>0%</td> <td>41%</td> <td>24%</td> <td>25%</td> <td>20%</td> <td>18%</td> </tr> </tbody> </table> <p>The mean cancellation rate was 1% in the previous review period. However, the data presented during the previous review period was not valid as PSH had counted "alternate groups" as "mall groups provided." However, "alternate groups" were "fillers" when regular providers were unavailable to facilitate the groups. PSH corrected this issue in the data presented in the table above showing an 18% cancellation rate. PSH</p>		Nov	Dec	Jan	Feb	Mar	Apr	Mean	Groups scheduled	7733	5278	8121	7756	7724	5998	6087	Groups cancelled	64	0	3370	1828	1949	1196	1201	Cancellation rate	1%	0%	41%	24%	25%	20%	18%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

should reduce the cancellation rate, primarily by ensuring that facilitators fulfill their scheduled hours. The Mall Director is having difficulty juggling the scheduled groups in the absence of facilitators.

The facility presented the following data regarding Mall group facilitation by discipline:

Average weekly hours provided by discipline		
	Previous review period	Current review period
Psychiatry Admissions (2)	2.00	2.44
Psychiatry Long-Term (4)	2.61	2.61
Psychology Admissions (5)	3.58	4.90
Psychology Long-Term (10)	7.53	6.65
Social Work Admissions (5)	4.83	5.83
Social Work Long-Term (10)	8.00	7.00
Rehab Therapy Admissions (7)	8.25	9.42
Rehab Therapy Long-Term (15)	12.68	10.62
Nursing (10)	10.00	10.00
Administration (1)	2.68	1.66

Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled
Psychiatry	1.96	1.32	68%
Psychology	4.86	3.71	76%
Social Work	5.33	4.14	78%
Rehab Therapy	8.94	7.37	82%
Nursing	2.39	1.95	82%
Administration	2.48	1.68	73%

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>As can be seen in the table above, disciplines provide 68% to 82% of their scheduled hours. This level of participation is insufficient to complete all scheduled Mall groups.</p> <p>According to the Mall Director, PSH depends on the WaRMSS Report Manager database to account for staff providing active treatment during Mall hours (e.g. assisting individuals refusing to attend Mall groups, holding mock court, and other emergency tasks). At this time, the facility finds this task difficult to manage. PSH's Quality Council has established a Corrective Action Team to review data on cancelled groups and to submit a plan of correction (date of completion given as August 2011).</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 1079 1906 1346"> <thead> <tr> <th></th> <th>11/10</th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> </tr> <tr> <td>Hours offered</td> <td>1683</td> <td>1683</td> <td>1848</td> <td>1782</td> <td>1815</td> <td>1782</td> <td>1766</td> </tr> <tr> <td>Scheduled/ offered</td> <td>91%</td> <td>91%</td> <td>100%</td> <td>96%</td> <td>98%</td> <td>96%</td> <td>96%</td> </tr> </tbody> </table> <p>PSH continues to provide enrichment activities in the evenings and</p>		11/10	12/10	1/11	2/11	3/11	4/11	Mean	Hours scheduled	1848	1848	1848	1848	1848	1848	1848	Hours offered	1683	1683	1848	1782	1815	1782	1766	Scheduled/ offered	91%	91%	100%	96%	98%	96%	96%
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Hours scheduled	1848	1848	1848	1848	1848	1848	1848																											
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Scheduled/ offered	91%	91%	100%	96%	98%	96%	96%																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>weekends. The number of hours scheduled was high and the facility maintained the same scheduled hours as during the previous review period. The provided hours was reduced by 2% (98% previous period and 96% during this review period). The activities were organized at the Unit and Central levels. The Supplemental Activity Coordinator and staff organize, audit, and provide needed resources at the central level, and the organization of the activities and encouragement of the individuals to participate in the activities are conducted at the Unit level. A tour of the Units found that activity calendars had been posted on the walls. Staff interviewed explained the activity schedules and efforts taken to motivate individuals to participate in the activities, including reminders through the "Good Morning Patton" announcements and staff meeting individuals on a personal basis. The staff is recruiting individuals to be co-providers of the Supplemental Activities.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, PSH assessed its compliance based on observations of an average sample of 98% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 1227 1890 1416"> <tr> <td data-bbox="991 1227 1081 1305">1.</td> <td data-bbox="1081 1227 1793 1305"><i>More staff are in the Milieu than in the nursing station.</i></td> <td data-bbox="1793 1227 1890 1305">100%</td> </tr> <tr> <td data-bbox="991 1305 1081 1383">2.</td> <td data-bbox="1081 1305 1793 1383"><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td data-bbox="1793 1305 1890 1383">100%</td> </tr> <tr> <td data-bbox="991 1383 1081 1416">3.</td> <td data-bbox="1081 1383 1793 1416"><i>There are unit recognition programs.</i></td> <td data-bbox="1793 1383 1890 1416">100%</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	100%	2.	<i>Some staff in the milieu are interacting with individuals, not simply observing them.</i>	100%	3.	<i>There are unit recognition programs.</i>	100%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and courteous manner.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Staff react calmly in an escalating situation.</i></td> <td>96%</td> </tr> </table> <p>A review of the charts of 12 individuals found that all 12 contained milieu interventions appropriate to the active intervention (AFR, CG, CJ, DA, JG, JJJ, KJ, KM, LR, MEH, SDH and WB).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	100%	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	100%	6.	<i>Staff respect confidentiality.</i>	100%	7.	<i>Some staff are actively engaged in listening.</i>	100%	8.	<i>Staff interact with individuals in a respectful and courteous manner.</i>	100%	9.	<i>Staff respect privacy.</i>	100%	10.	<i>Staff react calmly in an escalating situation.</i>	96%							
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility presented the following data:</p> <table border="1"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>11/10</th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>3/11</th> <th>4/11</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>163</td> <td>163</td> <td>163</td> <td>164</td> <td>175</td> <td>175</td> </tr> <tr> <td>Number of groups needed @ 1x/wk</td> <td>75</td> <td>74</td> <td>75</td> <td>75</td> <td>72</td> <td>72</td> </tr> </tbody> </table>	Exercise Groups Offered vs. Needed								11/10	12/10	1/11	2/11	3/11	4/11	Number of groups offered	163	163	163	164	175	175	Number of groups needed @ 1x/wk	75	74	75	75	72	72
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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Offered/ needed	>100%	>100%	>100%	>100%	>100%	>100%																
		<p>As seen in the table above, PSH is providing sufficient numbers of exercise groups to provide the opportunity for participation in an exercise program by all individuals at the facility.</p>																				
		<p>The facility also presented the following data:</p>																				
		<table border="1"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>584</td> <td>537</td> <td>92%</td> </tr> <tr> <td>31 - 35</td> <td>346</td> <td>322</td> <td>93%</td> </tr> <tr> <td>36 - 40</td> <td>143</td> <td>136</td> <td>95%</td> </tr> <tr> <td>>40</td> <td>75</td> <td>74</td> <td>99%</td> </tr> </tbody> </table>	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	584	537	92%	31 - 35	346	322	93%	36 - 40	143	136	95%	>40	75	74	99%
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>40	75	74	99%																			
		<p>As shown in the table above, not all individuals with high BMIs had been assigned to exercise groups. PSH should audit and review the reasons for individuals not being assigned to exercise groups. There can be genuine reasons that exercise is not indicated (e.g. physical health) but these reasons should be stated in the Present Status section of the individual's WRP.</p>																				
		<p>This monitor reviewed a randomly chosen set of four charts of individuals with high BMIs. All four individuals (CJ, KJ, KM and WB) were enrolled in exercise groups. KJ, who uses a walker, is provided exercise through Physical Therapy outside of Mall hours.</p>																				
		<p>Compliance: Substantial.</p>																				
		<p>Current recommendation: Continue to monitor this requirement.</p>																				

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.k</p>	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH C2k Family Therapy Auditing Form, PSH assessed its compliance using the following indicators (size of sample as a percentage of relevant population noted in parentheses):</p> <table border="1" data-bbox="991 561 1885 1157"> <tr> <td data-bbox="991 561 1066 711">1.</td> <td data-bbox="1066 561 1755 711"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1755 561 1885 711">100% (100%)</td> </tr> <tr> <td data-bbox="991 711 1066 935">2.</td> <td data-bbox="1066 711 1755 935"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1755 711 1885 935">100% (12%)</td> </tr> <tr> <td data-bbox="991 935 1066 1157">3.</td> <td data-bbox="1066 935 1755 1157"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1755 935 1885 1157">96% (17%)</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed 10 charts of individuals assessed to need family education/therapy (BC, EA, JAP, JNC, JU, KM, RG, TC, TFP and WDW). Documentation indicated that two of the families live very far from the</p>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100% (100%)	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	100% (12%)	3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	96% (17%)
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>facility (e.g. in Hawaii) and was unable to participate in any therapy/ education (JNC and WDW). One family (JAP) had not responded even with repeated mailing of letters. SW work staff were in communication with the remaining seven families and were providing education and feedback.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, December 2010:</p> <ul style="list-style-type: none"> • Continue implementing facility-wide system addressing and tracking non-adherence issues. • Ensure that WRPs addressing refusals are individualized, address the reason for refusals, and incorporate appropriate interventions in alignment with the individual's functioning. • Increase sample size addressing individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months. <p>Findings: Please see cell F.7.b.ii.</p> <p>Recommendation 4, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, PSH assessed its compliance based on a 22% mean sample of individuals with</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>at least one Axis III diagnosis who had a WRP due during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 302 1887 678"> <tr> <td data-bbox="991 302 1087 376">1.</td> <td data-bbox="1087 302 1793 376"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1793 302 1887 376">94%</td> </tr> <tr> <td data-bbox="991 376 1087 451">2.</td> <td data-bbox="1087 376 1793 451"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1793 376 1887 451">94%</td> </tr> <tr> <td data-bbox="991 451 1087 526">3.</td> <td data-bbox="1087 451 1793 526"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1793 451 1887 526">92%</td> </tr> <tr> <td data-bbox="991 526 1087 600">4.</td> <td data-bbox="1087 526 1793 600"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1793 526 1887 600">96%</td> </tr> <tr> <td data-bbox="991 600 1087 678">5.</td> <td data-bbox="1087 600 1793 678"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1793 600 1887 678">93%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the WRPs of 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that PSH has continued to make consistent improvements in this area since the last review, resulting in the majority of the WRPs reviewed for Focus 6 including appropriate objectives and interventions which comports with PSH's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	94%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	94%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	92%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	96%	5.	<i>There are appropriate interventions for each objective.</i>	93%
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C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional																

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	standards of care:	<p>The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility has maintained its practice, including training of providers of substance abuse groups based on the Transtheoretical Model of Stages of Change. As of May 3, 2011 there were 296 certified providers among the clinical staff at PSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Provide summary of both process and clinical outcome data regarding delivery of substance use services.</p> <p>Findings: The following is a summary of PSH's process outcome data:</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Process Outcomes	Previous review period	Current review period
		Individuals with Substance Abuse Dx	1038	1027
		Individuals screened by SAS	972	896
		Hours of SAS treatment offered per week	432	433
		SAS sessions scheduled	311	338
		%SAS sessions held	98%	98%
		AA/NA hours per month	79	77
		%AA/NA sessions held	94%	92%
		Individuals enrolled in SAS treatment	972	951
<p>PSH also evaluated the outcome of the SAR services provided this review period. The table below shows the summary of the data:</p>				
		Clinical Outcomes	Previous review period	Current review period
		Advanced at least one stage of change or sustained in maintenance.	42.7%	51.5%
		Refused treatment or regressed at least one stage of change.	28.5%	17.3%
		Did not advance in stage of change	28.8%	31.2%
		Out to Court/Other/Discharged	258	297
<p>PSH recognized some limitations of the Readiness Ruler (RR) method for assessment of the Stage of Change (SOC) of the individuals at the facility. These included conflicting SOC information for various substances, which created difficulty for assignments to a single SOC group, and the tendency of some long-stay individuals to refuse to complete the form upon repeated administration, or to provide extreme responses that conflicted with clinically observable SOC behavior.</p>				

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>In an effort to improve the process of assessment of the Stages of Change, the facility reported that newly admitted individuals will be formally staged after three months of admission to ensure that individuals have greater psychiatric stability and will have adjusted to the milieu at PSH. In addition, the facility collaborated with NSH on the development of a 14-item treatment readiness questionnaire. This instrument was created by Amy Davis and Patricia Tyler at NSH and included items specific to the population seen at California hospitals. PSH administered the NSH Staging Questionnaire to a cohort of individuals in the SOC groups 1-3 to compare data with the Readiness Ruler. If the NSH Staging Questionnaire proves more useful than the RR, PSH will use this method (every six months) with individuals in SOC groups 1-3 to examine readiness for advancement, particularly to Action stage groups</p> <p>PSH has yet to implement its previously mentioned plan to assess the extent to which the pre-discharge Stage of Change for substance use disorders is correlated with revocation of CONREP status due to substance abuse relapse.</p> <p>The facility's consumer satisfaction surveys summary data is as follows based on a sample of 200 individuals:</p> <table border="1" data-bbox="991 1089 1885 1390"> <thead> <tr> <th data-bbox="991 1089 1465 1166">Consumer Satisfaction Survey</th> <th data-bbox="1465 1089 1675 1166">Previous review period</th> <th data-bbox="1675 1089 1885 1166">Current review period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1166 1465 1279">1. Overall satisfaction with the information and skills provided by the group</td> <td data-bbox="1465 1166 1675 1279"></td> <td data-bbox="1675 1166 1885 1279"></td> </tr> <tr> <td data-bbox="991 1279 1465 1317">• Excellent</td> <td data-bbox="1465 1279 1675 1317">49%</td> <td data-bbox="1675 1279 1885 1317">61%</td> </tr> <tr> <td data-bbox="991 1317 1465 1354">• Good</td> <td data-bbox="1465 1317 1675 1354">35%</td> <td data-bbox="1675 1317 1885 1354">31%</td> </tr> <tr> <td data-bbox="991 1354 1465 1390">• Adequate</td> <td data-bbox="1465 1354 1675 1390">10%</td> <td data-bbox="1675 1354 1885 1390">6%</td> </tr> </tbody> </table>	Consumer Satisfaction Survey	Previous review period	Current review period	1. Overall satisfaction with the information and skills provided by the group			• Excellent	49%	61%	• Good	35%	31%	• Adequate	10%	6%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ul style="list-style-type: none"> Minimal 	4%	1%
		<ul style="list-style-type: none"> Poor 	2%	1%
		2. The instructor demonstrated knowledge of the course subject		
		<ul style="list-style-type: none"> Excellent 	54%	67%
		<ul style="list-style-type: none"> Good 	30%	26%
		<ul style="list-style-type: none"> Adequate 	12%	5%
		<ul style="list-style-type: none"> Minimal 	2%	1%
		<ul style="list-style-type: none"> Poor 	2%	1%
		3. The group resulted in change of the way I see substance use		
		<ul style="list-style-type: none"> Excellent 	45%	60%
		<ul style="list-style-type: none"> Good 	38%	29%
		<ul style="list-style-type: none"> Adequate 	11%	9%
		<ul style="list-style-type: none"> Minimal 	4%	3%
		<ul style="list-style-type: none"> Poor 	2%	1%
		4. The group resulted in change of the way I see myself		
		<ul style="list-style-type: none"> Excellent 	48%	56%
		<ul style="list-style-type: none"> Good 	35%	31%
		<ul style="list-style-type: none"> Adequate 	10%	11%
		<ul style="list-style-type: none"> Minimal 	4%	3%
		<ul style="list-style-type: none"> Poor 	3%	1%
		<p>Recommendation 2, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Substance Abuse Auditing Form, PSH assessed its compliance with this requirement based on an average sample of 17% of individuals with a current diagnosis of substance abuse (November 2010 - April 2011):</p>		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td data-bbox="976 183 1087 305">1.</td> <td data-bbox="1087 183 1793 305"><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td data-bbox="1793 183 1921 305">98%</td> </tr> <tr> <td data-bbox="976 305 1087 378">2.</td> <td data-bbox="1087 305 1793 378"><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td data-bbox="1793 305 1921 378">92%</td> </tr> <tr> <td data-bbox="976 378 1087 451">3.</td> <td data-bbox="1087 378 1793 451"><i>There is at least one objective related to the individual's stage of change.</i></td> <td data-bbox="1793 378 1921 451">98%</td> </tr> <tr> <td data-bbox="976 451 1087 524">4.</td> <td data-bbox="1087 451 1793 524"><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td data-bbox="1793 451 1921 524">98%</td> </tr> <tr> <td data-bbox="976 524 1087 638">5.</td> <td data-bbox="1087 524 1793 638"><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td data-bbox="1793 524 1921 638">99%</td> </tr> <tr> <td data-bbox="976 638 1087 751">6.</td> <td data-bbox="1087 638 1793 751"><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td data-bbox="1793 638 1921 751">98%</td> </tr> </table> <p data-bbox="976 792 1921 865">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="976 906 1192 938">Other findings:</p> <p data-bbox="976 943 1226 976">Same as in C.2.f.iv.</p> <p data-bbox="976 1016 1921 1089">In addition, this monitor and one of his experts separately observed the following substance use education groups:</p> <ol data-bbox="976 1130 1921 1421" style="list-style-type: none"> <li data-bbox="976 1130 1921 1203">1. <u>Beginning Relapse Prevention</u> (Action and Maintenance stages), facilitated by Georgiana Vinson, Registered Nurse; <li data-bbox="976 1203 1921 1308">2. <u>Education & Recovery from Addiction</u> (Pre-Contemplative stage), facilitated by Lisa Logan, Clinical Social Worker and Anthony Fletcher, Rehabilitation Therapist; and <li data-bbox="976 1308 1921 1421">3. <u>Co-Occurring Disorders</u> (Action stage), facilitated by Kathy Freeman, Clinical Social Worker and Melissa Roskos, Rehabilitation Therapist. 	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	98%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	92%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	98%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	98%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	99%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	98%
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4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	98%																		
5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	99%																		
6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	98%																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>There was general evidence that the groups had highly relevant content, that the quality of instruction was up to standards and that the engagement of the individuals was optimal.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide summary of both process and clinical outcome data regarding delivery of substance use services. 2. Continue to monitor this requirement. 																				
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on an average sample of 7% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 1079 1885 1312"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>99%</td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>96%</td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>100%</td> <td>94%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>100%</td> <td>99%</td> </tr> </tbody> </table> <p>Using the DMH Mall Facilitator Observation Monitoring Form PSH assessed compliance from observation of an 8% sample of all facilitators</p>			Previous review period	Current review period	1.	<i>Instructional skills</i>	99%	99%	2.	<i>Course structure</i>	96%	93%	3.	<i>Instructional techniques</i>	100%	94%	4.	<i>Learning process</i>	100%	99%
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

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		Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items except item 1,																																										

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>for which compliance was 86% in the previous period.</p> <p>This monitor observed five Mall groups (Cultural Awareness and Identity, Origami, Healthy Relationship: Boundaries and Respect, Substance Abuse Recovery: Co-Occurring Disorders 1, Action Stage, and Substance Abuse Recovery: Education and Recovery from Addiction, Pre-Contemplation Stage). Attendance was high in these groups (80% to 90%). The regular facilitators were absent for one group. The substitute facilitators did not conduct the lesson plan related to the group but rather provided alternate activities, and therefore, for auditing purposes, this group should be considered as cancelled. Two of the groups were managed well. Two aspects could have made these groups better: ensuring that all individuals are engaged and participation not left only to those who wanted to speak up/participate, and personalizing the lesson to each individual's needs and WRP objectives. Facilitation of the two Substance Abuse Recovery groups was excellent. The facilitator in one of the SAR groups did all the right things. She used the video effectively, stopping periodically, drawing attention to the event and asking appropriate questions to test the individuals' attention, memory, understanding, and interpretation of what they had been watching. She had on the wall a chart that showed the progression of the lessons and how they were connected from session to session. In the other SAR group, the providers conducted the lesson in an active manner with the individuals tracing the body outline of an individual onto a sheet of paper and having the individuals write, mark, and state how SA affects the physical and emotional aspects of one's body.</p> <p>This monitor reviewed nine completed Mall Facilitator Observation Forms: Victim Awareness, Success Stories, Exertion 3: Seasonal Sports, Substance Abuse Recovery (New Beginning), Substance Abuse Recovery (Pathways), Co-Occurring Disorders, Line Dancing, Discharge Planning, and Life Skills: Courtroom, Social and Behavioral Skills). All the forms had a check mark on of the three elements on the form (Yes, No, and N/A).</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>However, the comments sections were blank in all but one of the forms. It is useful to note down information beyond the "Yes, No, N/A" checkmarks. Additional information can be used for corrective steps, for reinforcement, and for feedback</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="993 932 1873 1094"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>136</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>125</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>92%</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	136	Number of certified SAR providers/co-providers	125	Percentage of SAR providers/co-providers who are certified	92%
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C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendation:</p>						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Recommendation, December 2010:

Monitor this requirement, analyze cancellation data, and take remedial actions to reduce cancellations t.

Findings:

The facility provided the following data on scheduled and cancelled appointments:

Missed Appointments Monitoring - Medical Services					
	Appointments		Reasons for Cancellation		
	Scheduled	Cancelled	Staffing	Transportation	Other
Nov	2,950	601	28	9	564
Dec	2,861	556	22	9	525
Jan	3,450	698	28	12	658
Feb	3,424	649	36	10	603
Mar	3,747	661	16	10	635
Apr	3,094	496	8	8	480
Total	19,526	3,661	138	58	3,465

The table above shows that 19% of the scheduled appointments had been cancelled during this review period (29% were cancelled during the previous review period). Five percent of the cancellations were due to staffing and transportation (cancellations due to staffing and transportation were 8% during the previous review period). According to PSH, "other" cancellations are typically refusals by individuals. The Psychology Department, in collaboration with the WRPTs, is addressing refusals through identification of reasons for the refusals and the provision of services to reduce refusals.

Compliance:

Substantial.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.s</p>	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for 13 individuals found that 12 of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (AFR, DA, GC, JG, JJJ, LR, MAW, MEH, MHL, RG, RLP and SDH). The remaining one (RAO) did not assign the individual to appropriate groups corresponding to diagnosis, needs, and/or cognitive level, or the groups listed in the interventions were not listed in the individual's Mall schedule.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.t</p>	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 97%. Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p>A review of the WRPs for 11 individuals found that 10 WRPs met the elements of this requirement (AFR, CJ, GC, JG, JJJ, KJ, LR, MEH, SDH and WB) and the remaining one (DA) was missing one or more elements or did not satisfy the criteria for this recommendation.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.u</p>	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility provided the following data:</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Individuals in need of WRP Education during the current and previous three Mall terms				
			Jun-Aug 2010	Sep-Nov 2010	Dec-Feb 2010/11	Feb-Apr 2011
		With identified need	313	318	307	295
		Receiving service	291	265	286	241
		% receiving service	92%	83%	93%	82%
		PSH also presented the following data:				
		2010/2011				Mean
		Sessions scheduled				386
		Sessions held				243
		Percentage of sessions held				63%
		Number scheduled				1801
		Number attending at least one group per month				1578
		Attendance rate				88%
		A review of nine charts found that all nine individuals had been enrolled in WRP education groups (CJ, DH, GH, JPW, KJ, KM, RP, TG and WB).				
		Compliance: Substantial.				
Current recommendation: Continue to monitor this requirement.						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.v</p>	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 636 1873 1088"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>2Q10</th> <th>3Q10</th> <th>4Q10</th> <th>1Q11</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>1057</td> <td>1206</td> <td>1219</td> <td>1216</td> </tr> <tr> <td># of individuals receiving service</td> <td>968</td> <td>1118</td> <td>1091</td> <td>1085</td> </tr> <tr> <td># of groups offered</td> <td>780</td> <td>1020</td> <td>1020</td> <td>996</td> </tr> <tr> <td># of hours offered</td> <td>1368</td> <td>1608</td> <td>1512</td> <td>1440</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, the number of groups offered and the number of hours offered. Provide comparative data from the previous to</p>	Individuals Needing and Provided Medication Education Groups						2Q10	3Q10	4Q10	1Q11	# of individuals needing service	1057	1206	1219	1216	# of individuals receiving service	968	1118	1091	1085	# of groups offered	780	1020	1020	996	# of hours offered	1368	1608	1512	1440
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		current review period for each data element.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Per PSH's definition of "non-adherence," no individual had refused to attend at least one Mall group for a period of 30 consecutive days during this review period. However, PSH reported having had individuals who had not attended Mall groups for short periods of time due to severe paranoia or other symptoms of mental illness, medical illness, acute hospitalization or recent return from court.</p> <p>According to Gari-Lyn Richardson, Director of Compliance, a report on non-adherence based on WaRMSS data is prepared and distributed to the WRPTs, who decide how to handle each individual's situation. Strategies used by WRPTs and the DCAT to reduce non-adherence include the following: behavioral interventions, By Choice point allocations, encouragement, escorting individual to group, increase groups as tolerated, individual therapy/counseling, IT assignment, Mall schedule changes, medication adjustment, and motivational interviewing.</p> <p>A review of the records of five individuals with poor Mall group attendance (DH, GH, JPW, RP and TG) found that the WRPTs have addressed Mall attendance with the individuals using a variety of strategies such as behavior guidelines, encouragement and reinforcement, and schedule changes.</p> <p>Compliance: Substantial.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Current recommendation: Continue to monitor this requirement.
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. PSH has achieved substantial compliance with all of the requirements in this section. 2. Although further work is needed, PSH has made sufficient progress in implementing corrective actions to improve the violence risk assessment for individuals who are readmitted after fewer than 90 days of discharge and in focusing the documentation of psychiatric reassessments on the individuals' most relevant clinical needs. 3. PSH continued its practice of providing CME activities that adequately address the facility's needs. <p>Areas of need include:</p> <ol style="list-style-type: none"> 1. <i>Ensure proper completion of the overall synthesis of the admission violence risk assessment.</i> 2. <i>Ensure that the psychiatric reassessments consistently include an individualized risk/benefit analysis, particularly for individuals who have multiple risk factors and continue to receive high-risk treatments.</i> <p>Summary of Progress on Psychological Assessments:</p> <p>As of the tour conducted in December 2010, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Nursing Assessments:</p> <p>PSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be</p>

		<p>the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <ol style="list-style-type: none"> 1. PSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance. 2. Current RT focused assessments should be updated to improve their clinical utility and meaningfulness, while ensuring that they continue to meet EP requirements. 3. An improvement has been noted in the timeliness and consistency in which individuals at high risk or in need of specialized RT services are referred for POST assessment. <p>Summary of Progress on Nutrition Assessments: PSH has maintained substantial compliance with the requirements of Section D.5.</p> <p>Summary of Progress on Social History Assessments: PSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Court Assessments: As of the tour conducted in June 2009, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Proctor, MD, Senior Psychology Supervisor, P&T Committee Chair 2. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 31 individuals: AC, AFR, AWB, CG, CL, DA, GLC, JDM, JJP, JMM, JS-1, JS-2, KR, MEH, MLR, MR, NM, OC, PH, PVT, RLK, SDH, SL-1, SL-2, SP, SSC, RA, RLK, SQS, VA and VCD 2. Monthly Psychiatric Progress Notes for the following 51 individuals: AG, AH, AM, BA, BG, CB, CC, CH, CL, COM, DGA, DLJ, DLL, DM, DVA, DW, DD, DSR, EMC, ETR, FCL, FLB, GA, GJW, JAG, JF, JHM, JL, JM, KD, LAB, LC, LDL, LT, MD, MH, PC, PGP, RRP, RRR, SH, SS, ST, SWS, TC, TCG, TT, TW, TY, TYH and VEB 3. Monthly Psychiatric Progress Notes following seclusion/restraint incidents for JMM, JS, NM, OC and PH 4. PSH template for the Brief Admission Psychiatric Assessment. 5. PSH Admission Psychiatric Assessment summary data (November 2010 to April 2011) 6. PSH Integrated Assessment: Psychiatric Section summary data (November 2010 to April 2011) 7. PSH Admission Medical Assessment Auditing summary (November 2010 to April 2011) 8. PSH Monthly PPN Audit summary data (November 2010 to April 2011) 9. PSH Weekly PPN Auditing summary data (November 2010 to April 2011) 10. PSH Physician Transfer Note Auditing summary (November 2010 to April 2011) 11. Brief Psychiatry Admission Assessment template 12. Comprehensive Psychiatry Admission Assessment template

Section D: Integrated Assessments

<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders (“DSM”) for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (November 2010 - April 2011). The average samples were 28% of admission assessments, 23% of integrated assessments and 17% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 711 1887 786"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 935 1887 1312"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Psychiatric history, including review of present and past history include diagnosis and medications given at previous facility</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	Admission Assessment			4.	<i>Admission diagnosis is documented</i>	100%	Integrated Assessment			2.b	<i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information</i>	100%	2.d	<i>Psychiatric history, including review of present and past history include diagnosis and medications given at previous facility</i>	100%	7.	<i>Diagnostic formulation</i>	100%	8.	<i>Differential diagnosis</i>	100%	9.	<i>Current psychiatric diagnoses</i>	100%
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Integrated Assessment																										
2.b	<i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information</i>	100%																								
2.d	<i>Psychiatric history, including review of present and past history include diagnosis and medications given at previous facility</i>	100%																								
7.	<i>Diagnostic formulation</i>	100%																								
8.	<i>Differential diagnosis</i>	100%																								
9.	<i>Current psychiatric diagnoses</i>	100%																								

Section D: Integrated Assessments

		<table border="1" data-bbox="993 228 1887 342"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="993 269 1073 305">3.</td> <td data-bbox="1073 269 1793 342"><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i></td> <td data-bbox="1793 269 1887 305">99%</td> </tr> </table> <p data-bbox="993 386 1902 456">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 500 1140 565">Compliance: Substantial.</p> <p data-bbox="993 609 1457 673">Current recommendation: Continue to monitor this requirement.</p>	Monthly PPN			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i>	99%									
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3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i>	99%															
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.															
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p data-bbox="993 873 1577 906">Current findings on previous recommendation:</p> <p data-bbox="993 943 1436 1008">Recommendation, December 2010: Continue current practice.</p> <p data-bbox="993 1052 1881 1154">Findings: The facility's report on the number and type of positions is summarized below:</p> <table border="1" data-bbox="993 1198 1887 1398"> <thead> <tr> <th>Psychiatric positions</th> <th>Previous Period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Direct care</td> <td>71</td> <td>70</td> </tr> <tr> <td>Supervisory</td> <td>14</td> <td>16</td> </tr> <tr> <td>Board-certified</td> <td>53</td> <td>61</td> </tr> <tr> <td>Board-eligible</td> <td>31</td> <td>25</td> </tr> </tbody> </table>	Psychiatric positions	Previous Period	Current period	Direct care	71	70	Supervisory	14	16	Board-certified	53	61	Board-eligible	31	25
Psychiatric positions	Previous Period	Current period															
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Section D: Integrated Assessments

		<p>As mentioned in previous reports, the facility has one staff psychiatrist who is board-certified in Family Practice but does not meet this requirement. This psychiatrist is practicing under supervision of a senior psychiatrist on a unit dedicated to medically fragile individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Provide summary regarding status of implementation of the current process of reprivileging, including the number (and percentage) of psychiatrists who have been repriviledged.</p> <p>Findings: Since the last review, 22 psychiatrists were repriviledged, representing 100% of those scheduled for renewal of privileges per the facility's procedure. The indicators used in this process comport with current standards.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>

Section D: Integrated Assessments

D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, PSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 26% of admissions each month during the review period (November 2010 - April 2011) and reported compliance rates of 99% or 100% for all items. Comparative data for all cells in D.1c.i indicated that PSH has maintained a rate of at least 90% from the previous review period for all items.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period (AFR, CG, CL, DA, MEH, PVT, RLK, SDH, SL-1 and SL-2) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	Same as above.
D.1.c.i.2	medical history;	Same as above.
D.1.c.i.3	physical examination;	Same as above.
D.1.c.i.4	diagnostic impressions; and	Same as above.
D.1.c.i.5	management of acute medical conditions	Same as above.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an	Current findings on previous recommendations:

Section D: Integrated Assessments

	<p>Admission Psychiatric Assessment that includes:</p>	<p>Recommendation 1, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Psychiatric Assessment Audit, PSH reported a compliance rate of 100% based on an average sample of 28% of admissions each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all sub-cells of D.1.c.ii.</p> <p>Recommendation 2, December 2010: Provide an update on the status of implementation of corrective actions identified in the facility's Report of the Assault Reduction Team (Sentinel Event of October 4, 2010).</p> <p>Findings: The following summarizes the facility's corrective actions:</p> <ol style="list-style-type: none"> 1. The Psychopharmacology service reviewed a medication algorithm STOP-A (for use in the most acutely ill individuals) with the senior psychiatrists (1/27/2011). The senior psychiatrists were then instructed to provide ongoing training and encouragement to the staff psychiatrists on more aggressive treatment of agitated individuals. 2. A work group was initiated to assist in reviewing policies and procedures for those individuals returning to Patton State Hospital after being found competent. The review will include ways to improve continuity of care. The Medical Executive Committee began to discuss ways to facilitate continuity of care given frequent limitations on bed availability. 3. An expanded violence risk assessment has been added to the admission assessment for those individuals who are readmitted after
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Section D: Integrated Assessments

		<p>fewer than 90-days.</p> <p>4. Information Technology will develop a plan to allow all clinicians access to clinical information stored electronically. This will allow rapid access to past records from prior admissions</p> <p>5. Administrative Directive #6.12 regarding Count Procedures was revised to specify that before initiating count procedures, staff will clear bedrooms and bathrooms areas to ensure that all individuals are assembled in a designed area.</p> <p>Other findings: During this review period, PSH has streamlined the admission psychiatric assessment to reduce the documentation burden. The streamlined Brief Admission Assessment meets EP requirements. This assessment includes an expanded violence risk assessment tool, which comports with current standards in risk assessment.</p> <p>A review of the charts of ten individuals whose admission assessments were completed using the streamlined tool found substantial compliance in all cases (AFR, CG, CL, DA, MEH, PVT, RLK, SDH, SL-1 and SL-2).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	Same as above.
D.1.c.ii.2	complete mental status examination;	Same as above.
D.1.c.ii.3	admission diagnoses;	Same as above.
D.1.c.ii.4	completed AIMS;	Same as above.
D.1.c.ii.5	laboratory tests ordered;	Same as above.
D.1.c.ii.6	consultations ordered; and	Same as above.

Section D: Integrated Assessments

D.1.c.ii.7	plan of care.	Same as above.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, PSH reported a compliance rate of 100% based on an average sample of 23% of Integrated Assessments due each month during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all sub-cells of D.1.c.iii.</p> <p>Other findings: During this review period, the facility implemented a template for a "Comprehensive" Psychiatric Assessment in lieu of the "Integrated" Assessment. This was necessary due to the previously mentioned streamlining of the Admission Psychiatric Assessment. The template for the Comprehensive Psychiatric Assessment satisfies requirements of the EP. The Integrated Assessments of seven individuals (AFR, CG, DA, PVT, SLK, SL-1 and SL-2) and Comprehensive Assessments of three individuals (CL, MEH and SDH) were reviewed. This review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure proper completion of the section that provides an overall synthesis of the violence risk assessment.

Section D: Integrated Assessments

D.1.c.iii. 1	psychiatric history, including a review of present and past history;	Same as above.
D.1.c.iii. 2	psychosocial history;	Same as above.
D.1.c.iii. 3	mental status examination;	Same as above.
D.1.c.iii. 4	strengths;	Same as above.
D.1.c.iii. 5	psychiatric risk factors;	Same as above.
D.1.c.iii. 6	diagnostic formulation;	Same as above.
D.1.c.iii. 7	differential diagnosis;	Same as above.
D.1.c.iii. 8	current psychiatric diagnoses;	Same as above.
D.1.c.iii. 9	psychopharmacology treatment plan; and	Same as above.
D.1.c.iii. 10	management of identified risks.	Same as above.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p>Findings: This monitor reviewed the facility's list of CME activities during the</p>

Section D: Integrated Assessments

review period. The review found that PSH has continued to provide comprehensive and adequate continuing education to its medical staff and that attendance at these events was, in general, adequate.

Recommendation 2, December 2010:

Provide stratified data regarding the number of individuals who have had diagnoses listed as NOS, Deferred, and/or R/O for three or more months during the review period compared with the last period.

Findings:

The facility reported that during the current review period, 210 individuals had diagnoses listed as Rule Out, Deferred or NOS, the same number as in the previous review period. Given the current census, this number indicates that PSH has maintained adequate practice in finalizing diagnoses, as clinically appropriate.

Other findings:

A review of the charts of the following ten individuals who have received diagnoses listed as NOS for three or more months found substantial compliance in all cases.

Initials	Diagnosis (NOS)
AWB	Cognitive Disorder NOS
JDM	Psychosis, NOS
JJP	Cognitive Disorder NOS
JS-2	Depressive Disorder NOS
MLR	Psychosis, NOS
SP	Depressive Disorder NOS
SQS	Mental Disorder NOS
A-1	Psychotic Disorder, NOS
VA-2	Dementia NOS
VCD	Dementia NOS

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as D.1.d.i.</p> <p>Findings: Same as D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as D.1.d.i.</p> <p>Findings: Same as D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as D.1.d.i.</p>

Section D: Integrated Assessments

D.1.d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p> <p>Findings: During this review period, one individual was admitted to PSH who received a primary diagnosis of Mild Mental Retardation (under PC 1370-incompetent to stand trial) and "no diagnosis" on Axis I. The facility's review indicated that the diagnosis was justified.</p> <p>Other findings: At the time of this review, this monitor found no individual with "no diagnosis" on Axis I.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p>
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, PSH reported a compliance rate of 99% based on an average sample of 21% of</p>

Section D: Integrated Assessments

		<p>individuals with length of stay less than 60 days during the review period (November 2010 - April 2011). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>PSH also used the DMH Monthly PPN Audit to assess compliance, reporting a compliance rate of 99% based on an average sample of 17% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of ten individuals who were admitted during this review period (AFR, CG, CL, DA, MEH, PVT, RLK, SDH, SL-1 and SL-2) assessed the timeliness of the weekly notes for individuals hospitalized fewer than 60 days and monthly notes for individuals hospitalized for 90 or more days. There was evidence of substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, December 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Implement corrective actions to address the unnecessary documentation of irrelevant laboratory findings and of theoretical side effects of treatment (at the expense of actual side effects). • Implement corrective actions to address the occasional discrepancy between emergency psychiatric assessment by the covering

Section D: Integrated Assessments

		<p>psychiatrist and the assessment by the attending psychiatrist.</p> <p>Findings: PSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 17% of individuals who had been hospitalized for 90 days or more, and reported mean compliance rates of 99% or 100% for all of the requirements in D.1.f.i to D.1.f.vii. Comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review for all items.</p> <p>The facility reported that the monitor's findings regarding the issue of redundant/irrelevant documentation were discussed during Department of Psychiatry Meetings in December 2010 and May 2011. The template for the Monthly Progress Note was discussed as a future target of streamlining and the importance of focusing documentation on most relevant status was discussed. In addition, the facility conducted a review of psychiatric (and psychological) documentation following severe assaults and a plan was initiated to create a requirement for attending psychiatrists and treating psychologists to address recent assaults in a timely manner and not wait for the monthly reassessment (see F.1.d).</p> <p>Other findings: This monitor reviewed monthly Psychiatric Progress Notes for the following 51 individuals: AG, AH, AM, BA, BG, CB, CC, CH, CL, COM, DGA, DLJ, DLL, DM, DVA, DW, DD, DSR, EMC, ETR, FCL, FLB, GA, GJW, JAG, JF, JHM, JL, JM, KD, LAB, LC, LDL, LT, MD, MH, PC, PGP, RRP, RRR, SH, SS, ST, SWS, TC, TCG, TT, TW, TY, TYH and VEB. The review found that the facility has made further progress in the quality and format of the psychiatric reassessments, particularly in focusing the reassessments on pertinent laboratory data and the individualization of the risk/benefit analysis. However, a few reassessments still contained generic risk/benefit analyses regarding the use of high-risk pharmacotherapy, including for individuals who suffered serious adverse drug reactions,</p>
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Section D: Integrated Assessments

		<p>have multiple risk factors, and continue to receive high-risk treatments.</p> <p>This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period to assess the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The following table outlines the reviews:</p> <table border="1" data-bbox="991 524 1906 902"> <thead> <tr> <th>Initials</th> <th>Date of seclusion/restraint</th> <th>PRN/Stat Use</th> </tr> </thead> <tbody> <tr> <td>JMM</td> <td>4/30/11</td> <td>Haloperidol and diphenhydramine (PRN)</td> </tr> <tr> <td>JS</td> <td>4/24/11</td> <td>Chlorpromazine (PRN)</td> </tr> <tr> <td>NM</td> <td>5/4/11</td> <td>Olanzapine (PRN) and trazodone (PRN)</td> </tr> <tr> <td>OC</td> <td>4/7/11</td> <td>Ziprasidone, lorazepam and diphenhydramine (Stat)</td> </tr> <tr> <td>PH</td> <td>4/18/11</td> <td>Haloperidol, lorazepam and diphenhydramine (PRN)</td> </tr> </tbody> </table> <p>This review found substantial compliance in all cases with the requirements regarding the use of emergency medications. In addition, the psychiatric progress notes contained evidence of appropriate modifications of treatment, as clinically indicated, following the use of seclusion/restraint.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that the psychiatric reassessments consistently include an individualized risk/benefit analysis, particularly for individuals who 	Initials	Date of seclusion/restraint	PRN/Stat Use	JMM	4/30/11	Haloperidol and diphenhydramine (PRN)	JS	4/24/11	Chlorpromazine (PRN)	NM	5/4/11	Olanzapine (PRN) and trazodone (PRN)	OC	4/7/11	Ziprasidone, lorazepam and diphenhydramine (Stat)	PH	4/18/11	Haloperidol, lorazepam and diphenhydramine (PRN)
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Section D: Integrated Assessments

		have multiple risk factors and continue to receive high-risk treatments.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	Same as above.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	Same as above.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	Same as above.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	Same as above.
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	Same as above.
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	Same as above.
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with	Same as above.

Section D: Integrated Assessments

	<p>psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>																			
<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure full implementation of the streamlined format of the transfer assessment. <p>Findings: PSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 21% of the individuals who experienced inter-unit transfer per month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 894 1887 1125"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: A review of the charts of six individuals who experienced inter-unit transfers during the review period found substantial compliance in five cases and partial compliance in one (RA). The following table outlines the</p>	1.	<i>Psychiatric course of hospitalization,</i>	100%	2.	<i>Medical course of hospitalization,</i>	100%	3.	<i>Current target symptoms,</i>	100%	4.	<i>Psychiatric risk assessment,</i>	99%	5.	<i>Current barriers to discharge,</i>	100%	6.	<i>Anticipated benefits of transfer.</i>	100%
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Section D: Integrated Assessments

		<p>reviews:</p> <table border="1"><thead><tr><th>Initials</th><th>Date of transfer</th></tr></thead><tbody><tr><td>AC</td><td>3/18/11</td></tr><tr><td>GLC</td><td>3/4/11</td></tr><tr><td>KR</td><td>5/3/11</td></tr><tr><td>RA</td><td>4/27/11</td></tr><tr><td>RLK</td><td>4/7/11</td></tr><tr><td>SSC</td><td>3/8/11</td></tr></tbody></table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Initials	Date of transfer	AC	3/18/11	GLC	3/4/11	KR	5/3/11	RA	4/27/11	RLK	4/7/11	SSC	3/8/11
Initials	Date of transfer															
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Section D: Integrated Assessments

2. Psychological Assessments		
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	As of the tour conducted in December 2010, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	
D.2.d.i	expressly state the clinical question(s) for	

Section D: Integrated Assessments

	the assessment;	
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	
D.2.d.iii	specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	
D.2.d.iv	be based on current, accurate, and complete data;	
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	
D.2.d.vi	include the implications of the findings for interventions;	
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	
D.2.d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1	

Section D: Integrated Assessments

	and IV.B.2], above.	
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis;	
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic	

Section D: Integrated Assessments

	<p>questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	
<p>D.2.g</p>	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	

Section D: Integrated Assessments

3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Lidia Lau, RN, ACNS 2. Sandra Doerner, RN, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Nursing Admission Assessment Monitoring Audit summary data, November 2010 - April 2011 2. PSH Nursing Integrated Assessment Monitoring Audit summary data, November 2010 - April 2011 3. PSH's training rosters 4. Admission and integrated assessments and WRPs for the following 40 individuals: AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 24% mean sample of admissions each month during the review period (November 2010 - April 2011) and</p>

Section D: Integrated Assessments

		<p>reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that PSH has maintained the quality of the assessments and all 40 were found to be in substantial compliance. These findings comport with PSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 22% mean sample of admissions each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 743 1887 894"> <tr> <td data-bbox="991 743 1087 894">1.</td> <td data-bbox="1087 743 1793 894"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 743 1887 894">94%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that PSH had also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings comport with PSH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	94%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	94%			

Section D: Integrated Assessments

D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 266 1887 563"> <tr> <td data-bbox="991 266 1087 563">2.</td> <td data-bbox="1087 266 1793 563"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 266 1887 563">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 786 1887 972"> <tr> <td data-bbox="991 786 1087 972">2.</td> <td data-bbox="1087 786 1793 972"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 786 1887 972">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	97%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	99%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	97%						
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	99%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <p>PSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <p>PSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>						

Section D: Integrated Assessments

		90% from the previous review period.
D.3.a.iv	allergies;	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.v	pain;	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>

Section D: Integrated Assessments

D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.ix	conditions needing immediate nursing interventions.	<p><u>Admission Assessments</u> PSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> PSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	Current findings on previous recommendation:

Section D: Integrated Assessments

		<p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Patton State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: A review of PSH training rosters verified that all 63 RNs who were required to complete competency-based training regarding Nursing Assessments passed the training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.3.d	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p>	<p>Compliance: Substantial.</p>

Section D: Integrated Assessments

<p>D.3.d.i</p>	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 24% mean sample of admissions each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>D.3.d.ii</p>	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 22% mean sample of admissions each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the</p>

Section D: Integrated Assessments

		<p>previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on a mean sample of 19% of WRPCs observed each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 971 1911 1123"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>97%</td> <td>97%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>97%</td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of 40 individuals (AFR, ARC, BDM, CCX, CG, CMB, DLT, DRS, DWW, EKE, ERA, ET, GS, JAD, JF, JJG, JQ, JR, JRM, JST, JWA, KCP, MEH, MT, NMJ, PG, RAH, RG, RLK, RMJ, RPE, RRB, RSH, RSS, RW, SDH, SDJ, SJ, THH and TRK) found that an RN attended the WRPC</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	97%	97%	<i>Psychiatric Technician attendance at WRPC</i>	97%	97%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	97%	97%									
<i>Psychiatric Technician attendance at WRPC</i>	97%	97%									

Section D: Integrated Assessments

		<p>in 35 cases and a PT attended the WRPC in 24 cases.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that PTs consistently attend the WRPTs.2. Continue to monitor this requirement.
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alejandro Fernandez, Senior Rehabilitation Therapist 2. Chris Keierleber, Senior Rehabilitation Therapist 3. Denise Byerly, POST Coordinator 4. Greg Siples, Chief of Rehabilitation Therapy 5. Kathleen McIntire, Senior Rehabilitation Therapist 6. Rebecca Griffin, Senior Rehabilitation Therapist 7. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 8. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had Integrated Assessments: Rehabilitation Therapy Section from November 2010 - April 2011 2. Records of the following 13 individuals who had Integrated Assessments: Rehabilitation Therapy Section from November 2010 - April 2011: ARC, AS, DA, DDG, DEN, GLH, HW, IAL, PCG, RAA, RRD, SB and SDH 3. List of individuals who had Occupational Therapy assessments from November 2010 - April 2011 4. Records of the following eight individuals who had Occupational Therapy assessments from November 2010 - April 2011: GJG, RLA, RRD, SB, SC, SP, TS and VGR 5. List of individuals who had Physical Therapy assessments from November 2010 - April 2011 6. Records of the following seven individuals who had Physical Therapy assessments from November 2010 - April 2011: BG, DEN, GJG, KE, PCG, TS and VT 7. List of individuals who had Speech Therapy assessments from November 2010 - April 2011 8. Records of the following five individuals who had Speech Therapy

Section D: Integrated Assessments

		<p>assessments from November 2010 - April 2011: AAD, GS, IAL, PCG and TS</p> <p>9. List of individuals who had Vocational Rehabilitation assessments from November 2010 - April 2011</p> <p>10. Records of the following nine individuals who had Vocational Rehabilitation assessments from November 2010 - April 2011: AR, CC, CGD, DFS, EH, EKG, ISL, LJ and SH</p> <p>11. List of individuals who had CIPRTA assessments from November 2010 - April 2011</p> <p>12. Records of the following individual who had CIPRTA assessment from November 2010 - April 2011: GC</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: A review of the revised Integrated Assessment: Rehabilitation Therapy Section (IA:RTS) found that the new format supported continued comprehensive findings yet in a more concise and clinically useful structure. Focused assessment tools should be revised, updated, and streamlined based on review and analysis of audit data, clinician recommendations for improving clinical utility, and changes in systemic needs and evolving standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>

Section D: Integrated Assessments

<p>D.4.b</p>	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness (seven calendar days from admission) based on an average sample of 26% of IA:RTSs due each month for the review period November 2010 - April 2011 (total of 120 out of 465) and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTSs with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (fourteen days from referral) based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 23) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2010 -</p>
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Section D: Integrated Assessments

		<p>April 2011 (total of 85) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 36) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (30 days from referral) based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2010 - April 2011 (total of 102) and reported a mean compliance rate of 98%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found eight records in compliance (AR, CC, CGD, DFS, EH, EKG, LJ and SH) and one record not in compliance (ISL).</p>
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Section D: Integrated Assessments

		<p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2010 - April 2011 (total of two) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessment with timeliness found the record in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 26% of IA:RTSs due each month for the review period November 2010 - April 2011 (total of 120 out of 465) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals to assess compliance of</p>

Section D: Integrated Assessments

		<p>IA:RTSs with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 23) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 85) and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 36) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>
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Section D: Integrated Assessments

		<p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2010 - April 2011 (total of 102) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2010 - April 2011 (total of two) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessments with D.4.b.i criteria found the record in substantial compliance.</p> <p>Compliance: Substantial.</p>
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Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.4.b.ii	<p>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 26% of IA:RTSs due each month for the review period November 2010 - April 2011 (total of 120 out of 465):</p> <table border="1" data-bbox="993 711 1892 862"> <tr> <td data-bbox="993 711 1087 784">3.</td> <td data-bbox="1087 711 1776 784"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 711 1892 784">100%</td> </tr> <tr> <td data-bbox="993 784 1087 862">4.</td> <td data-bbox="1087 784 1776 862"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 784 1892 862">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTSs with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 23):</p> <table border="1" data-bbox="993 1344 1892 1417"> <tr> <td data-bbox="993 1344 1087 1417">3.</td> <td data-bbox="1087 1344 1776 1417"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 1344 1892 1417">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%									
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%									
3.	<i>Identifies the individual's current functional status, and</i>	100%									

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="989 196 1087 263">4.</td> <td data-bbox="1087 196 1776 263"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 196 1892 263">100%</td> </tr> </table>	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%				
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 85):</p>				
		<table border="1"> <tr> <td data-bbox="989 751 1087 818">3.</td> <td data-bbox="1087 751 1776 818"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 751 1892 818">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 36):</p>				
		<table border="1"> <tr> <td data-bbox="989 1383 1087 1416">3.</td> <td data-bbox="1087 1383 1776 1416"><i>Identifies the individual's current functional status,</i></td> <td data-bbox="1776 1383 1892 1416">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status,</i>	100%	
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Section D: Integrated Assessments

		<table border="1"> <tr> <td></td> <td><i>and</i></td> <td></td> </tr> <tr> <td>4.</td> <td><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td>100%</td> </tr> </table>		<i>and</i>		4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2010 - April 2011 (total of 102):</p> <table border="1"> <tr> <td>3.</td> <td><i>Identifies the individual's current functional status, and</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2010 - April 2011 (total of</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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Section D: Integrated Assessments

		<p>two):</p> <table border="1" data-bbox="991 264 1887 417"> <tr> <td data-bbox="991 264 1087 339">3.</td> <td data-bbox="1087 264 1776 339"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 264 1887 339">100%</td> </tr> <tr> <td data-bbox="991 339 1087 417">4.</td> <td data-bbox="1087 339 1776 417"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 339 1887 417">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessment with D.4.b.ii criteria found the record in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%						
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 26% of IA:RTSs due each month for the review period November 2010 - April 2011 (total of 120 out of 465):</p> <table border="1" data-bbox="991 1343 1887 1416"> <tr> <td data-bbox="991 1343 1087 1382">5.</td> <td data-bbox="1087 1343 1776 1382"><i>Identifies the individual's life goals,</i></td> <td data-bbox="1776 1343 1887 1382">100%</td> </tr> <tr> <td data-bbox="991 1382 1087 1416">6.</td> <td data-bbox="1087 1382 1776 1416"><i>Strengths, and</i></td> <td data-bbox="1776 1382 1887 1416">100%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%
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Section D: Integrated Assessments

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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTSs with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 23):</p>					
		<table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	100%	<table border="1"> <tr> <td>100%</td> </tr> </table>	100%
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 85):</p>					
		<table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	100%	<table border="1"> <tr> <td>100%</td> </tr> </table>	100%
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Section D: Integrated Assessments

		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2010 - April 2011 (total of 36):</p> <table border="1" data-bbox="991 672 1890 789"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2010 - April 2011 (total of 102):</p> <table border="1" data-bbox="991 1305 1890 1422"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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Section D: Integrated Assessments

		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2010 - April 2011 (total of two):</p> <table border="1" data-bbox="991 711 1887 824"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessment with D.4.b.iii criteria found the record in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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7.	<i>Motivation for engaging in wellness activities.</i>	100%									
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing	Current findings on previous recommendation:									

Section D: Integrated Assessments

	<p>rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH reported that in the review period, both physical therapists requiring training were trained to competency in CIPRTA and PTFA completion. One physical therapist assistant was trained to competency in the application of physical therapy findings using either the CIPRTA and/or PTFA.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of the June 2009 tour.</p> <p>Compliance: Substantial.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Delores Otto-Moreno, Assistant Director of Nutrition Services 2. Grace Ferris, Assistant Director of Nutrition Services 3. Kristina Hooper, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for November 2010 - April 2011 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from November 2010 - April 2011 for each assessment type 3. Records of the following seven individuals with type D.5.d assessments from November 2010 - April 2011: AG, DRW, GS, JL, JTW, PG and ULL 4. Records of the following six individuals with type D.5.e assessments from November 2010 - April 2011: BCM, EV, ML, RO, RRS and TLM 5. Records of the following four individuals with type D.5.f assessments from November 2010 - April 2011: DNC, HME, JSD and TRK 6. Records of the following five individuals with type D.5.g assessments from November 2010 - April 2011: CCC, IM, NAD, RR and SL 7. Records of the following four individuals with type D.5.i assessments from November 2010 - April 2011: CJ, NY, SGM and SWS 8. Records of the following six individuals with type D.5.j.i assessments from November 2010 - April 2011: DAH, HKA, LL, LRR, SHK and TS 9. Records of the following eight individuals with type D.5.j.ii assessments from November 2010 - April 2011: AEA, AYR, CL, GBB, JFT, PBD, SHT and SMM

Section D: Integrated Assessments

D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: No individuals met criteria or were referred for a type D.5.a. Nutrition assessment during the review period.</p> <p>Compliance: Unable to determine.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable. PSH does not have a medical-surgical unit.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d</p>

Section D: Integrated Assessments

	<p>be completed within 7 days of admission.</p>	<p>assessments due each month for the review period November 2010 - April 2011 (total of 30):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>93%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>97%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	98%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	93%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	97%
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Section D: Integrated Assessments

		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																		
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period November 2010 - April 2011 (total of 24):</p> <table border="1" data-bbox="991 1081 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>92%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated,</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	92%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated,</i>	100%
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Section D: Integrated Assessments

			<i>prioritized and validated</i>	
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11.	<i>Recommendations are appropriate and complete</i>	100%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.e criteria found five records in substantial compliance (EV, ML, RO, RRS and TLM) and one record not in compliance (BCM--assessment not found in record).</p> <p>Compliance: Substantial.</p>		

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement.</p>																																				
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period November 2010 - April 2011 (total of 16):</p> <table border="1" data-bbox="991 711 1885 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	100%
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Section D: Integrated Assessments

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D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 15% of Nutrition Type D.5.g assessments due each month for the review period November 2010 - April 2011 (total of 48 out of 310):</p>																					

Section D: Integrated Assessments

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Section D: Integrated Assessments

		<p>N/A in either period.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.5.h	<p>Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 17% of Nutrition assessments (all types) due each month of the review period November 2010 - April 2011 (366 out of 2187). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 39 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section D: Integrated Assessments

<p>D.5.i</p>	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 11% of Nutrition Type D.5.i assessments due each month for the review period November 2010 - April 2011 (total of 129 out of 1197):</p> <table border="1" data-bbox="991 597 1885 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	98%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	97%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	98%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	99%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

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D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p data-bbox="993 984 1577 1016">Current findings on previous recommendation:</p> <p data-bbox="993 1062 1457 1127">Recommendation, December 2010: Continue to monitor this requirement.</p> <p data-bbox="993 1172 1887 1349">Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 53% of Nutrition Type D.5.j.i assessments due each month for the review period November 2010 - April 2011 (total of 52 out of 99):</p> <table border="1" data-bbox="993 1385 1887 1421"> <tr> <td data-bbox="993 1385 1087 1421">1.</td> <td data-bbox="1087 1385 1776 1421"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1776 1385 1887 1421">98%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	98%												
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Section D: Integrated Assessments

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		3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11.	<i>Recommendations are appropriate and complete</i>	100%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period that were not N/A in the previous period.</p>		

Section D: Integrated Assessments

		<p>A review of the records of six individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 13% of Nutrition Type D.5.j.ii assessments due each month for the review period November 2010 - April 2011 (total of 67 out of 514):</p> <table border="1" data-bbox="991 933 1890 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>84%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	84%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	100%
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8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	100%																								

Section D: Integrated Assessments

			<i>identified</i>	
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11.	<i>Recommendations are appropriate and complete</i>	98%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 2-18 (excluding inapplicable items) and improved compliance for item 1 from 78% in the previous period.</p> <p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		

Section D: Integrated Assessments

6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Lisa Hilder, LCSW, Supervisor Social Worker 2. Rachel Strydom, LCSW, Supervising Social Worker 3. Samantha Lillo, LCSW, Family Services Clinic 4. Tiffany Rector, JD, LCSW (A), Supervising Social Worker and Section Leader 5. Veronica Kaufman, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following eight individuals: CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB 2. PSH Social History Assessments Monitoring Form summary data, November 2010 - April 2011 3. DMH Integrated Assessments: Social Work Section 4. DMH 30-Day Psychosocial Assessments 									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of the Integrated Assessments: Social Work Section due each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1304 1892 1416"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%									
2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at</i>	100%									

Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1887 305"> <tr> <td data-bbox="993 191 1094 305"></td> <td data-bbox="1094 191 1793 305"><i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 191 1887 305"></td> </tr> </table> <p data-bbox="993 347 1898 415">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 457 1898 565">A review of the records of eight individuals to evaluate the Integrated Assessments: Social Work Section found that all eight assessments were current and comprehensive (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB).</p> <p data-bbox="993 607 1898 750">Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of the 30-Day Psychosocial Assessments due each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 786 1887 1013"> <tr> <td data-bbox="993 786 1087 824">1.</td> <td data-bbox="1087 786 1793 824"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 786 1887 824">99%</td> </tr> <tr> <td data-bbox="993 824 1087 863">2.</td> <td data-bbox="1087 824 1793 863"><i>Current, and</i></td> <td data-bbox="1793 824 1887 863">100%</td> </tr> <tr> <td data-bbox="993 863 1087 1013">3.</td> <td data-bbox="1087 863 1793 1013"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 863 1887 1013">100%</td> </tr> </table> <p data-bbox="993 1055 1898 1123">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 1166 1898 1344">A review of the records of eight individuals to evaluate the 30-Day Psychosocial Assessments found that all eight assessments were current and comprehensive (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB). Overall, the quality of the assessments has improved significantly. The assessments for MHL, RG and RLK were especially well written.</p>		<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>		1.	<i>Is, to the extent reasonably possible, accurate</i>	99%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
	<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>													
1.	<i>Is, to the extent reasonably possible, accurate</i>	99%												
2.	<i>Current, and</i>	100%												
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%												

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of the 30-Day Psychosocial Assessments due each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 821 1892 976"> <tr> <td data-bbox="993 821 1087 898">4.</td> <td data-bbox="1087 821 1797 898"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1797 821 1892 898">100%</td> </tr> <tr> <td data-bbox="993 898 1087 938">5.</td> <td data-bbox="1087 898 1797 938"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1797 898 1892 938">100%</td> </tr> <tr> <td data-bbox="993 938 1087 976">6.</td> <td data-bbox="1087 938 1797 976"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1797 938 1892 976">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of eight individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all eight assessments identified and resolved factual inconsistencies (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB).</p> <p>Compliance: Substantial.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement</p>						
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of Integrated Assessments: Social Work Section due each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 711 1890 751"> <tr> <td data-bbox="993 711 1087 751">7.</td> <td data-bbox="1087 711 1795 751"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1795 711 1890 751">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to evaluate timeliness of the Integrated Assessments: Social Work Section found that all eight assessments were timely (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB).</p> <p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1193 1890 1234"> <tr> <td data-bbox="993 1193 1087 1234">8.</td> <td data-bbox="1087 1193 1795 1234"><i>Fully documented by 30th day of admission</i></td> <td data-bbox="1795 1193 1890 1234">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to evaluate timeliness of the</p>	7.	<i>Is included in the 7-day integrated assessment</i>	99%	8.	<i>Fully documented by 30th day of admission</i>	99%
7.	<i>Is included in the 7-day integrated assessment</i>	99%						
8.	<i>Fully documented by 30th day of admission</i>	99%						

Section D: Integrated Assessments

		<p>30-Day Psychosocial Assessments found that all eight assessments were timely (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 932 1892 1122"> <tr> <td data-bbox="993 932 1087 1008">9.</td> <td data-bbox="1087 932 1795 1008"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1795 932 1892 1008">100%</td> </tr> <tr> <td data-bbox="993 1008 1087 1122">10.</td> <td data-bbox="1087 1008 1795 1122"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1795 1008 1892 1122">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all eight assessments included this information (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB).</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%						

Section D: Integrated Assessments

		<p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 21% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 375 1890 565"> <tr> <td data-bbox="993 375 1087 451">9.</td> <td data-bbox="1087 375 1795 451"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1795 375 1890 451">100%</td> </tr> <tr> <td data-bbox="993 451 1087 565">10.</td> <td data-bbox="1087 451 1795 565"><i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i></td> <td data-bbox="1795 451 1890 565">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that all eight assessments included this information (CJ, KM, KMJ, MHL, RAZ, RG, RLK and WB J).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%						

Section D: Integrated Assessments

7. Court Assessments		
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	As of the tour conducted in October 2010, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	
D.7.a.vii	previous community releases, if the individual has	

Section D: Integrated Assessments

	had previous CONREP revocations;	
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	

Section D: Integrated Assessments

D.7.c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has continued to maintain substantial compliance with the requirements of this section. 2. The SW department at PSH has conducted numerous activities related to the expeditious discharge of individuals at the facility, including presenting to the community, publishing in newsletters, educating community agencies, and conducting timely reviews of cases with the courts and other agencies.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Lisa Hilder, LCSW, Supervisor Social Worker 2. Rachel Strydom, LCSW, Supervising Social Worker 3. Samantha Lillo, LCSW, Family Services Clinic 4. Tiffany Rector, JD, LCSW (A), Supervising Social Worker and Section Leader 5. Veronica Kaufman, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 18 individuals: AB, BR, CD, DF, DWD, ET, GD, JH, MD, MHL, MPC, NW, PT, RAO, RG, RLK, RSS, and SC 2. Discharge Planning and community Integration Department Protocol 3. Discharge Planning Department Newsletter 4. Discharge Planning Database 5. CONREP evaluation report 6. List of Individuals Discharged 7. List of Individuals Referred for Discharge but still hospitalized <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, Unit EB04) for quarterly review of LG

Section E: Discharge Planning and Community Integration

		<p>2. WRPC (Program III, Unit 31) for quarterly review of OVM</p> <p>3. WRPC (Program III, Unit 33) for quarterly review of TMM</p>
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals found that 16 WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AB, BR, CD, DF, DWD, ET, GD, JH, MD, MHL, MPC, NW, PT, RAO, RLK and RSS). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining WRP (RG).</p> <p>Compliance: Substantial.</p>

Section E: Discharge Planning and Community Integration

		<p>Current recommendation: Continue to monitor this requirement</p>
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals found that 16 WRPs included the individual's psychosocial functioning in the Present Status section (AB, BR, CD, DF, DWD, ET, GD, JH, MD, MHL, MPC, NW, PT, RAO, RG and RSS). The remaining WRP did not include the information or the information was not comprehensive (RLK).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

		<p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals found that 15 WRPs contained documentation that discharge barriers were discussed with the individual (AB, BR, CD, DF, DWD, ET, GD, JH, MD, MHL, MPC, NW, PT, RAO and RSS). The remaining two WRPs did not (RG and RLK).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 16 individuals found that 15 WRPs documented</p>

Section E: Discharge Planning and Community Integration

		<p>the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (AB, BR, CD, DF, DWD, ET, GD, JH, MD, MPC, NW, PT, RAO, RG and RSS). The remaining WRP did not (MHL).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals found that 13 WRPs contained documentation indicating that the individual was an active participant in the discharge process (AB, BR, CD, DF, DWD, ET, GD, JH, MD, MPC, NW, PT and RSS). The remaining two WRPs contained no documentation that the individual participated in the discussion (RAO and RG).</p> <p>This monitor observed three WRPCs (LG, OVM and TMM). The individuals were engaged in their discharge matters in all three team conferences.</p>

Section E: Discharge Planning and Community Integration

		<p>A review of the records of eight individuals found that five WRPs contained measurable objectives and interventions to address the individual's discharge criteria (BR, ET, PT, RAO and RSS) and three did not (MHL, RG and RLK).</p> <p>A review of the records of eight individuals found that all eight WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (BR, ET, MHL, PT, RAO, RG, RLK and RSST).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period</p>

Section E: Discharge Planning and Community Integration

		<p>(November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of eight individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in five WRPs (BR, ET, PT, RAO and RSS) and three did not (MHL, RG and RLK). According to Dr. Christison, PSH has conducted a streamlining project, one of the activities of which was to make the objectives more meaningful rather than merely compliant to a quantitative numerical value. The project is still continuing with instructions and training. The data will be better reflected at the next review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs</p>

Section E: Discharge Planning and Community Integration

		<p>identified the staff member responsible for the interventions (BR, ET, MHL, PT, RAO, RG, RLK and RSS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (BR, ET, MHL, PT, RAO, RG, RLK and RSS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	Compliance: Substantial.														
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Documentation review found that PSH recommended 316 individuals for discharge during this review period. Two-hundred and ninety-nine of them were discharged, leaving 17 still hospitalized (as of May 20, 2011). The table below shows the individuals still hospitalized post-referral for discharge, their referral date, their current status, and what the facility is doing about it:</p> <table border="1" data-bbox="991 821 1906 1416"> <thead> <tr> <th data-bbox="991 821 1096 898">Individual</th> <th data-bbox="1096 821 1241 898">Referral Date</th> <th data-bbox="1241 821 1570 898">Status</th> <th data-bbox="1570 821 1906 898">Efforts by PSH to solve issues</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 898 1096 1230">TB</td> <td data-bbox="1096 898 1241 1230">5/21/08</td> <td data-bbox="1241 898 1570 1230">Continued immigration issues. CONREP is willing to accept TB upon immigration clearance. A new attorney has taken up TB's cause on a pro bono basis.</td> <td data-bbox="1570 898 1906 1230">SW staff awaiting immigration outcome. Meanwhile SW staff is educating TB on utilizing CONREP resources for MI stability and rebuilding a social support system in the community.</td> </tr> <tr> <td data-bbox="991 1230 1096 1416">JM</td> <td data-bbox="1096 1230 1241 1416">8-4-10</td> <td data-bbox="1241 1230 1570 1416">Awaiting CONREP interview. CONREP has not given dates, but has stated concerns and the rest of the</td> <td data-bbox="1570 1230 1906 1416">Unit SW meets with JM to review CONREP conditions. Reviewed resources including SSI, schooling, MH services</td> </tr> </tbody> </table>			Individual	Referral Date	Status	Efforts by PSH to solve issues	TB	5/21/08	Continued immigration issues. CONREP is willing to accept TB upon immigration clearance. A new attorney has taken up TB's cause on a pro bono basis.	SW staff awaiting immigration outcome. Meanwhile SW staff is educating TB on utilizing CONREP resources for MI stability and rebuilding a social support system in the community.	JM	8-4-10	Awaiting CONREP interview. CONREP has not given dates, but has stated concerns and the rest of the	Unit SW meets with JM to review CONREP conditions. Reviewed resources including SSI, schooling, MH services
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Section E: Discharge Planning and Community Integration

			evaluating team is reviewing the case.	and social support systems. Staff has used role-playing with JM to reduce anxiety of the interview process	
		PA	2-23-10	Accepted for COT at Southpoint, an SA program facility in San Diego	Unit SW staff is working with individual's attorney. The attorney stated that a hearing for a final decision was set for June 2, 2011.
		PC	12-08	Recommended for placement in a community facility under supervision of the Orange County Public Guardian's Office. The conservator stated that no place in Orange County will take PC with his alleged crime (PC187).	PSH DPCIP is looking for placement for PC. Still unsuccessful, PC is too young or the placement is looking for a private pay resident.
		VR	5-20-10	Recently assaulted (1/29/11). This has now become a barrier to discharge.	WRPT has created objectives and interventions for assault. VR will attend DBT: Interpersonal Effectiveness Group.
		RH	10-6-10	CONREP reported that RH is unsuitable for COT.	SW is working with DPCIP for direct discharge to a board and care in the community.
		PS	4-27-10	Court letter (9/9/10)	Psychiatrist completing

Section E: Discharge Planning and Community Integration

				stated individual continues to meet criteria for MDO, and suggested placement under a conservatorship. Individual's desire is to have his sister assigned as conservator.	paperwork to proceed with conservatorship.
		DR	11-23-09	San Bernardino CONREP had requested a comprehensive risk assessment (9-13-2010).	SW to assist San Bernardino CONREP in coordinating discharge.
		MS	9-9-09	Court ordered placement in less restrictive facility. Gateway CONREP is making contacts with facilities to follow court order.	SW in contact with Gateway regarding progress.
		MA	2-14-10	CONREP report (8/9/10) stated individual was not ready for less restrictive facility.	WRT has made another Pre-COT recommendation to San Diego CONREP (2/22/2011). WRT will send MA's progress report in August 2011.
		KR	6-16-10	KR's medical and forensic status are barriers.	PSH DPCIP is working the unit and the individual to locate and secure appropriate housing for KR.

Section E: Discharge Planning and Community Integration

		MW	4-30-09	CONREP disapproved WRPT's recommendation, instead indicated MW might be appropriate for locked community facility.	On April 2011, WRPT testified at MW's restoration hearing and is awaiting court report. MW is waiting to testify on her own behalf when hearing resumes. Meanwhile SW is in contact with CONREP regarding "locked" facility placement.
		KE	11-19-09	Previously CONREP disapproved placement. KE recently met with a CONREP representative (April 19, 2011) and is awaiting decision.	SW has begun the discharge process and will coordinate with the DPCIP Department and other PSH departments for clothing, medications, and referral for SSI.
		LS	8-17-07	CONREP has asked court to waive Jessica's Law, as they cannot accept individuals under the law. Gateway CONREP had sent a letter to the judge (11/1/2010).	SW has requested clothing when discharge procedures are completed, referral for Voc Rehab and SSI has been completed.
		JS	4-14-10	PSH had received a minute order for discharge to Sylmar. Discharge date is pending. JS was interviewed by Sylmar staff.	SW sent clothes size to DPCIP. SW will complete a SSI packet.

Section E: Discharge Planning and Community Integration

		AC	6-17-10	Sylmar evaluated AC in October and deemed inappropriate at that time. Court has requested progress report, which was duly sent. WRPT and individual again interviewed by CONREP (4/11), and reported progress to the court and Sylmar. Sylmar had requested medical information before making final decision.	SW sent the medical information to Sylmar, along with a letter to the court.
		JM	7-14-10	Court has ordered for two independent evaluators meet with JM prior to the upcoming hearing (May 6, 2011). San Bernardino CONREP has recommended JM to Southpoint.	SW has requested for clothing for when discharge is completed. SSI referral has also been completed.
		JG	11-19-10	WRT has recommended JG for COT. Current plans are that JG be transferred to Southpoint and then to a B&C	PSH is waiting for court decision and subsequent discharge date. SW has requested clothing and SSI request has been completed.
<p>For individuals under non-1370 legal commitments (e.g. PC 1026, 2962/72, LPS), a review of facility-provided information found that 35 individuals</p>					

Section E: Discharge Planning and Community Integration

		<p>had met discharge criteria but remain hospitalized during this review period. Thirty-one remain hospitalized due to external barriers (i.e. CONREP interview/placement delays, court hearing date, locating placement, CONREP/WRPT disagreements, immigration barriers, and PC 290 placement barriers), and four due to medical issues, PSH is still completing referral packets and physical examinations etc.</p> <p>Since the last review, PSH's DPCIP had organized numerous activities related to discharge matters. Staff interviews and documentation reviews found that the DPICP had conducted the following activities during this review period:</p> <p><u>Education:</u></p> <ol style="list-style-type: none">1. Presentation at Forensic Symposium2. Presenting Discharge Database statistics to PSH staff involved in discharge planning3. Presentations at Forensic Conference in September4. Research into immigration issues with ICE5. Education to other hospitals on Patton's discharge protocol6. Program-wide training7. Continuation of the Social Work Newsletter <p><u>Proposals:</u></p> <ol style="list-style-type: none">1. SSI Liaison Proposal2. CONREP Groups Proposal3. Transitional Unit Proposal4. Recommendations re: proposed legislation SB 21 <p><u>Collaborations:</u></p> <ol style="list-style-type: none">1. Second Court Commitments Committee meeting hosted by Patton including Riverside and San Bernardino2. Established relationships with Monterey and Alameda3. Initiate relationship with Riverside
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Section E: Discharge Planning and Community Integration

		<ol style="list-style-type: none"> 4. Expanding collaboration with San Bernardino - 5150 case 5. Communication with jails 6. Initiate relationship with DMV 7. Collaboration with LA County to utilize FSP (Full Service Partnership) services <p>Quality Assurance:</p> <ol style="list-style-type: none"> 1. Trend direct discharges and establish protocols to improve outcomes for the individuals and the community 2. Identify barriers to expeditiously discharging individuals through the discharge database 3. Track visitors to encourage proactive communication by Unit Social Work staff 4. Develop protocol for DPCIP staff (in addition to updates to existing protocol) and standardization of forms 5. Facility evaluations 6. Maintenance of Clothing Room Inventory <p>Current recommendation: Continue to monitor this requirement.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section E: Discharge Planning and Community Integration

		<p>A review of the charts of 10 individuals referred for discharge or were recently discharged found that nine contained documentation of the assistance needed by the individual and that provided by the facility for engagement in the new setting (CD, DF, DWD, ET, MD, MPC, PT, RSS and SC). The remaining WRP did not (NW).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to PSH as it does not serve children and adolescents.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services: PSH has maintained substantial compliance with all of the requirements in this section.</p> <p>Areas of need include: <i>Ensure that the psychiatric reassessments consistently include an individualized risk/benefit analysis, particularly for individuals who have multiple risk factors and continue to receive high-risk treatments.</i></p> <p>Summary of Progress on Psychological Services:</p> <ol style="list-style-type: none">1. PSH has achieved substantial compliance with all requirements in this section.2. PSH has introduced a number of changes to the By Choice program that enhance individuals' motivation, widened levels of incentive items for exchange, and applied technology to monitor and audit point recordings.3. PSH has significantly improved in the completion of Neuropsychology referrals, meeting the required timeline. <p>Summary of Progress on Nursing Services: PSH has maintained substantial compliance with all requirements of this section except those pertaining to assessment and documentation of change in status.</p> <p>Areas of need include:</p> <ol style="list-style-type: none">1. <i>Although some progress was noted during the current review, PSH needs to focus its efforts on implementing strategies addressing problematic issues regarding changes in status to ensure that the nursing assessments and documentation are clinically adequate and in alignment with standards of practice for nursing.</i>2. <i>PSH also needs to increase the quality of the clinical information</i>

	<p><i>provided during shift change, as this area had not shown improvement for the past two reviews.</i></p> <p>Summary of Progress on Rehabilitation Therapy Services:</p> <ol style="list-style-type: none">1. PSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.2. The quality and detail of 24-hour support plans has improved from last review period.3. PSH does not currently have a system by which to report and document progress towards vocational rehabilitation and IT assignment objectives in the WRP for Vocational active treatment interventions that fall outside of designated Mall hours. <p>Summary of Progress on Nutrition Services:</p> <ol style="list-style-type: none">1. PSH has maintained substantial compliance with the requirements of this section.2. Currently, all individuals who are at high risk for metabolic syndrome and with new diabetes diagnosis are not consistently referred for nutrition assessment upon change in status in a timely manner. <p>Summary of Progress on Pharmacy Services:</p> <p>As of the tour conducted in December 2010, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on General Medical Services:</p> <p>PSH has maintained substantial compliance with all of the requirements in</p>
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>this section.</p> <p>Areas of need include: <i>Ensure that the review of external hospitalizations includes psychiatric input to identify possible severe ADRs to psychiatric treatment.</i></p> <p>Summary of Progress on Infection Control: PSH has achieved substantial compliance with the requirements of this section.</p> <p>Summary of Progress on Dental Services: PSH's Dental Department has continued to maintain substantial compliance with all EP requirements except in the area addressing dental refusals, which are the responsibility of the WRPTs.</p> <p>Areas of need include: <i>The WRPTs need to develop, regularly review, and appropriately revise adequate and appropriate WRPs in alignment with the refusal risk levels of the dental refusals in order to come into substantial compliance with the requirement pertaining to refusals.</i></p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Proctor, MD, Senior Psychology Supervisor, P&T Committee Chair 2. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 48 individuals: ALD, AW, BD, BEH, CF, CLG, DAJ, DB, DCM, DJW, DML, EA, EG, EM, FCL, GA, HMR, JA, JF, JI, JJS, JK, JL, JLC, JP, JPD-1, JPD-2, JTF, KAI, KLA, LAB, LTH, MDC, ME, MG, MP, PD, PSP, RR, RT, RV, SB, SES, SS, WD, WK, WM and WSD 2. PSH Admission Psychiatric Assessment Auditing summary data (November 2010 to April 2011) 3. PSH Integrated Assessment: Psychiatry Section Auditing summary data (November 2010 to April 2011) 4. PSH Monthly PPN Audit summary data (November 2010 to April 2011) 5. PSH PRN and Stat monitoring summary data (November 2010 to April 2011) 6. PSH Tardive Dyskinesia database 7. PSH Polypharmacy database 8. PSH Movement Disorder Monitoring summary data (November 2010 to April 2011) 9. Pharmacy and Therapeutics Committee Minutes (November 2010 to April 2011) 10. Last ten Adverse Drug Reactions (ADRs) for this review period 11. PSH aggregated data regarding ADRs (November 2010 to April 2011) 12. ADR tracking sheet for the review period 13. Adverse Drug Reaction Report for period 3/1/11 - 3/31/11, dated 5/4/11 14. Revised policies and procedures for ADRs:

Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> a. PSH Pharmacy and Therapeutics Manual ADR Policy #1.07, October 2010 and b. PSH Nursing Policy and Procedure #537 A: ADR Reporting Program, February 2011 <p>15. Intensive Case Analyses of severe ADRs in four individuals (SR, DN, KS and SD).</p> <p>16. STOP-A (Selected Treatment of Psychomotor Agitation) Algorithm</p> <p>17. Drug Utilization Evaluations (DUEs) completed by PSH during this review period:</p> <ul style="list-style-type: none"> a. Monitoring of Lithium Levels; b. Use of potentially Inappropriate medications (PIM) in Older Adults; c. Assessment and Treatment following Assaults; d. Use of Bupropion and e. Use of Dosing Strategies Consistent with STOP-A algorithm <p>18. Revised policy and procedure for Drug Utilization Evaluations (DUEs), August 1, 2010</p> <p>19. PSH aggregated data regarding medication variances (November 2010 to April 2011)</p> <p>20. Last ten MVRs for this review period</p> <p>21. MVR tracking sheet for the review period</p> <p>22. Psychiatric Outcome data for the previous and current review period on the following: Aggression, Abuse/Neglect/Exploitation, Polypharmacy, Serious Medication Variances, Restraint and Seclusion, Prescribed Medications to High Risk populations, Severe Adverse Drug Reactions, and Substance Abuse Services</p>
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>provide specific summary outline of these updates.</p> <p>Findings: The following summarizes the updates to the DMH policy regarding psychiatric medication guidelines during this review period:</p> <ol style="list-style-type: none"> 1. A class warning that antipsychotics may induce neonatal dyskinetic movements; 2. The language regarding lamotrigine side effects was changed from "Headaches" to "Headaches, including due to aseptic meningitis;" 3. A proposal that Drug Utilization Evaluation (DUE) should include a sample of 20 individuals or all those individuals taking a medication, if less than 20; 4. A guideline regarding the use for lurasidone was approved; and 5. The Clozapine Protocol table of standard doses of second-generation antipsychotics was updated to include asenapine 10 to 20 mg/day, iloperidone 12 to 24 mg/day, and lurasidone 40 to 80 mg/day. <p>In addition, the following updates to the Patton State Hospital Pharmacy and Therapeutics Manual were made:</p> <ol style="list-style-type: none"> 1. The section regarding Approved Terms and Abbreviations was updated to include TST (Tuberculin Skin Test). Per direction from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the abbreviation qod was expanded to include likely variants, i.e. QOD, Q.O.D. and q.o.d. 2. The New Generation Antipsychotics Monitoring Tables were revised to maintain congruence with the medication protocols. <p>Recommendation 2, December 2010: Continue to monitor this requirement.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: PSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 28%, 23% and 17% respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 711 1892 787"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 938 1892 1052"> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <table border="1" data-bbox="991 1203 1892 1425"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.b</td> <td><i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>99%</td> </tr> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care</i>	100%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation</i>	100%	10.	<i>Psychopharmacology treatment plan</i>	99%	Monthly PPN			2.b	<i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available</i>	100%	3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines</i>	100%
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F.1.a.iii	tailored to each individual's symptoms;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	100%
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F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.c</td> <td><i>Monitored for effectiveness against clearly identified target variables</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.c	<i>Monitored for effectiveness against clearly identified target variables</i>	100%
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F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>99%</td> </tr> </table>	Monthly PPN			2.g	<i>Current AIMS</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following</i>	99%						
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F.1.a.vi	modified based on clinical rationales;	Same as in F.1.a.iii and F.1.a.v.									
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.v.									
F.1.a.viii	Properly documented.	<table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>100%</td> </tr> <tr> <td>Monthly PPN</td> <td>2.b, 2.g, 3 and 5.a-d</td> <td>100%</td> </tr> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2.b, 2.g, 3 and 5.a-d	100%
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Integrated Assessment (Psychiatry)	7 and 10	100%									
Monthly PPN	2.b, 2.g, 3 and 5.a-d	100%									
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 17% of individuals who have been hospitalized for 90 or more days during the review period (November 2010 - April 2011). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 27% and 38% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p>									

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td data-bbox="989 228 1087 378">6.</td> <td data-bbox="1087 228 1793 378"><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td data-bbox="1793 228 1885 378">100%</td> </tr> </table> <p data-bbox="989 418 1900 488">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1"> <tr> <th colspan="3">Nursing Services PRN</th> </tr> <tr> <td data-bbox="989 565 1087 602">1.</td> <td data-bbox="1087 565 1793 602"><i>Safe administration of PRN medication.</i></td> <td data-bbox="1793 565 1885 602">98%</td> </tr> <tr> <td data-bbox="989 602 1087 678">2.</td> <td data-bbox="1087 602 1793 678"><i>Documentation of the circumstances requiring PRN medication.</i></td> <td data-bbox="1793 602 1885 678">98%</td> </tr> <tr> <td data-bbox="989 678 1087 755">3.</td> <td data-bbox="1087 678 1793 755"><i>Documentation of the individual's response to PRN medication.</i></td> <td data-bbox="1793 678 1885 755">97%</td> </tr> </table> <p data-bbox="989 795 1900 865">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1"> <tr> <th colspan="3">Nursing Services Stat</th> </tr> <tr> <td data-bbox="989 943 1087 980">1.</td> <td data-bbox="1087 943 1793 980"><i>Safe administration of Stat medication.</i></td> <td data-bbox="1793 943 1885 980">97%</td> </tr> <tr> <td data-bbox="989 980 1087 1057">2.</td> <td data-bbox="1087 980 1793 1057"><i>Documentation of the circumstances requiring Stat medication.</i></td> <td data-bbox="1793 980 1885 1057">96%</td> </tr> <tr> <td data-bbox="989 1057 1087 1133">3.</td> <td data-bbox="1087 1057 1793 1133"><i>Documentation of the individual's response to Stat medication.</i></td> <td data-bbox="1793 1057 1885 1133">97%</td> </tr> </table> <p data-bbox="989 1174 1900 1243">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 1284 1142 1354">Compliance: Substantial.</p>	Monthly PPN			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	100%	Nursing Services PRN			1.	<i>Safe administration of PRN medication.</i>	98%	2.	<i>Documentation of the circumstances requiring PRN medication.</i>	98%	3.	<i>Documentation of the individual's response to PRN medication.</i>	97%	Nursing Services Stat			1.	<i>Safe administration of Stat medication.</i>	97%	2.	<i>Documentation of the circumstances requiring Stat medication.</i>	96%	3.	<i>Documentation of the individual's response to Stat medication.</i>	97%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>															
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Improve documentation of specific potential risks of drug-drug interactions for individuals receiving polypharmacy. <p>Findings: PSH used the standardized DMH Monthly PPN Audit Form to assess compliance (November 2010 - April 2011). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 821 1887 1125"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines. (%S = 14%)</i></td> <td>99%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 12%)</i></td> <td>99%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 15%)</i></td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Additionally, PSH reported the following comparative data:</p>	PPN - Revised			5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>		5.d.i.	<i>Benzodiazepines. (%S = 14%)</i>	99%	5.d.ii.	<i>Anticholinergics. (%S = 12%)</i>	99%	5.d.iii.	<i>Polypharmacy. (%S = 15%)</i>	97%
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Section F: Specific Therapeutic and Rehabilitation Services

		Indicators	Previous period	Current period
		<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	109	110
		<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i>	81	78
		<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more</i>	68	63
		<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning), for 60 days or more</i>	25	20
		<i>Total number receiving anticholinergics for 60 days or more</i>	172	181
		<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above, for 60 days or more</i>	34	48
		<i>Total number with intra-class polypharmacy</i>	215	220
		<i>Total number with inter-class polypharmacy</i>	454	423
		<p>The above data indicate that PSH has maintained appropriate caution in the use of these classes of medications.</p> <p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</p> <p>3. Anticholinergic medications for elderly individuals; and</p> <p>4. Various forms of polypharmacy.</p> <p>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following outlines these reviews (the diagnoses are listed only if they signified high risk conditions):</p> <p><u>Benzodiazepine use</u></p> <table border="1" data-bbox="991 597 1896 979"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BEH</td> <td>Clonazepam</td> <td>Mild Mental Retardation</td> </tr> <tr> <td>CF</td> <td>Lorazepam</td> <td>Polysubstance Dependence and Borderline Intellectual Functioning</td> </tr> <tr> <td>GA</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JF</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>MG</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>PSP</td> <td>Lorazepam</td> <td>Cannabis Dependence</td> </tr> <tr> <td>RV</td> <td>Clonazepam</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>SB</td> <td>Lorazepam</td> <td>Alcohol Dependence and Cannabis Abuse</td> </tr> </tbody> </table> <p>This review found substantial compliance in all cases.</p> <p><u>Anticholinergic use</u></p> <table border="1" data-bbox="991 1166 1883 1393"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BD</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>JK</td> <td>Diphenhydramine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>JL</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>PD</td> <td>Benztropine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>RT</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	BEH	Clonazepam	Mild Mental Retardation	CF	Lorazepam	Polysubstance Dependence and Borderline Intellectual Functioning	GA	Lorazepam	Polysubstance Dependence	JF	Lorazepam	Polysubstance Dependence	MG	Clonazepam	Polysubstance Dependence	PSP	Lorazepam	Cannabis Dependence	RV	Clonazepam	Cognitive Disorder, NOS	SB	Lorazepam	Alcohol Dependence and Cannabis Abuse	Individual	Medication(s)	Diagnosis	BD	Benztropine	Borderline Intellectual Functioning	JK	Diphenhydramine	Borderline Intellectual Functioning	JL	Benztropine	Borderline Intellectual Functioning	PD	Benztropine	Cognitive Disorder NOS	RT	Benztropine	Borderline Intellectual Functioning
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Section F: Specific Therapeutic and Rehabilitation Services

		RV	Benztropine	Cognitive Disorder NOS																																	
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		WSD	Benztropine	Borderline Intellectual Functioning																																	
		<p>This review found substantial compliance in five cases and partial compliance in three (BD, WK and WSD).</p> <p><u>Anticholinergic use for individuals age 65 or above:</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>DCM</td> <td>Hydroxyzine</td> <td></td> </tr> <tr> <td>EG</td> <td>Benztropine</td> <td>Tardive Dyskinesia</td> </tr> <tr> <td>RR</td> <td>Trihexyphenidyl</td> <td></td> </tr> <tr> <td>WD</td> <td>Trihexyphenidyl</td> <td></td> </tr> </tbody> </table> <p>This review found substantial compliance in two cases (RR and WD), partial compliance in one (EG) and noncompliance in one (DCM).</p> <p><u>Polypharmacy use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>DB</td> <td>Olanzapine, risperidone, citalopram and lithium</td> <td></td> </tr> <tr> <td>EA</td> <td>Haloperidol, olanzapine, benztropine, topiramate and sertraline</td> <td></td> </tr> <tr> <td>EM</td> <td>Olanzapine, quetiapine, sertraline and zolpidem</td> <td></td> </tr> <tr> <td>JPD-2</td> <td>Divalproex, olanzapine and paliperidone (intra-class)-partial</td> <td></td> </tr> <tr> <td>KAI</td> <td>Aripiprazole, lamotrigine, bupropion and fluoxetine</td> <td></td> </tr> </tbody> </table>			Individual	Medication(s)	Diagnosis	DCM	Hydroxyzine		EG	Benztropine	Tardive Dyskinesia	RR	Trihexyphenidyl		WD	Trihexyphenidyl		Individual	Medication(s)	Diagnosis	DB	Olanzapine, risperidone, citalopram and lithium		EA	Haloperidol, olanzapine, benztropine, topiramate and sertraline		EM	Olanzapine, quetiapine, sertraline and zolpidem		JPD-2	Divalproex, olanzapine and paliperidone (intra-class)-partial		KAI	Aripiprazole, lamotrigine, bupropion and fluoxetine	
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="987 190 1134 267">KLA</td> <td data-bbox="1134 190 1644 267">Risperidone, clozapine, divalproex, duloxetine and lamotrigine</td> <td data-bbox="1644 190 1873 267"></td> </tr> <tr> <td data-bbox="987 267 1134 345">LTH</td> <td data-bbox="1134 267 1644 345">Clozaril, olanzapine, sertraline (intra-class)</td> <td data-bbox="1644 267 1873 345"></td> </tr> <tr> <td data-bbox="987 345 1134 456">MDC</td> <td data-bbox="1134 345 1644 456">Olanzapine, risperidone, sertraline, divalproex, topiramate and benztropine</td> <td data-bbox="1644 345 1873 456"></td> </tr> </table>	KLA	Risperidone, clozapine, divalproex, duloxetine and lamotrigine		LTH	Clozaril, olanzapine, sertraline (intra-class)		MDC	Olanzapine, risperidone, sertraline, divalproex, topiramate and benztropine		<p>This review found substantial compliance in seven cases and partial compliance in one (MDC).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following: <ol style="list-style-type: none"> a. Benzodiazepines; b. Benzodiazepines and have any diagnosis of substance use disorder; c. Benzodiazepines and have any diagnosis of cognitive impairment; d. Anticholinergics; e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above; f. Intra-class polypharmacy; and g. Inter-class polypharmacy. <p>The data for items a to e should continue to be limited to the use of the medication (s) for 60 or more days.</p>
KLA	Risperidone, clozapine, divalproex, duloxetine and lamotrigine											
LTH	Clozaril, olanzapine, sertraline (intra-class)											
MDC	Olanzapine, risperidone, sertraline, divalproex, topiramate and benztropine											
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with	Current findings on previous recommendations:										

Section F: Specific Therapeutic and Rehabilitation Services

the use of new generation antipsychotic medications.

Recommendations 1 and 2, December 2010:

- Continue to monitor this requirement.
- Ensure consistent documentation of trends (improvement or worsening) in the side effects of treatment.

Findings:

Using the DMH Monthly PPN Auditing Form, PSH assessed its compliance based on an average sample of 17% of individuals receiving these medications during the review period during the review period (November 2010 - April 2011):

Monthly PPN		
5.d.v	<i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i>	100%

Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.

Other findings:

This monitor reviewed the charts of 14 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
ALD	Olanzapine	Diabetes Mellitus, Dyslipidemia, Obesity and Hypertension
CLG	Risperidone	Obesity and Hyperprolactinemia
DAJ	Risperidone	Dyslipidemia, Obesity and Hyperprolactinemia
DJW	Iloperidone	Hyperprolactinemia and Morbid Obesity

Section F: Specific Therapeutic and Rehabilitation Services

		FCL	Lurasidone	Diabetes Mellitus, Hypercholesterolemia and Obesity
		HMR	Olanzapine	Dyslipidemia and Obesity
		JJS	Olanzapine and risperidone	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
		JL	Olanzapine	Diabetes Mellitus, Hypertriglyceridemia, Obesity and Hypertension
		JLC	Clozapine and haloperidol decanoate	Obesity, Metabolic Syndrome and Galactorrhea (by history)
		JP	Risperidone and olanzapine	Diabetes Mellitus, Hyperlipidemia,, Overweight and Hypertension
		JPD	Clozapine	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
		JTF	Clozapine	Diabetes Mellitus, Dyslipidemia, Obesity and Hypertension
		ME	Asenapine	Hyperlipidemia, Obesity and Metabolic Syndrome
		MP	Quetiapine	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
		<p>The review found general evidence of timely and adequate laboratory monitoring of the individuals for the metabolic/endocrine risks of treatment. Some deficiencies were identified as follows:</p> <ol style="list-style-type: none"> 1. In some individuals suffering from metabolic and endocrine dysfunction, the risk/benefit analysis regarding continued treatment with risperidone (DAJ), clozapine (JLC) or quetiapine (MP) was generic and did not address current metabolic/endocrine status. 2. In one individual, the psychiatric progress notes contained inaccurate information regarding the use of quetiapine (FCL). 3. One individual (ME) received treatment with one of the newest agents (asenapine) for the past year without evidence of monitoring of serum amylase/lipase during the course of treatment (this 		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>individual had refused laboratory testing for much of the past year but testing was performed on at least one occasion).</p> <p>In addition, findings in F.7.a regarding one individual (DG) were relevant to this requirement. This case provided an example that the facility has yet to ensure that individuals receiving quetiapine are properly monitored for the risk of postural hypotension as recommended by this monitor during the last tour. In a personal interview, George Proctor, MD, Senior Psychiatrist provided documentation that corrective action was underway.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Implement corrective action to ensure that individuals receiving quetiapine are properly monitored for the risk of postural hypotension. 3. Ensure that the psychiatric reassessments consistently include an individualized risk/benefit analysis, particularly for individuals who have multiple risk factors and continue to receive high-risk treatments.
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Movement Disorders Auditing Form, PSH assessed its compliance based on average samples ranging from 16% to 28% of individuals relevant to each indicator during the review period (November 2010 - April 2011):</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 228 1087 305">1.</td> <td data-bbox="1087 228 1793 305"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 228 1892 305">100%</td> </tr> <tr> <td data-bbox="989 305 1087 418">2.</td> <td data-bbox="1087 305 1793 418"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 305 1892 418">99%</td> </tr> <tr> <td data-bbox="989 418 1087 532">3.</td> <td data-bbox="1087 418 1793 532"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 418 1892 532">99%</td> </tr> <tr> <td data-bbox="989 532 1087 609">4.</td> <td data-bbox="1087 532 1793 609"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 532 1892 609">100%</td> </tr> <tr> <td data-bbox="989 609 1087 722">5.</td> <td data-bbox="1087 609 1793 722"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1793 609 1892 722">100%</td> </tr> <tr> <td data-bbox="989 722 1087 799">6.</td> <td data-bbox="1087 722 1793 799"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1793 722 1892 799">96%</td> </tr> <tr> <td data-bbox="989 799 1087 875">7.</td> <td data-bbox="1087 799 1793 875"><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td data-bbox="1793 799 1892 875">95%</td> </tr> <tr> <td data-bbox="989 875 1087 951">8.</td> <td data-bbox="1087 875 1793 951"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1793 875 1892 951">96%</td> </tr> </table> <p data-bbox="989 984 1892 1052">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 1097 1188 1125">Other findings:</p> <p data-bbox="989 1133 1892 1271">This monitor reviewed the charts of six individuals (AW, DML, LAB, SES, SS and WM) who were diagnosed with tardive dyskinesia per the facility's database. This review found that PSH has maintained progress as follows:</p> <ol data-bbox="989 1317 1892 1421" style="list-style-type: none"> <li data-bbox="989 1317 1892 1385">1. Admission AIMS tests were completed on all individuals who were admitted during the past year. <li data-bbox="989 1390 1892 1421">2. Quarterly AIMS monitoring was completed in all charts reviewed. 	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	99%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	99%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	100%	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	96%	7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	95%	8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	96%
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Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 3. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in all charts reviewed. 4. The psychiatric progress notes provided adequate tracking of the status of TD in all charts reviewed. 5. The objectives related to TD utilized appropriate learning outcomes for all individuals reviewed. 6. Some charts documented attempts to use (or consideration of) safer treatment alternatives for the individuals. 7. None of the individuals diagnosed with TD received unnecessary long-term treatment with anticholinergic agents during this review period. <p>The psychiatric reassessments did not address a significant increase in AIMS score for an individual (SS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Increase reporting of ADRs.</p> <p>Findings: The facility has implemented this recommendation (see data provided for the next recommendation).</p> <p>Recommendation 2, December 2010: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period

Section F: Specific Therapeutic and Rehabilitation Services

		<p>compared with number reported during the previous period;</p> <p>b. Classification of probability and severity of ADRs;</p> <p>c. Any negative outcomes for individuals who were involved in serious reactions;</p> <p>d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</p> <p>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p> <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 708 1887 1167"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>144</td> <td>169</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>3</td> <td>0</td> </tr> <tr> <td>Possible</td> <td>97</td> <td>129</td> </tr> <tr> <td>Probable</td> <td>42</td> <td>40</td> </tr> <tr> <td>Definite</td> <td>2</td> <td>0</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>77</td> <td>123</td> </tr> <tr> <td>Moderate</td> <td>61</td> <td>42</td> </tr> <tr> <td>Severe</td> <td>6</td> <td>4</td> </tr> </tbody> </table> <p>Of the four severe ADRs, none resulted in permanent sequelae to the individual involved. The facility conducted intensive case analyses (ICAs) on all of these reactions. The following table outlines the reactions and the suspected medications:</p>		Previous period	Current period	Total ADRs	144	169	Classification of Probability of ADRs			Doubtful	3	0	Possible	97	129	Probable	42	40	Definite	2	0	Classification of Severity of ADRS			Mild	77	123	Moderate	61	42	Severe	6	4
	Previous period	Current period																																	
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Section F: Specific Therapeutic and Rehabilitation Services

Initials	ADR	Suspected Medication(s)
DN	Partial Small Bowel Obstruction	Quetiapine and atorvastatin
KS	Small Bowel Ileus	Quetiapine, topiramate and lamotrigine
SD	Hyponatremic Encephalopathy and Rhabdomyolysis	Hydrochlorothiazide
SR	Altered Level of Consciousness	Bupropion, perphenazine and lithium

The ICAs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate.

The reviews of the charts of individuals who required external hospitalization during this review period (see F.7.a) found that one individual (DG) suffered severe postural hypotension while receiving high-risk medication (quetiapine) and another individual (IH) developed a cerebrovascular event and suffered from several risk factors while receiving high-risk antipsychotic medication. However, these events were not reported as severe ADRs as they should have been.

The facility reported that the most common ADR during this review period involved constipation, usually related to antipsychotic treatment and that a hospital-wide audit and training was developed to address this problem. The second most common ADR involved extrapyramidal side effects of antipsychotic medications.

Compliance:
Substantial.

Current recommendation:
Continue review and analysis of ADRs and present summary of aggregated data to address the following:

Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with the number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: During this review period, the facility completed the DUE on the laboratory monitoring of lithium levels that was reported in the previous review. In addition, the facility conducted the following DUEs:</p> <ul style="list-style-type: none"> 1. Use of potentially inappropriate medications (PIM) in older individuals; 2. Use of dosing strategies consistent with STOP-A (Selected Treatment of Psychomotor Agitation) Algorithm; 3. Use of bupropion; and 4. Pharmacological interventions for individuals following assaults. <p>Other findings: The DUEs utilized appropriate criteria and methodology, were aligned with the facility's needs and the recommendations for systemic</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>corrective/educational actions were generally adequate</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>			
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue to present data to address the following:</p> <ol style="list-style-type: none"> a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d. Number of critical breakdown points by outcome; e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. <p>Findings: PSH reported the following data regarding MVRs:</p> <table border="1" data-bbox="1003 1339 1732 1412"> <tr> <td data-bbox="1003 1339 1453 1412">Number of Medication Variances</td> <td data-bbox="1453 1339 1587 1412">Previous Period</td> <td data-bbox="1587 1339 1732 1412">Current Period</td> </tr> </table>	Number of Medication Variances	Previous Period	Current Period
Number of Medication Variances	Previous Period	Current Period			

Section F: Specific Therapeutic and Rehabilitation Services

		Prescribing	45	75
		Transcribing	152	85
		Ordering/Procurement	33	29
		Dispensing	257	72
		Administration	342	229
		Drug Security	6	1
		Documentation	336	278
		Total variances	1171	769
			Previous	Current
		Critical Breakdown Points	Period	Period
		Total Critical Breakdown Points	1026	719
		Potential MVRs	662	444
		Actual MVRs	364	275
		# Prescribing	39	75
		# Transcribing	127	85
		# Order/Procure	25	29
		# Dispensing	255	72
		# Administration	243	179
		# Drug Security	6	1
		# Documentation	331	278
		Outcome A	374	155
		Outcome B	287	289
		Outcome C	358	271
		Outcome D	7	4
		Outcome E	0	0
		Outcome F	0	0
		Outcome G	0	0
		Outcome H	0	0
		Outcome I	0	0
		During this review period, none of the MVRs reached the threshold for		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>an ICA.</p> <p>Recommendation 2, December 2010: Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p>Findings: Compared to the data provided during the previous review period, current data showed a downward trend in the categories of administration, documentation, transcription, dispensing, drug security and transcription and an upward trend in the detection of prescription variances. Based on the facility's data, the main factor contributing to the increase in prescription variances was improved data collection by the Pharmacy Department.</p> <p>The facility conducted an adequate analysis of its medication variance data. The analysis included a variety of adequate corrective measures to address patterns/trends of variances.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to present data to address the following:<ol style="list-style-type: none">a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);d. Number of critical breakdown points by outcome;
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Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. <p>2. Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, December 2010:</p> <ul style="list-style-type: none"> • Same as in F.1.a through F.1.h. • Continue to present data regarding outcomes of mental health services. • Utilize the outcome data regarding mental health care to inform the facility's performance improvement efforts and the oversight function of the facility's Quality Council, as indicated (same as in section I.2). <p>Findings: Same as in F.1.a through F.1.h.</p> <p>The facility presented data regarding outcomes of its clinical services as requested in this cell. The data addressed the rate per 1000 days of the following indicators:</p> <ul style="list-style-type: none"> 1. Any aggression to self resulting in major injury; 2. Any peer-to-peer aggression resulting in major injury; 3. Any aggression to staff resulting in major injury; 4. Individuals having alleged abuse/neglect/exploitation; 5. Individuals having confirmed abuse/neglect/exploitation; 6. Individuals with two or more intra-class psychotropic medications for

Section F: Specific Therapeutic and Rehabilitation Services

		<p>psychiatric reasons;</p> <ol style="list-style-type: none"> 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons; 8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder; 9. Unique count of individuals in restraint; 10. Unique count of restraint events; 11. Unique count of individuals in seclusion; 12. Unique count of seclusion events; 13. Individuals on benzodiazepines who are diagnosed with substance use; 14. Individuals on benzodiazepine diagnosed with cognitive disorders; 15. Elderly on anticholinergic medications (age >65); 16. Individuals diagnosed with cognitive disorder on anticholinergics; 17. Individuals diagnosed with TD prescribed anticholinergics; 18. Count of severe ADRs; and 19. Count of severe medication variances. <p>In addition, the facility presented outcome data regarding its substance use services (see cell C.2.o).</p> <p>The following summary observations are relevant:</p> <ol style="list-style-type: none"> 1. The data showed positive trends in most items (# 1-4, 6-9, 11-12 and 18-19 as well as substance use data in C.2.o). 2. The data in items #13-17 were addressed in F.1.c. 3. The data in item #5 showed an increase but the numbers were very limited (two cases compared to one). 4. Insignificant increase was noted in item 10. <p>As mentioned in the previous report, these outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see Section I.2).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Continue to present data regarding outcomes of mental health services. 3. Utilize the outcome data regarding mental health care to inform the facility's performance improvement efforts and the oversight function of the facility's Quality Council, as indicated (same as in section I.2).
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.k	<p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and</p>	<p>Current findings on previous recommendation:</p>

Section F: Specific Therapeutic and Rehabilitation Services

	the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Recommendation, December 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Substantial.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendation:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation, December 2010: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Current recommendations: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive	<p>Current findings on previous recommendation:</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>impairments, regardless of duration of treatment; and</p>	<p>Recommendation, December 2010: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.v	<p>all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	<p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	<p>Each State hospital shall ensure that the medication management of individuals with</p>	<p>Current findings on previous recommendation:</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Recommendation, December 2010: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
F.1.o	<p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.</p>	<p>This requirement applies exclusively to Metropolitan State Hospital.</p>

Section F: Specific Therapeutic and Rehabilitation Services

2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. David Haimson, PhD, Chief of Psychology 2. Gari-Lyn Richardson, Director of Standards Compliance 3. Helga Thordarson, PhD, Senior Supervising Psychologist 4. Mark Williams, PhD, PBS Team member 5. Melanie Bye, PhD, Mall Director 6. Steve Berman, PhD, By Choice Coordinator 7. Susan Velasquez, PhD, PSSC Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 24 individuals: AFR, BEH, CDC, DA, FS, GC, JD, JG, JJJ, JM, JP, LG, LR, MA, MEH, PS, QVM, RJ, SA, SDH, TMM, TY, WDW, and WW 2. Positive Behavior Support Plans developed and implemented in the last six months 3. Behavioral guidelines developed and implemented in the last six months 4. Structural and functional assessments completed in the last six months 5. List of staff trained to implement Positive Behavior Support Plans. 6. By Choice Training Documents 7. ETRC/PSSC minutes 8. List of individuals reviewed by the Psychology Specialty Services Committee (PSSC) 9. PSSC meeting minutes 10. List of individuals who have utilized higher-than-threshold levels of seclusion, restraints, and psychiatric PRN or Stat medication for maladaptive behaviors in the last six months 11. List of individual with high psychology triggers 12. List of individuals receiving DCAT services

Section F: Specific Therapeutic and Rehabilitation Services

		<p>13. List of individuals identified as needing neuropsychological services</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program III, Unit 33) for quarterly review of TMM 2. WRPC (Program 1, Unit EBO4) for quarterly review of LG 3. WRPC (Program 111, Unit 31) for quarterly review of OVM 4. Mall Group: Cultural Awareness and Identity 5. Mall Group: Origami 6. Mall Group: Healthy Relationship: Boundaries and Respect 7. Mall Group: Substance Abuse Recovery: Co-Occurring Disorders 1, Action Stage 8. Mall Group: Substance Abuse Recovery: Education and Recovery from Addiction, Pre-contemplation Stage 9. Therapeutic Community group activity (Unit 36) 10. Therapeutic Community group activity (Unit 32) 11. PSSC/ETRC Meeting
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: According to the Chief of Psychology, PSH has five PBS teams. One team is lacking a nursing staff member (interview is to be conducted to fill this position sometime in May 2011), another team is lacking a PT, and the teams also lack data analysts (these are not going to be filled in as the positions were not opened for hiring). The facility engages student trainees for this task. The current number of PBS teams meets the EP criterion of 1:300.</p> <p>Compliance: Substantial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue current practice.</p>																																																
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the number of new staff at PSH (N), the number of staff trained for each month of this review period (n), and the percent staff trained (%C) is a summary of the facility's data:</p> <table border="1" data-bbox="991 711 1906 938"> <thead> <tr> <th colspan="8">Staff Training</th> </tr> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>9</td> <td>N/A</td> <td>7</td> <td>N/A</td> <td>10</td> <td>13</td> <td>13</td> </tr> <tr> <td>N</td> <td>9</td> <td>N/A</td> <td>7</td> <td>N/A</td> <td>10</td> <td>13</td> <td>13</td> </tr> <tr> <td>%S</td> <td>100%</td> <td>N/A</td> <td>100%</td> <td>N/A</td> <td>100%</td> <td>100%</td> <td></td> </tr> <tr> <td>% C</td> <td>100%</td> <td>N/A</td> <td>100%</td> <td>N/A</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>No new staff were hired in the months of March and May.</p> <p>Staff interviews and documentation reviews found that PBS staff had received continuous training through the review period. Documentation review also found that all staff responsible for implementing behavioral intervention plans had been trained prior to implementing the behavioral plans. PBS staff also had taken numerous excellent steps with the intent of increasing treatment fidelity by unit staff. For example, PBS staff used non-contingent reinforcement by way of having positive conversations with the unit staff members twice a week to develop a positive/therapeutic alliance, presented outcome data to staff during shift change, and were on the unit frequently to discuss the behavioral</p>	Staff Training									Feb	Mar	Apr	May	Jun	Jul	Mean	N	9	N/A	7	N/A	10	13	13	N	9	N/A	7	N/A	10	13	13	%S	100%	N/A	100%	N/A	100%	100%		% C	100%	N/A	100%	N/A	100%	100%	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>plans with the responsible staff and the individual.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Monitoring-By Choice Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month of this review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 894 1887 971"> <tr> <td data-bbox="991 894 1087 971">2.</td> <td data-bbox="1087 894 1793 971"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 894 1887 971">94%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of least 90% since the previous review period.</p> <p>A review of the records of nine individuals found that six of the WRPs reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (AFR, DA, GC, JJJ, LR and MEH). In the remaining three WRPs (JG, JP and SDH), the By Choice point allocation was not properly documented or was not updated. The WRPs contained documentation that the individual was a participant in his/her By Choice point allocation.</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	94%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	94%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>This monitor observed three WRPCs (LG, QVM and TMM). All three WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, PSH assessed its compliance based on a mean sample of 2% of the Level of Care staff:</p> <table border="1" data-bbox="991 483 1871 1276"> <tr> <td>1.</td> <td><i>Staff understands the goal of the By Choice system</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Staff can state the current point cycle</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Staff can state the procedure for assigning participation points on an individual's point card.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i></td> <td>96%</td> </tr> <tr> <td>9.</td> <td><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Staff understands the goal of the By Choice system</i>	100%	2.	<i>Staff can state the current point cycle</i>	99%	3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	99%	4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%	5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	100%	6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	99%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	98%	8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	96%	9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	99%	10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	98%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: Using the Fidelity of Implementation by Individuals Form, PSH also assessed fidelity of By Choice implementation based on a mean sample of 20% of individuals in the facility:</p> <table border="1" data-bbox="991 376 1871 1166"> <tr> <td>1.</td> <td><i>The individual understands the goal of the By Choice system.</i></td> <td>78%</td> </tr> <tr> <td>2.</td> <td><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td>87%</td> </tr> <tr> <td>3.</td> <td><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td>94%</td> </tr> <tr> <td>4.</td> <td><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td>95%</td> </tr> <tr> <td>5.</td> <td><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td>71%</td> </tr> <tr> <td>6.</td> <td><i>Individual can indicate how many points he or she may earn each day.</i></td> <td>64%</td> </tr> <tr> <td>7.</td> <td><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td>52%</td> </tr> <tr> <td>8.</td> <td><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td>59%</td> </tr> <tr> <td>9.</td> <td><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td>86%</td> </tr> <tr> <td>10.</td> <td><i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i></td> <td>24%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% since the previous review period for items 3 and 4 and mixed changes in compliance for the remaining items:</p>	1.	<i>The individual understands the goal of the By Choice system.</i>	78%	2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	87%	3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	94%	4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	95%	5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	71%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	64%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	52%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	59%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	86%	10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	24%
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Section F: Specific Therapeutic and Rehabilitation Services

		Previous period	Current period
Mean compliance rate			
1.		72%	78%
2.		94%	87%
5.		71%	71%
6.		71%	64%
7.		54%	52%
8.		61%	59%
9.		90%	86%
10.		18%	24%
<p>Using the By Choice Monitoring Form: Satisfaction Check, PSH surveyed a mean sample of 20% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>			
		Previous period	Current period
1.	<i>By Choice motivates me to participate in treatment</i>	73%	69%
2.	<i>The point system motivates me to improve my behavior</i>	72%	69%
3.	<i>The point system motivates me to learn new skills</i>	67%	64%
4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	60%	57%
5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	66%	61%
6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	70%	64%

Section F: Specific Therapeutic and Rehabilitation Services

		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	69%	64%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	66%	63%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	66%	64%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	63%	61%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	73%	72%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	66%	66%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	61%	61%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	62%	61%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	74%	73%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, PSH further assessed fidelity of implementation based on an average sample of 50% of By Choice staff:</p>			
		1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	100%	
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%	
		3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	51%	
		4.	<i>The incentive store has an inventory control system.</i>	87%	

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 191 1066 264">5.</td> <td data-bbox="1066 191 1774 264"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1774 191 1871 264">100%</td> </tr> <tr> <td data-bbox="989 264 1066 342">6.</td> <td data-bbox="1066 264 1774 342"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1774 264 1871 342">96%</td> </tr> <tr> <td data-bbox="989 342 1066 420">7.</td> <td data-bbox="1066 342 1774 420"><i>The incentive store staff has completed incentive store training.</i></td> <td data-bbox="1774 342 1871 420">100%</td> </tr> <tr> <td data-bbox="989 420 1066 498">8.</td> <td data-bbox="1066 420 1774 498"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1774 420 1871 498">100%</td> </tr> <tr> <td data-bbox="989 498 1066 576">9.</td> <td data-bbox="1066 498 1774 576"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1774 498 1871 576">100%</td> </tr> <tr> <td data-bbox="989 576 1066 654">10.</td> <td data-bbox="1066 576 1774 654"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1774 576 1871 654">100%</td> </tr> <tr> <td data-bbox="989 654 1066 719">11.</td> <td data-bbox="1066 654 1774 719"><i>There is an Alert List in the incentive store for use by store staff.</i></td> <td data-bbox="1774 654 1871 719">100%</td> </tr> </table>	5.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	6.	<i>There is a By Choice Manual located in the incentive store.</i>	96%	7.	<i>The incentive store staff has completed incentive store training.</i>	100%	8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%	9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%	10.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%	11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%	
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% since the previous review period for all items, except for items 3 and 4, which have to do with inventory of items and were 88% and 96% respectively in the previous period. Funding appears to be a growing issue with the By Choice incentive store inventory.</p> <p>The table below is an overall summary of By Choice fidelity data:</p> <table border="1"> <tr> <td data-bbox="989 1052 1444 1092">Level of Care Staff</td> <td data-bbox="1444 1052 1585 1092">89%</td> </tr> <tr> <td data-bbox="989 1092 1444 1133">Individuals</td> <td data-bbox="1444 1092 1585 1133">71%</td> </tr> <tr> <td data-bbox="989 1133 1444 1174">By Choice Program Staff</td> <td data-bbox="1444 1133 1585 1174">94%</td> </tr> </table> <p>The By Choice Incentive System Coordinator has made many improvements to the process and procedures of this system, including: expanding the incentive items (purchase personal photo portraits, individually designed holiday greeting cards, Wii tournaments, live band and social dances), inclusion of "cue sheets" for all Mall providers as to what constitutes levels of points, and validity checks.</p>	Level of Care Staff	89%	Individuals	71%	By Choice Program Staff	94%																
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The Chief of Psychology confirmed that he continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1"> <tr> <td data-bbox="989 414 1087 526">1.</td> <td data-bbox="1087 414 1793 526"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1793 414 1887 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 602">2.</td> <td data-bbox="1087 526 1793 602"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 526 1887 602">100%</td> </tr> <tr> <td data-bbox="989 602 1087 678">3.</td> <td data-bbox="1087 602 1793 678"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1793 602 1887 678">100%</td> </tr> <tr> <td data-bbox="989 678 1087 790">4.</td> <td data-bbox="1087 678 1793 790"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1793 678 1887 790">100%</td> </tr> <tr> <td data-bbox="989 790 1087 902">5.</td> <td data-bbox="1087 790 1793 902"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 790 1887 902">100%</td> </tr> <tr> <td data-bbox="989 902 1087 979">6.</td> <td data-bbox="1087 902 1793 979"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 902 1887 979">100%</td> </tr> <tr> <td data-bbox="989 979 1087 1055">7.</td> <td data-bbox="1087 979 1793 1055"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1793 979 1887 1055">100%</td> </tr> <tr> <td data-bbox="989 1055 1087 1167">8.</td> <td data-bbox="1087 1055 1793 1167"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1055 1887 1167">100%</td> </tr> <tr> <td data-bbox="989 1167 1087 1203">9.</td> <td data-bbox="1087 1167 1793 1203"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 1167 1887 1203">100%</td> </tr> <tr> <td data-bbox="989 1203 1087 1386">10.</td> <td data-bbox="1087 1203 1793 1386"><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1203 1887 1386">100%</td> </tr> <tr> <td data-bbox="989 1386 1087 1424">11.</td> <td data-bbox="1087 1386 1793 1424"><i>Patterns of challenging behavior were recognized</i></td> <td data-bbox="1793 1386 1887 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%	11.	<i>Patterns of challenging behavior were recognized</i>	100%
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8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%																																	
9.	<i>A functional assessment rating scale was completed.</i>	100%																																	
10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%																																	
11.	<i>Patterns of challenging behavior were recognized</i>	100%																																	

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 190 1890 230"> <tr> <td data-bbox="991 190 1087 230"></td> <td data-bbox="1087 190 1795 230"><i>based on the structural and functional assessments.</i></td> <td data-bbox="1795 190 1890 230"></td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the three PBS plans developed and implemented by PSH during this review period (FS, PS and RJ) found that all three had been developed and implemented based on data derived from structural and functional assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>based on the structural and functional assessments.</i>	
	<i>based on the structural and functional assessments.</i>				
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 1084 1890 1159"> <tr> <td data-bbox="991 1084 1087 1159">5</td> <td data-bbox="1087 1084 1795 1159"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1795 1084 1890 1159">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans developed and implemented by PSH during this review period (FS, PS and RJ) found that the hypotheses in all three were based on structural and functional assessments and aligned</p>	5	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%
5	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>with findings from the structural/functional assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 784 1890 898"> <tr> <td style="text-align: center;">5</td> <td><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td style="text-align: center;">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans developed and implemented by PSH during this review period (FS, PS and RJ) found that all three had documented previous behavioral interventions and their effects.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not</p>	<p>Current findings on previous recommendation:</p>			

Section F: Specific Therapeutic and Rehabilitation Services

	<p>include the use of aversive or punishment contingencies;</p>	<p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans and behavior guidelines during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 522 1890 636"> <tr> <td data-bbox="991 522 1087 636">17.</td> <td data-bbox="1087 522 1793 636"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1793 522 1890 636">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 10 behavioral intervention plans (BEH, CDC, FS, MA, PS, RJ, SA, TY, WDW and WW) found that all 10 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>The quality of most of the structural and functional assessments was good, as was the quality of most of the behavioral intervention plans. However, a few plans had left out the reactive/active strategies to reduce the challenging behaviors and instead had gone on to a "crisis plan" mode to diffuse the challenging behavior. In some cases, the crisis plan strategies were not individualized; for example, the crisis plan of an individual whose challenging behavior was pulling out a GT-tube was more appropriate for addressing aggressive behavior.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.c.v</p>	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans or behavior guidelines during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 597 1890 711"> <tr> <td data-bbox="991 597 1087 711">22.</td> <td data-bbox="1087 597 1795 711"><i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></td> <td data-bbox="1795 597 1890 711">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of fidelity/integrity check for the PBS plans and behavior guidelines of 10 individuals (BEH, CDC, FS, MA, PS, RJ, SA, TY, WDW and WW) found that PSH had conducted fidelity checks on all 10 behavioral intervention plans.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%
22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%			
<p>F.2.c.vi</p>	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the type of trigger, the number of individuals</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</p> <table border="1" data-bbox="991 337 1906 800"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th></th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>4</td> <td>6</td> <td>6</td> <td>4</td> <td>7</td> <td>18</td> <td>19</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Seclusion</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> <td><1</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>1:1</td> <td>78</td> <td>84</td> <td>72</td> <td>75</td> <td>90</td> <td>93</td> <td>82</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to staff</td> <td>33</td> <td>36</td> <td>35</td> <td>25</td> <td>35</td> <td>38</td> <td>34</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to self</td> <td>6</td> <td>5</td> <td>6</td> <td>3</td> <td>7</td> <td>8</td> <td>6</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>The PSSC continues to review all triggers during the PSSC/ETRC meeting for the key indicators listed in the table above. The PSSC then determines the cases that require follow-up assessments and interventions.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	DMH Psychology Services Monitoring Form									Nov	Dec	Jan	Feb	Mar	Apr	Mean	Restraint	4	6	6	4	7	18	19	%C	100	100	100	100	100	100	100	Seclusion	0	0	0	1	0	0	<1	%C	100	100	100	100	100	100	100	1:1	78	84	72	75	90	93	82	%C	100	100	100	100	100	100	100	Aggression to staff	33	36	35	25	35	38	34	%C	100	100	100	100	100	100	100	Aggression to self	6	5	6	3	7	8	6	%C	100	100	100	100	100	100	100
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F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed or revised</p>																																																																																																

Section F: Specific Therapeutic and Rehabilitation Services

		<p>during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans that PSH developed and implemented during this review period (FS, PS and RJ) found that all three contained documentation indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individuals' behaviors of concern.</p> <p>Current recommendation: Continue current practice.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1117 1892 1230"> <tr> <td data-bbox="993 1117 1087 1230">19.</td> <td data-bbox="1087 1117 1793 1230"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1793 1117 1892 1230">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans that PSH developed and implemented</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>during this review period (FS, PS and RJ) found that the plans were specified in the Present Status section of the individuals' WRPs, with appropriate objectives and interventions. A review of seven charts of individuals with behavioral guidelines (BEH, CDC, MA, SA, TY, WDW and WW) also found that all seven guidelines were appropriately documented.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 933 1892 1008"> <tr> <td data-bbox="993 933 1087 1008">24.</td> <td data-bbox="1087 933 1793 1008"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 933 1892 1008">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans that PSH developed and implemented during this review period (FS, PS and RJ) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individuals' WRPs. A review of the charts of seven individuals with behavioral guidelines (BEH, CDC, MA, SA, TY, WDW and WW) also found that all seven guidelines had been documented appropriately in the Present Status sections of the WRPs.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>						
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of behavior guidelines developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 711 1887 824"> <tr> <td data-bbox="993 711 1087 824">20.</td> <td data-bbox="1087 711 1793 824"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1793 711 1887 824">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of five Behavior Guidelines (JD, JM, MA, SA and TY) found that staff training was conducted prior to implementation of all five plans.</p> <p>Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1230 1887 1308"> <tr> <td data-bbox="993 1230 1087 1308">21.</td> <td data-bbox="1087 1230 1793 1308"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1793 1230 1887 1308">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the three PBS plans developed and implemented during the review period (FS, PS and RJ) and related assessment and staff training data found that the staff responsible for implementing all three plans had been trained to competency.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility reported that all PBS team members are primarily responsible for the provision of behavioral interventions; facilitate one PSR Mall group weekly during their assigned work hours; and are assigned to PBS duties when performing mandatory overtime on state holidays.</p> <table border="1" data-bbox="991 932 1896 1195"> <tr> <td data-bbox="991 932 1098 1008">15.a.i</td> <td data-bbox="1098 932 1787 1008"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1787 932 1896 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1098 1084">15.a.ii</td> <td data-bbox="1098 1008 1787 1084"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1787 1008 1896 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1098 1195">15.b</td> <td data-bbox="1098 1084 1787 1195"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1787 1084 1896 1195">100%</td> </tr> </table> <p>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%									
15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%									
15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue current practice</p>
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See F.2.a.ii.</p> <p>Findings: See F.2.a.ii.</p> <p>Current recommendations: See F.2.a.ii.</p>
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH has one DCAT team. The team has been active in conducting assessments for behavioral intervention plans, facilitating Mall groups, conducting cognitive assessments to assist individuals in their Mall groups, assisting individuals who are non-adherent to Mall groups, and working with Social Work staff on discharge planning. The team had been involved in assessing and developing 27 intervention plans (prevention strategies, behavior guidelines, and PBS plans).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH has one PSSC team (previously known as the BCC) chaired by the Chief of Psychology or designee. This monitor attended one of the PSSC meetings during this tour. The team was well organized and cases were discussed with input from WRPT members to address the comprehensiveness and quality of the behavioral assessments and intervention plans. A review of PSSC meeting minutes for the last six months found that meetings were held regularly and the attendance was high. The cases reviewed and findings were well documented in the minutes.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement and implementation of the plan to reduce the turnaround time for completion of neuropsychological assessments.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of referrals received each month during the review period (November 2010 - April 2011):</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1887 678"> <thead> <tr> <th></th> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>No v</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>9</td> <td>12</td> <td>13</td> <td>14</td> <td>17</td> <td>10</td> <td>12.5</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>6</td> <td>12</td> <td>12</td> <td>13</td> <td>17</td> <td>10</td> <td>9.8</td> </tr> <tr> <td>18.a. iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>30.25</td> </tr> </tbody> </table> <p data-bbox="991 721 1898 899">The data in the table above includes all assessments (Focused Neuropsychological Assessments, Brief Cognitive Assessments, Seizure Batteries, Seizure Battery—Consultations, and Neuropsychological Consultations). PSH has worked hard to complete the assessments within the required timeline, and achieved it.</p> <p data-bbox="991 943 1142 1008">Compliance: Substantial.</p> <p data-bbox="991 1052 1457 1117">Current recommendation: Continue to monitor this requirement.</p>			Jun	Jul	Aug	Sep	Oct	No v	Mean	18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	9	12	13	14	17	10	12.5	18.a. ii	<i>Of those in 18.a.i, number completed</i>	6	12	12	13	17	10	9.8	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							30.25
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18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							30.25																														
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p data-bbox="991 1166 1579 1198">Current findings on previous recommendation:</p> <p data-bbox="991 1242 1436 1307">Recommendation, December 2010: Continue current practice.</p> <p data-bbox="991 1351 1881 1416">Findings: Psychologists at PSH continue to have the authority to write orders for</p>																																				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Proctor, M.D. 2. Lidia Lau, RN, ACNS 3. Sandra Doerner, RN, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Nursing Services Monitoring PRN Audit summary data, November 2010 - April 2011 2. PSH Nursing Services Monitoring Stat Audit summary data, November 2010 - April 2011 3. PSH Nursing Staff Familiarity Monitoring Audit summary data, November 2010 - April 2011 4. PSH Medical Transfer Audit summary data, November 2010 - April 2011 5. PSH Nursing Services Audit summary data, November 2010 - April 2011 6. PSH Medication Administration Monitoring Audit summary data, November 2010 - April 2011 7. PSH training rosters 8. Medication Variance forms for the review period 9. DMH Nursing Weekly Progress Note (MH-C 9109) 10. DMH RN Progress Note for Assessment and Evaluation (MH-C 9110) 11. DMH Nursing Transfer Note (MH-C 9095) 12. DMH RN Return from Outside Hospitalization Note (MH-C # pending) 13. DMH RN Change in Physical Status Note (MH-C 9094) 14. DMH Physician Order Form (Transfer to Outside Facility) (MH-C 9092) 15. DMH Medical Transfer Audit form and instructions 16. Medical records for the following 95 individuals: AA, AB, AE, AG, AGM, AIS, ARV, AT, AV, BM, CAK, CHR, CL, CMR, CR, CRL, CV, DD,

Section F: Specific Therapeutic and Rehabilitation Services

		<p>DDP, DG, DKG, DLR, DR, EC, EEJ, EL, ELC, ETP, FD, GA, GB, GD, GEB, GH, HE, HI, HLE, IEE, JB, JDB, JM, JMM, JOW, JP, JR, JS, JTR, JW, KAM, KGT, KH, KR, LLU, MAW, MCP, MDR, MDT, MH, MR, MV, NML, OC, OV, OVM, PH, PPJ, PTK, QMF, RBA, RC, RG, RH, RJM, RLR, RPO, RR, RT, RV, RW, SA, SAM, SC, SD, SDR, SHC, SWK, TCW, TG, TLT, TV, UML, VEB, VGC, VM and YRR</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 06) for monthly review of JD 2. WRPC (Program I, unit 74) for quarterly review of EM 3. WRPC (Program I, unit EB11) for monthly review of NK 4. Shift report on Program I, unit 06 5. Medication administration on Program I, unit 06
F.3.a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:</p>	<p>Compliance: Substantial.</p>
F.3.a.i	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 27% mean sample of PRNs administered each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH also assessed its compliance based on a 38% mean sample of Stat medications administered each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 227 PRN and Stat orders (162 PRN and 65 Stat) for 83 individuals (AB, AE, AG, AGM, AIS, ARV, AV, CAK, CHR, CL, CMR, CR, CRL, DDP, DG, DKG, DLR, EC, EEJ, EL, ELC, ETP, FD, GA, GB, GEB, GH, HE, HLE, IEE, JB, JDB, JM, JMM, JOW, JP, JR, JS, JTR, JW, KAM, KGT, KH, KR, LLU, MAW, MCP, MDR, MDT, MR, MV, NML, OC, OV, OVM, PH, PPJ, PTK, QMF, RBA, RG, RH, RJM, RLR, RPO, RT, RV, RW, SA, SAM, SC, SDR, SHC, SWK, TCW, TG, TLT, TV, UML, VEB, VGC, VM and YRR) found that 223 included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all appropriate notes.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 27% mean sample of PRNs administered each month during the review period (November 2010 - April 2011):</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 228 1887 378"> <tr> <td data-bbox="991 228 1087 378">3.</td> <td data-bbox="1087 228 1793 378"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i></td> <td data-bbox="1793 228 1887 378">98%</td> </tr> </table> <p data-bbox="991 418 1902 488">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 529 1902 711">A review of 162 incidents of PRN medications for 33 individuals (AB, AIS, ARV, CMR, CRL, DKG, DLR, EL, GEB, GH, HLE, JM, JMM, JP, JS, JTR, KGT, KR, LLU, MAW, MDR, MDT, MV, OVM, PPJ, QMF, RBA, RG, RPO, RV, SWK, TCW and VGC) found adequate documentation in the IDNs of the circumstances requiring the PRN in 157 incidents.</p> <p data-bbox="991 751 1902 894">Using the DMH Nursing Services Monitoring Stat Audit, PSH also assessed its compliance based on a 38% mean sample of Stat medications administered each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 935 1887 1084"> <tr> <td data-bbox="991 935 1087 1084">4.</td> <td data-bbox="1087 935 1793 1084"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i></td> <td data-bbox="1793 935 1887 1084">96%</td> </tr> </table> <p data-bbox="991 1125 1902 1195">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1235 1902 1416">A review of 65 incidents of Stat medications for 50 individuals (AE, AG, AGM, AV, CAK, CHR, CL, CR, DDP, DG, EC, EEJ, ELC, ETP, FD, GA, GB, HE, IEE, JB, JDB, JOW, JR, JW, KAM, KH, MCP, MR, NML, OC, OV, PH, PTK, RH, RJM, RLR, RT, RW, SA, SAM, SC, SDR, SHC, TG, TLT, TV, UML, VEB, VM and YRR) found adequate documentation in the IDNs of the</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i>	98%	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i>	96%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i>	98%						
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i>	96%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>circumstances requiring the Stat in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 27% mean sample of PRNs administered each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 748 1890 862"> <tr> <td data-bbox="991 748 1087 862">5.</td> <td data-bbox="1087 748 1793 862"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 748 1890 862">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 162 incidents of PRN medications for 33 individuals (AB, AIS, ARV, CMR, CRL, DKG, DLR, EL, GEB, GH, HLE, JM, JMM, JP, JS, JTR, KGT, KR, LLU, MAW, MDR, MDT, MV, OVM, PPJ, QMF, RBA, RG, RPO, RV, SWK, TCW and VGC) found a timely comprehensive assessment in the IDNs of the individual's response in 160 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH also assessed its compliance based on a 38% mean sample of Stat medications administered each month during the review period (November 2010 - April 2011):</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	97%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	97%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">6.</td> <td style="width: 80%; padding: 5px;"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td style="width: 15%; text-align: center; vertical-align: top;">94%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 65 incidents of Stat medications for 50 individuals (AE, AG, AGM, AV, CAK, CHR, CL, CR, DDP, DG, EC, EEJ, ELC, ETP, FD, GA, GB, HE, IEE, JB, JDB, JOW, JR, JW, KAM, KH, MCP, MR, NML, OC, OV, PH, PTK, RH, RJM, RLR, RT, RW, SA, SAM, SC, SDR, SHC, TG, TLT, TV, UML, VEB, VM and YRR) found a timely comprehensive assessment in the IDNs of the individual's response in 63 incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	94%
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	94%			
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: A review of 50 MVRs found that PSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported. In addition, from a discussion with George Proctor, MD, who has been very involved in reviewing a number of aspects of the facility's Medication Variance Systems and data, the facility has begun positively recognizing units for reporting medication variances. This positive acknowledgment reinforces staff to report problematic issues related to medications so they can be analyzed and remedial interventions implemented.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.I for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.3.d	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, PSH assessed its compliance based on an average sample of 42% of the nursing staff:</p> <table border="1" data-bbox="991 1341 1892 1414"> <tr> <td data-bbox="991 1341 1087 1414">8.</td> <td data-bbox="1087 1341 1793 1414"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to</i></td> <td data-bbox="1793 1341 1892 1414">100%</td> </tr> </table>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to</i>	100%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><i>discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In three WRPCs observed, all team members were familiar with the individual and his/her goals and interventions in the WRPs. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	<i>discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	
<i>discuss the individual's therapeutic milieu interventions as described in the WRP.</i>				
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, December 2010:</p> <ul style="list-style-type: none"> • Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. • Audit change of status requirement by first reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool. • Continue training focused on building and improving nursing competency regarding assessments and documentation addressing changes in status. <p>Findings: The Nurse Administrator reported that since November 2010, an RN has been assigned to review all Emergency Room Transfers and hospitaliz-</p>		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>ations in real time. This designated RN was assigned to work closely with the unit RNs, Unit Supervisors, and RN Mentors to ensure that nursing documentation is adequately and appropriately completed. In December 2010, the facility began auditing the nursing documentation four weeks prior to the acute emergency transfer and since April 2011 has reviewed the documentation one week after the individual's return to the facility.</p> <p>In addition, the Clinical Administrator Assistant receives the audit information regarding this area from Standards Compliance and reviews this information with the appropriate Program Directors. Also, since the last review, the facility has implemented the use of RN mentors for each Program. The RN mentors work with the Program Directors to address problematic issues regarding emergency transfers and hospitalizations.</p> <p>Recommendations from the Statewide Nurse Administrator Summit held at ASH on 3/21/11 and 3/22/11 included the following developments of/ revisions to forms and policies:</p> <ul style="list-style-type: none"> • DMH Nursing Weekly Progress Note (MH-C 9109) and policy • DMH RN Progress Note for Assessment and Evaluation (MH-C 9110) and policy • DMH Nursing Transfer Note (MH-C 9095); DMH RN Return from Outside Hospitalization Note (MH-C # pending); DMH RN Change in Physical Status Note (MH-C 9094) and policy • Provision Of Medical Care to Individuals - policy update • DMH Physician Order Form (Transfer to Outside Facility) (MH-C 9092) • Appendix D: Pressure Ulcer Wound Stages and Support for Wound Healing for the CA DMH Joint Medical Nursing Policy: Pressure Ulcer and Wounds <p>In addition, the facility reported that a monitoring tool was currently being finalized addressing this area to include a review of the nursing</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>documentation prior to the acute event. However, a review of the monitoring tool and instructions for Medical Transfers found that no qualitative standards for nursing such as RANs and/or Nursing protocols for evaluating nursing documentation were included.</p> <p>Recommendations 4 and 5, December 2010:</p> <ul style="list-style-type: none"> • Ensure that audits addressing change of shift report accurately reflect the shift report observed. • Continue efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses. <p>Findings: The facility had recently begun using the Change of Shift training DVD that was developed by NSH to train the Unit Supervisors and Shift Leads/designees.</p> <p>Recommendation 6, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, PSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 1078 1887 1305"> <tr> <td data-bbox="991 1078 1087 1192">1.</td> <td data-bbox="1087 1078 1793 1192"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1078 1887 1192">97%</td> </tr> <tr> <td data-bbox="991 1192 1087 1305">7.</td> <td data-bbox="1087 1192 1793 1305"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 1192 1887 1305">94%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	94%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	94%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 15 individuals who were transferred to a community hospital/emergency room (AA, AT, BM, CV, DD, DR, GB, GD, HI, JS, MH, RC, RG, RR and SD) found overall improvement in the nursing documentation in most of the records reviewed. In five of the records reviewed (AT, DR, GD, RC and RR), the nursing documentation was adequate regarding nursing assessments prior to transfer to and upon return from the community hospital/ER. For four individuals (DD, HI, RG and SD), the Change of Status forms indicated that assessments such as lung sounds or neuro checks were conducted; however, no results of these assessments were found in the documentation, rendering the nursing assessments inadequate and incomplete. The records for six individuals (AA, BM, CV, GB, JS and MH) revealed the following problematic issues:</p> <p><u>Nursing Assessments</u></p> <ul style="list-style-type: none"> • No regular nursing assessments conducted for an individual noted to have episodes of urinary incontinence. • No adequate nursing assessment or description found for a pain scale rating of 10/10. • No nursing assessment or vital signs found for complaints of pain, and reports of vomiting blood. • No nursing assessment documented prior to giving medication for complaints of pain. • No nursing assessment or vital signs found in response to an individual crying uncontrollably, rocking back and forth, and prior to administering an injection of Ativan. • No nursing assessment found for complaints of constipation. • The IDNs noted an individual's abdomen was tight and distended. No bowels sounds were assessed. • No nursing assessment found for complaints of nausea, vomiting, and diarrhea. • No nursing assessment found prior to administering Maalox for complaints of stomach pain.
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Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none">• No bowel sounds assessed for complaints of bloating and abdomen being hard to the touch.• No neuro checks assessed for an individual found stuporous and drooling.• No nursing assessment conducted for a description of an individual unable to control legs and hands.• Gaps in time between nursing assessments when changes in status were identified.• No assessments of bowel sounds and palpation of the abdomen found when PRNs were given for episodes of constipation.• Lack of follow up assessments for symptoms of constipation.• Lack of a complete nursing assessment upon return to the facility specifically addressing the symptoms that precipitated the hospitalization for a stroke. <p><u>Documentation</u></p> <ul style="list-style-type: none">• Change of status form indicated an individual was complaining of having abdominal pain for past one to two months. No documentation of this found in the IDNs.• The administration, individual's tolerance of procedure or results of a PRN for Fleets mineral oil enema was not documented in the IDNs.• IDNs indicated individual refused Lactulose for five days. This information was not included in the Nursing Weekly note and there was no nursing assessment for constipation found in the notes.• Lack of consistent documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline.• No reference to the use of Neuro checks sheets or flow sheets used for documentation in the nursing progress notes. <p>Although there was obvious improvement noted in some of the records, these findings did not comport with PSH's data. At the time of the review, the facility had implemented the interventions listed above to</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>address some of the problematic issues in this area. The facility needs to develop and implement a system for documentation, such as the use of the RANs and/or Nursing Protocols, so that nurses have a structure guiding their documentation to ensure completeness and consistency. At the time of the review, the Nursing Department was aware that it had more work to do in this area to achieve substantial compliance with this requirement.</p> <p>Using the DMH Nursing Services Audit, PSH assessed its compliance based on a 86% sample of Change of Shift Reports observed during in the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 634 1887 748"> <tr> <td data-bbox="991 634 1087 748">10.</td> <td data-bbox="1087 634 1793 748"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 634 1887 748">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on Program I, unit O6 found that the report was consistent with the findings from the last review in that it was largely generic and significantly lacked individualized clinically relevant information regarding the individuals' status. There was no association made between individuals' symptoms in relation to their Axis diagnoses and clinical information indicating if the individuals were doing better or worse regarding their symptoms. These findings do not comport with PSH's data. The facility needs to continue significant efforts in mentoring appropriate shift reports.</p> <p>Compliance: Partial due to findings related to changes in status and shift report.</p>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The facility needs to develop and implement a system for practice and documentation in alignment with Nursing Standards of Practice that includes the use of RANs and/or Nursing Protocols. 2. Continue training and mentoring focused on building and improving nursing competency regarding assessments and documentation addressing changes in status. 3. Further review of the monitoring tool and instructions addressing Medical Transfers regarding nursing documentation should be conducted to ensure it is representative of the requirements for this area and includes qualitative standards for nursing such as RANs and/or Nursing protocols for evaluating nursing documentation. 4. Increase efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses. 5. Continue to monitor these requirements.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Substantial.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period. Compliance rates for other items in this audit are reported in the following cells.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>In medication administration observed on Program I, unit O6, the medication nurse demonstrated good interactions with the individuals receiving medications and provided appropriate medication education. All medication administration procedures were appropriately followed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.f.ii	education is provided to individuals during medication administration;	The facility reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	The facility reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	There were no previous recommendations, as PSH did not care for any bed-bound individuals during the previous review period. There were no bed bound individuals during the review period.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	Compliance: Substantial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH's training rosters verified that 12 newly hired RNs and nine newly hired PTs received and passed competency-based training addressing Employee Medication Certification, Mental Health Nursing, Therapeutic Strategy Interventions (TSI), and Positive Behavior Support Principles.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH's training rosters indicated that 100% of the existing unit staff are currently in compliance with this requirement. See F.3.h.i for New Employee medication certification training data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alejandro Fernandez, Senior Rehabilitation Therapist 2. Chris Keierleber, Senior Rehabilitation Therapist 3. Denise Byerly, POST Coordinator 4. Greg Siples, Chief of Rehabilitation Therapy 5. Kathleen McIntire, Senior Rehabilitation Therapist 6. Rebecca Griffin, Senior Rehabilitation Therapist 7. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 8. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for November 2010 - April 2011 2. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 21 individuals participating in observed PSR Mall groups: CA, CC, CCB, CM, DA, DC, DMJ, GWD, HMD, JC, JCW, JH, JPF, LEL, OB, PB, RB-1, RB-2, RM, RR and SG 4. List of individuals who received direct physical therapy services from November 2010 - April 2011 5. List of individuals who received direct speech therapy services from November 2010 - April 2011 6. List of individuals who received direct occupational therapy services from November 2010 - April 2011 7. Records of the following 20 individuals who received direct physical, speech, and/or occupational therapy services from November 2010 - April 2011: AAD, AKA, CC, CH, DEN, EH, GJG, JHB, KE, RB, RLA, RRA, RRD, SB, SBP, SC, SMK, TS, VGR and VT 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following five individuals with 24-Hour Rehabilitation Support Plans: GS, JP, RD, SBP and TS

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 10. List of individuals with INPOP plans 11. Records of the following three individuals with an INPOP plan: HV, RB and VT 12. List of individuals at high risk for falls 13. Records of the following individuals at high risk for falls: JRH, LJS and TC 14. List of individuals with three or more falls in 30 days and falls resulting in major injury during the review period 15. Records of the following individuals who had three or more falls in 30 days or a fall with a major injury during the review period: KMS, MGM, RB and WC 16. List of individuals at high risk for skin breakdown 17. Records of the following two individuals at high risk for impaired skin integrity: MJP and SRF 18. List of individuals with an incident of a decubitus ulcer during the review period 19. Records of the following individuals with an incident of a decubitus ulcer during the review period: GS and JBD <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Successful Stories PSR Mall group 2. Drumming PSR Mall group 3. Sewing and Textiles PSR Mall group 4. Kickball PSR Mall group 5. Enhancing Self Control PSR Mall group 6. Motivation through Creative Arts PSR Mall group 7. Music Making PSR Mall group 8. Creative Arts Therapy through Watercolors PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services	Compliance: Substantial.

Section F: Specific Therapeutic and Rehabilitation Services

	that address, at a minimum:													
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The table below presents the number of hours scheduled versus number of hours provided in direct OT, PT and SLP treatment during the week of 3/07/11:</p> <table border="1" data-bbox="989 638 1587 792"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>89</td> <td>70</td> </tr> <tr> <td>OT</td> <td>25</td> <td>21</td> </tr> <tr> <td>SLP</td> <td>26</td> <td>24</td> </tr> </tbody> </table> <p>The facility reported that the discrepancy between hours scheduled and provided was due primarily to refusals, followed by illness and scheduling.</p> <p>Other findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period November 2010 - April 2011, and reported a mean compliance rate of 95%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals receiving direct occupational, physical, and/or speech therapy direct treatment to assess compliance with F.4.a.i criteria found 16 records in substantial compliance (AAD, AKA, CC, CH, DEN, EH, JHB, KE, RB, RLA, RRA, RRD, SB, SMK, TS and VGR) and four records in partial compliance (GJG, SBP, SC and VT).</p>		Scheduled	Provided	PT	89	70	OT	25	21	SLP	26	24
	Scheduled	Provided												
PT	89	70												
OT	25	21												
SLP	26	24												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>In terms of individual outcomes, objectives were met or documentation of progress towards objectives was noted for 14 out of 21 individuals whose records were reviewed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement e.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 33% of plans completed during the review period November 2010 - April 2011, and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals with INPOP plans to assess compliance with F.4.a.ii criteria found all three in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported that all 55 nurses identified as requiring training in</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>
F.4.c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 36% of individuals with 24-hour support plans during the review period November 2010 - April 2011, and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of five individuals with 24-hour support plans to assess compliance with F.4.c criteria found four records in substantial compliance (JP, RRD, SBP and TS) and one record in partial compliance (GS).</p> <p>During observation of an individual with a 24-hour support plan during lunch on the unit, it was noted that he demonstrated no at-risk behaviors. The facility should continue to work on the mealtime milieu to ensure that the eating environment is not only safe, but also not unnecessarily restrictive, and that individuals are able to experience optimal enjoyment</p>

Section F: Specific Therapeutic and Rehabilitation Services

and socialization during meals.

The table below presents the number of hours scheduled versus number of hours provided in PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 4/11/11:

	Scheduled	Provided
RT	785	614
Voc Rehab	214	142

Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period November 2010 - April 2011, and reported a mean compliance rate of 93%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 21 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 18 records in substantial compliance (CA, CC, CCB, CM, DA, DC, DMJ, GWD, HMD, JCW, JPF, OB, PB, RB-1, RB-2, RM, RR and SG) and three records in partial compliance (JC, JH and LEL).

In terms of individual outcomes, objectives were met or documentation of progress towards objectives was noted in the records of eight out of 15 individuals reviewed (individuals recently enrolled in groups not reviewed in terms of progress toward individual outcomes).

Observation of eight PSR Mall groups found that in all groups the appropriate lesson plan was in use and the groups provided activities that were in line with the individuals' assessed needs. PSH should continue to

Section F: Specific Therapeutic and Rehabilitation Services

		<p>work to ensure that individuals are offered RT groups across all clinical foci of treatment, and that a processing component is incorporated into focus 10 lesson plans as clinically indicated.</p> <p>PSH offers a comprehensive vocational services program, which has been developed and based on review of vocational literature. However, there is not currently a system by which to report and document progress towards vocational rehabilitation and IT assignment objectives in the WRP for vocational active treatment interventions that fall outside of designated Mall hours.</p> <p>Other findings:</p> <p>A review of records of four individuals who had three or more falls in 30 days or fall resulting in major injury found that only one appeared to have mobility-related falls in which POST evaluation was indicated, and this individual was referred for and received physical therapy assessment and services. A review of records of two individuals at high risk for falls found that physical and/or occupational therapy assessment and services were provided to both individuals for whom it appeared to be clinically indicated. However, it seemed that one individual (JRH) could have benefitted from a 24-hour plan to address safety during ADLs due to fall risk, but no plan was developed or implemented. A review of records of two individuals who had incidents of decubitus found that one individual for whom it was indicated was receiving occupational and physical therapy services and had a 24-hour plan in place, but the plan did not contain documentation of strategies, positioning, or equipment for pressure relief to address decubitus risk and/or future occurrence. A review of records of two individuals at high risk for impaired skin integrity found that one of the two appeared to require physical therapy services to address pressure concerns, and this individual was receiving direct treatment to improve mobility and learn pressure relief exercises.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period November 2010 - April 2011:</p> <table border="1" data-bbox="989 821 1887 1198"> <tr> <td data-bbox="989 821 1087 898">e.</td> <td data-bbox="1087 821 1766 898"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1766 821 1887 898">100%</td> </tr> <tr> <td data-bbox="989 898 1087 974">f.</td> <td data-bbox="1087 898 1766 974"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1766 898 1887 974">100%</td> </tr> <tr> <td data-bbox="989 974 1087 1050">g.</td> <td data-bbox="1087 974 1766 1050"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1766 974 1887 1050">100%</td> </tr> <tr> <td data-bbox="989 1050 1087 1127">h.</td> <td data-bbox="1087 1050 1766 1127"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1766 1050 1887 1127">100%</td> </tr> <tr> <td data-bbox="989 1127 1087 1198">i.</td> <td data-bbox="1087 1127 1766 1198"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1766 1127 1887 1198">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
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g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

Section F: Specific Therapeutic and Rehabilitation Services

		Current recommendation: Continue to monitor this requirement.
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Section F: Specific Therapeutic and Rehabilitation Services

5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Delores Otto-Moreno, Assistant Director of Nutrition Services 2. Grace Ferris, Assistant Director of Nutrition Services 3. Kristina Hooper, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from November 2010 - April 2011 for each assessment type 2. Records of the following 39 individuals with types a-j.ii assessments from November 2010 - April 2011: AEA, AG, AYR, CCC, CJ, CL, DAH, DNC, DRW, EV, GBB, GS, HKA, HME, IM, JFT, JL, JSD, JTW, LL, LRR, ML, NAD, NY, PBD, PG, RO, RR, RRS, SGM, SHK, SHT, SL, SMM, SWS, TLM, TRK, TS and ULL 3. Meal Accuracy Report audit data from November 2010 - April 2011 4. Nutrition Care Monitoring Tool audit data from November 2010 - April 2011 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals at risk for choking and aspiration 6. Records of the following three individuals referred for speech therapy assessment due to suspected risk of choking and aspiration: GS, IAL and TS 7. Records of the following two individuals with an incident of choking during the review period: GK and RLR 8. List of individuals with a new diabetes diagnosis during the review period 9. Records of the following four individuals with a new diagnosis of diabetes during the review period: CJL, DJ, FR and RD

Section F: Specific Therapeutic and Rehabilitation Services

		<p>10. List of individuals at risk for metabolic syndrome 11. Records of the following five individuals at high risk for metabolic syndrome: AD, AH, CA, JT and THH</p>						
<p>F.5.a</p>	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 17% of Nutrition Assessments (all types) due each month from November 2010 - April 2011 (total of 366 out of 2187):</p> <table border="1" data-bbox="989 748 1887 899"> <tr> <td data-bbox="989 748 1083 786">7.</td> <td data-bbox="1083 748 1776 786"><i>Nutrition education is documented.</i></td> <td data-bbox="1776 748 1887 786">99%</td> </tr> <tr> <td data-bbox="989 786 1083 899">8</td> <td data-bbox="1083 786 1776 899"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1776 786 1887 899">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 39 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>Other findings: PSH assessed its compliance with tray accuracy based on an average sample of 22% of the average daily census from November 2010- April 2011 (total of 1933 out of 8912) and found that 98% of trays audited were in 100% compliance.</p>	7.	<i>Nutrition education is documented.</i>	99%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%
7.	<i>Nutrition education is documented.</i>	99%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of records of five individuals at high risk for metabolic syndrome and four individuals with a new diagnosis of diabetes found that six records (AD, AT, CA, CJL, DJ and FR) contained evidence of a nutrition assessment performed according to NST criteria or following diagnosis that addressed all pertinent risk factors, and three records did not address all pertinent risk factors or provided no clinical recommendations (JT, RD and THH). For individuals with new diabetes diagnoses, two records (CJL and DJ) showed evidence that clinical nutrition recommendations were modified in response to change in status for individuals, and two records (FR and RD) did not show evidence of plan modification in response to change in status.</p> <p>The facility reported that all food service technicians and cooks are provided training on therapeutic diet textures upon New Employee Orientation, with updates provided as clinically indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. During the maintenance phase, develop and implement a system to ensure that individuals with a change in nutrition status such as new diabetes diagnosis receive timely nutrition assessments, and that plans are updated as needed.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with WRP integration based on an average sample of 17% of Nutrition Assessments (all types) due each month from November 2010 - April 2011 (366 out of 2187):</p> <table border="1" data-bbox="989 412 1885 600"> <tr> <td data-bbox="989 412 1087 488">19.</td> <td data-bbox="1087 412 1793 488"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 412 1885 488">93%</td> </tr> <tr> <td data-bbox="989 488 1087 600">20.</td> <td data-bbox="1087 488 1793 600"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 488 1885 600">83%</td> </tr> </table> <p>Comparative data indicated improved compliance from the previous review period:</p> <table border="1" data-bbox="989 748 1885 940"> <thead> <tr> <th data-bbox="989 748 1518 824"></th> <th data-bbox="1518 748 1711 824">Previous period</th> <th data-bbox="1711 748 1885 824">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 824 1885 863">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 863 1518 902">19.</td> <td data-bbox="1518 863 1711 902">88%</td> <td data-bbox="1711 863 1885 902">93%</td> </tr> <tr> <td data-bbox="989 902 1518 940">20.</td> <td data-bbox="1518 902 1711 940">80%</td> <td data-bbox="1711 902 1885 940">83%</td> </tr> </tbody> </table> <p>A review of the records of 14 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	93%	20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	83%		Previous period	Current period	Mean compliance rate			19.	88%	93%	20.	80%	83%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	93%																		
20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	83%																		
	Previous period	Current period																		
Mean compliance rate																				
19.	88%	93%																		
20.	80%	83%																		

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.5.c</p>	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: No incidents of aspiration pneumonia were reported during the review period. Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>Other findings: A review of the records of two individuals with an incident of choking found that both individuals had an assessment by a speech therapist with subsequent recommendations incorporated into the treatment plan; a 24-hour support plan was developed for RLR as clinically indicated due to dysphagia diagnosis and physiological swallowing difficulties. Individual was also enrolled in direct speech therapy for laryngeal strengthening exercises, though participation was limited. This individual was observed during his lunch meal and he did not exhibit any signs or symptoms that would indicate that he was at risk. A review of the records of three individuals referred for speech therapy assessment due to risk for choking and/or aspiration found that all three records contained evidence of timely speech therapy assessments, with clinical recommendations made to address assessment findings. However, for two of three individuals, (GS and IAL), recommendations made in December 2010 and January 2011 for diagnostic tests (MBSS and GI consultation) had still not been implemented as of the week of the review.</p> <p>Compliance: Substantial.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: No training was provided to dietitians during this review period, as it was reported not to be indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding should be updated and revised as needed to align with accepted standards of practice.</p> <p>Compliance: Substantial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		Current recommendation: Continue current practice.
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Section F: Specific Therapeutic and Rehabilitation Services

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	As of the tour conducted in December 2010, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	

Section F: Specific Therapeutic and Rehabilitation Services

7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alan Ta, MD, Physician and Surgeon 2. Chinh Pham, MD, Physician and Surgeon 3. Dien Mach, MD, Chief Physician and Surgeon 4. Duc Nguyen, MD, Physician and Surgeon 5. Hai Le, MD, Physician and Surgeon 6. James Maurer, MD, Staff Psychiatrist 7. Joshua Horsley, MD, Staff Psychiatrist 8. Kenny Win, MD, Physician and Surgeon 9. Khanh Ngo, MD, Physician and Surgeon 10. Khue Nguyen, MD, Physician and Surgeon 11. Luminita Andronescu, MD, Physician and Surgeon 12. Luzmin Inderias, MD, Physician and Surgeon 13. My Tran, MD, Physician and Surgeon 14. Nazem Ghobrial, MD, Staff Psychiatrist 15. Nibonth Viravathana, MD, Physician and Surgeon 16. Nitin Kulkarni, MD, Assistant Medical Director 17. Paul Kratofil, DO, Staff Psychiatrist 18. Rebecca Kornbluh, MD, Acting Chief of Psychiatry 19. Sandra Doerner, RN, Nurse Administrator 20. Stephane Johnson, MD, Staff Psychiatrist 21. Susan Protacio, MD, Physician and Surgeon 22. Talat Khan, MD, Physician and Surgeon 23. Tim Alder, MD, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 14 individuals who were transferred to an outside medical facility during this review period: AA, AT, BM, CV, DD, DR, GD, HI, JS, MH, RC, RG, RR and SD 2. Quarterly Progress Note for the following 17 individuals: AY, BD, CR,

Section F: Specific Therapeutic and Rehabilitation Services

		<p>DD, DEN, DMM, EB, GB, GJG, GW, KJF, LJ, LTH, RG, SWM, TP and WC</p> <ol style="list-style-type: none"> 3. Policy and Procedure #01.10: History and Physical Examination, revised 4. Policy and Procedure #14.13: Admission Chest X-rays, revised 5. Medical Emergency Response sheets for RR 6. List of all individuals admitted to external hospitals during the review period 7. Case Presentation of Acute Change of Mental Status by Chinh Pham, MD 8. PSH summary document regarding Emergency Drills (November 2010 to April 2011): Deficiencies/Concerns and Improvement Plan. 9. PSH summary document regarding Actual Emergencies (November 2010 to April 2011): Deficiencies/Concerns and Improvement Plan. 10. PSH Medical-Surgical Progress Note Auditing summary data (November 2010 to April 2011) 11. PSH Medical Transfer Auditing summary data (November 2010 to April 2011) 12. PSH Medical Emergency Response Evaluation, Mock Codes, summary data (November 2010 to April 2011) 13. PSH Medical Emergency Response Evaluation, Emergency Medical Transport, summary data (November 2010 to April 2011) 14. PSH Integration of Medical Conditions into the WRP Auditing summary data (November 2010 to April 2011) 15. Hospitalization and ER Visit Medical Records summary data (November 2010 to April 2011) 16. PSH Diabetes Mellitus Auditing summary data (November 2010 to April 2011) 17. PSH Hypertension Auditing summary data (November 2010 to April 2011) 18. PSH Dyslipidemia Auditing summary data (November 2010 to April 2011) 19. PSH Asthma/COPD Auditing summary data (November 2010 to April 2011)
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>2011) 20. PSH Medicine Peer Review data (November 2010 to April 2011) 21. PSH Process and Clinical Outcome summary data (previous and current review period) for the following indicators:</p> <ol style="list-style-type: none"> a. Diabetes mellitus b. Dyslipidemia c. Obesity d. Hypertension e. Bowel dysfunction f. Falls g. Aspiration pneumonia h. Seizure disorder i. Metabolic syndrome j. Specialty consultations k. Unexpected mortalities
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Ensure consistent and clear documentation of the communication between PSH and the outside medical facility regarding the medication regimen that was prescribed for individuals upon the return transfer to PSH. • Develop and implement a mechanism to provide adequate medication history to outside facilities upon the transfer of individuals who suffer from seizure activity. <p>Findings: During this review period, the Chief Physician and Surgeon and the Medical Services Administrator had several communications with outside facilities (Arrowhead Regional and St. Bernadine's Medical Centers and Community Hospital of San Bernardino) regarding the proper implementation of these recommendations. The Chief Physician and</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Surgeon and/or his senior medical staff discussed with PSH Physicians and Surgeons, including the MODs, the importance of consistent and clear documentation of the communication with outside medical facilities regarding the medication regimen that was prescribed for individuals upon the return transfer to PSH. In addition, the template for the Transfer Assessment (MH-C 9093) was modified (April 1, 2010) to alert the transferring physician to include any psychotropic medications, including anticonvulsant medications, that may influence the status of the individuals upon their presentation to outside facilities.</p> <p>Recommendation 3, December 2010: Revise the current procedure regarding the use of quetiapine at doses that exceed generally accepted standards to include adequate monitoring for the risk of postural hypotension.</p> <p>Findings: In a personal interview, George Proctor, MD, Senior Psychiatrist presented documentation that corrective action was underway.</p> <p>Recommendation 4, December 2010: Provide a summary outline of any changes in the current medical and joint medical nursing ADs, policies and procedures.</p> <p>Findings: The facility made several updates in its Policy and Procedure #01.10: History and Physical Examination. The most significant update involved medical documentation requirements to address individuals' refusal of any part of the annual physical examination. In addition, Policy and Procedure #14.13 regarding, Admission Chest X-rays was modified to include requirements regarding chest x-rays of individuals who are HIV positive and guidance for the management of individuals who refuse admission chest x-ray.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: This monitor reviewed the charts of 14 individuals who were transferred to an outside medical facility during this review period and interviewed the physicians and surgeons who were involved in their care. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 488 1885 1138"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>1/30/11</td> <td>Severe bilateral hand tremors and shortness of breath</td> </tr> <tr> <td>2</td> <td>2/2/11</td> <td>Chest pain</td> </tr> <tr> <td>3</td> <td>3/15/11</td> <td>R/O bowel obstruction</td> </tr> <tr> <td>4</td> <td>12/8/10</td> <td>Abdominal pain and low grade fever</td> </tr> <tr> <td>5</td> <td>4/28/11</td> <td>Altered level of consciousness</td> </tr> <tr> <td>6</td> <td>4/1/11</td> <td>Altered level of consciousness</td> </tr> <tr> <td>7</td> <td>4/4/11</td> <td>Vertigo</td> </tr> <tr> <td>8</td> <td>1/10/11</td> <td>Cerebrovascular accident</td> </tr> <tr> <td>9</td> <td>2/8/11</td> <td>Altered level of consciousness</td> </tr> <tr> <td>10</td> <td>4/8/11</td> <td>Coffee ground emesis</td> </tr> <tr> <td>11</td> <td>4/2/11</td> <td>Abdominal pain</td> </tr> <tr> <td>12</td> <td>4/14/11</td> <td>Abdominal pain</td> </tr> <tr> <td>13</td> <td>12/25/11</td> <td>S/P cardiopulmonary resuscitation</td> </tr> <tr> <td>14</td> <td>3/3/11</td> <td>Hyponatremia and hypokalemia</td> </tr> </tbody> </table> <p>The review found general evidence of timely and adequate medical care. However, the following deficiencies were noted:</p> <ol style="list-style-type: none"> 1. The psychiatric reassessment of an individual who developed a cerebrovascular event and suffered from several risk factors did not include an adequate risk/benefit analysis regarding the continued use 	Individual	Date/time of MD evaluation	Reason for transfer	1	1/30/11	Severe bilateral hand tremors and shortness of breath	2	2/2/11	Chest pain	3	3/15/11	R/O bowel obstruction	4	12/8/10	Abdominal pain and low grade fever	5	4/28/11	Altered level of consciousness	6	4/1/11	Altered level of consciousness	7	4/4/11	Vertigo	8	1/10/11	Cerebrovascular accident	9	2/8/11	Altered level of consciousness	10	4/8/11	Coffee ground emesis	11	4/2/11	Abdominal pain	12	4/14/11	Abdominal pain	13	12/25/11	S/P cardiopulmonary resuscitation	14	3/3/11	Hyponatremia and hypokalemia
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>of a high-risk antipsychotic agent (HI). This event was not reported as a severe ADR002C as it should have been.</p> <ol style="list-style-type: none"> 2. The nursing assessment of an individual complaining of abdominal pain and constipation did not document a timely examination of the individual (CV). 3. An individual (DG) suffered severe orthostatic drop in blood pressure while receiving high-risk medication (quetiapine) at high dose. There was no monitoring of orthostatic changes in blood pressure (DG) prior to the event. However, this monitoring was instituted following outside hospitalization. This event was not reported as a severe ADR, as it should have been. 4. The nursing reassessments of an individual who developed gastrointestinal complaints did not include timely and adequate examination of the individual (BM). 5. A nursing progress note indicated that an individual was reportedly "hypotensive" but no nursing assessment was documented (RG). <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide a summary outline of any changes in the current medical and joint medical/nursing ADs, policies and procedures. 2. Ensure that the review of external hospitalizations includes psychiatric input to identify possible severe ADRs to psychiatric treatment.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care,	Current findings on previous recommendation:

Section F: Specific Therapeutic and Rehabilitation Services

	<p>including but not limited to, vision care, dental care, and laboratory and consultation services;</p>	<p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, PSH assessed its compliance based on an average sample of 11% of all individuals with at least one diagnosis on Axis III during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 524 1887 899"> <tr> <td data-bbox="991 524 1087 599">1.</td> <td data-bbox="1087 524 1793 599"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 524 1887 599">99%</td> </tr> <tr> <td data-bbox="991 599 1087 711">2.</td> <td data-bbox="1087 599 1793 711"><i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 599 1887 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 899">3.</td> <td data-bbox="1087 711 1793 899"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 711 1887 899">90%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items</p> <p>Other findings: This monitor reviewed the most recent Quarterly Progress notes for the following 17 individuals: AY, BD, CR, DD, DEN, DMM, EB, GB, GJG, GW, KJF, LJ, LTH, RG, SWM, TP and WC. The review found general evidence that the facility has maintained substantial compliance with this requirement.</p> <p>Compliance: Substantial.</p>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%	2.	<i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	100%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	90%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>																		
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Provide an outline of the issues identified during the performance of medical emergency drills and corresponding corrective actions. <p>Findings: Using the DMH Medical Transfer Auditing Form, PSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 748 1887 1421"> <tr> <td data-bbox="991 748 1087 862">1.</td> <td data-bbox="1087 748 1793 862"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 748 1887 862">97%</td> </tr> <tr> <td data-bbox="991 862 1087 1008">2.</td> <td data-bbox="1087 862 1793 1008"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 862 1887 1008">99%</td> </tr> <tr> <td data-bbox="991 1008 1087 1081">3.</td> <td data-bbox="1087 1008 1793 1081"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1008 1887 1081">97%</td> </tr> <tr> <td data-bbox="991 1081 1087 1227">4.</td> <td data-bbox="1087 1081 1793 1227"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1793 1081 1887 1227">100%</td> </tr> <tr> <td data-bbox="991 1227 1087 1382">5.</td> <td data-bbox="1087 1227 1793 1382"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1793 1227 1887 1382">98%</td> </tr> <tr> <td data-bbox="991 1382 1087 1421">6.</td> <td data-bbox="1087 1382 1793 1421"><i>Timely written progress notes by the regular medial</i></td> <td data-bbox="1793 1382 1887 1421">99%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	99%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	97%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	100%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	98%	6.	<i>Timely written progress notes by the regular medial</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="978 183 1087 305"></td> <td data-bbox="1087 183 1793 305"><i>physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></td> <td data-bbox="1793 183 1921 305"></td> </tr> <tr> <td data-bbox="978 305 1087 418">7.</td> <td data-bbox="1087 305 1793 418"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 305 1921 418">94%</td> </tr> </table> <p data-bbox="978 459 1921 602">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 1 through 6. The compliance rate for item 7 improved from 82% in the previous review period.</p> <p data-bbox="978 643 1921 824">PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 22% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (November 2010 - April 2011). The following is a summary of the data:</p> <table border="1"> <tr> <td data-bbox="978 862 1087 938">1.</td> <td data-bbox="1087 862 1793 938"><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td data-bbox="1793 862 1921 938">94%</td> </tr> <tr> <td data-bbox="978 938 1087 1015">2.</td> <td data-bbox="1087 938 1793 1015"><i>The WRP includes each medical condition listed on the Medical Conditions form</i></td> <td data-bbox="1793 938 1921 1015">94%</td> </tr> <tr> <td data-bbox="978 1015 1087 1091">3.</td> <td data-bbox="1087 1015 1793 1091"><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td data-bbox="1793 1015 1921 1091">92%</td> </tr> <tr> <td data-bbox="978 1091 1087 1167">4.</td> <td data-bbox="1087 1091 1793 1167"><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td data-bbox="1793 1091 1921 1167">96%</td> </tr> <tr> <td data-bbox="978 1167 1087 1243">5.</td> <td data-bbox="1087 1167 1793 1243"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1793 1167 1921 1243">93%</td> </tr> </table> <p data-bbox="978 1279 1921 1349">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="978 1390 1921 1422">Using the same tool, the facility reviewed a 100% sample of individuals</p>		<i>physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	94%	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	94%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	94%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	92%	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	96%	5.	<i>There are appropriate intervention(s) for each objective</i>	93%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>who have refused medical treatment or laboratory tests (n = 7). Comparative data indicated a decline in compliance from 83% in the previous review period to 22% during this period.</p> <p>PSH indicated that the audit of the records of the seven individuals who were referred to the WRP psychologists as High Concern Medical Refusers (HCMRs) found that only two of the seven records passed the audit items addressing mention of a protocol/response in the WRP Present Status section and relevant objectives and interventions in the WRPs. PSH noted that of the five cases that did not pass the audit, four of the individuals did receive a psychological evaluation with interventions and/or a plan in response to the referral, but the WRPs did not contain these interventions or plans. The seventh HCMR was for an individual who was discharged from the hospital two weeks after the referral was made. PSH indicated that the WRPT knew that the discharge was to occur at the time that the HCMR referral was made, and consequently the psychologist did not initiate an HCMR protocol. Thus, PSH indicated that although the required documentation was not completed, six of the seven individuals did receive services in response to the HCMR referral. PSH's corrective actions are listed below.</p> <p>A review of PSH's list of high risk refusals for the review period (November 2010 through April 2011) indicated that only seven individuals were identified as high risk related to their refusal of medical treatments/appointments. This was a significantly low number considering the census of the facility and was due in part to the problematic issues regarding the lack of consistency and communication between PCPs and WRP psychologists resulting in PCPs making fewer referrals as reported by the facility. Consequently, at the time of the review, the facility's system addressing refusals was not being adequately implemented, especially regarding the identification of high-risk refusals. From a conversation with the facility's Medical Director and information provided by PSH, the overall process regarding refusals, especially high</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>risk or high concern medical refusals will be reviewed, clarified, revised as needed, and training provided to the facility's staff.</p> <p>A review of records of six individuals (AC, DRL, GR, JTL, KT and SRD) that were designated as high risk regarding their refusals for medical treatments/appointments found that all six had documentation mentioning refusals noted in the Present Status section of the WRPs. However, there was no indication that these refusals had been designated as high risk or included the reasons they were considered to be high risk. In addition, the focus statements addressing refusals, the objectives, and interventions included in the WRPs were not adequate for individuals who were identified as being at high risk and were not reflective of information and interventions found in some of the psychologists' and physicians' notes regarding the high concern medical refusals.</p> <p>For example, the psychologist's notes for one individual indicated that the refusal for blood work was due to the weakness the individual reported experiencing in the past after having blood drawn. The psychologist's notes indicated that arrangements were made so that a snack would be provided following the blood draw: "tangible incentives." Thus, the test was rescheduled, the blood draw was completed, and the test results were provided to the physician. However, the focus statements, objectives and interventions contained in the WRP for this individual did not reflect the refusal issues and strategies used that resulted in the completion of the needed tests for other treatments that the individual was refusing. In fact, two of the six individuals reviewed (AC and KT) actually complied with the recommended high risk medical testing and the physicians' notes indicated that subsequently, their refusal risks were lowered.</p> <p>In addition, although all had an open focus addressing refusals included in the WRPs, the quality of the objectives and interventions were not</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>adequate for individuals who were identified as being at high risk regarding their refusals. The interventions found in the high risk WRPs were basically the same as found in the WRPs for those individuals with lower refusal risk levels and only to be implemented monthly. Providing only monthly interventions for individuals designated at high risk is not adequate. Consequently, the WRPs reviewed were not reflective of interventions that had been implemented or a higher level of intensity for individuals deemed at high risk for treatment/appointment refusals.</p> <p>PSH provided a document, <i>High Concern Medical Refuser Response</i>, which indicated that the facility had identified problematic issues related to the current system addressing refusals. Specifically, these included:</p> <ul style="list-style-type: none"> • Lack of consistency and communication between PCPs and WRP Psychologists resulting in PCPs making fewer referrals due to these referrals not being adequately and consistently addressed and followed; • Confusion of the PCPs and psychologists regarding the relationship of probate issues and high concern medical refusal procedures and interventions;and • The current system addressing high concern medical refusals did not include a clear process ensuring follow-up and accountability for these particular referrals. <p>In response to these problematic issues, the facility reported that the following processes and strategies would be implemented:</p> <ul style="list-style-type: none"> • Chiefs of Medicine and Psychology will attend each discipline's department meeting to clarify issues and procedures addressing high concern medical refusals. • High concern medical refusals identified by PCPs will be referred to the WRP psychologist and Standards Compliance will also be notified by email of the referral.
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Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> • Standards Compliance will notify the Chief of Psychology, Chief of Medicine, and Senior Supervisors of the high concern medical refusal referral as well as those identified by the MRMC. • The Chief of Psychology or designee will maintain a log of all referrals and will follow up weekly to ensure that all referrals are being addressed. • The Senior Supervisor will follow up within five days of notification of the referral to ensure that the high concern medical refusal protocol has been initiated, and within 30 days to ensure that interventions are being implemented, and appropriate documentation is contained in the psychology notes and WRPs. • PCPs and psychologists will meet together with the individual to discuss the medical issues and potential risks of the refusals as needed. • Training will be provided to the PCPs and psychologists addressing intervening and dealing with the refusal of medical care, the high concern medical refusal process, and the associated documentation requirements. <p>Since the last CM visit, a RN nurse mentor was assigned to each Program to mentor nursing staff on nursing documentation. The Standards Compliance Director has provided initial and follow-up training to the Nurse Mentors on how to adequately address refusals, including how to individualize the plan of care based on the specific reason for refusal.</p> <p>In summary, the facility has provided adequate review, analysis and corrective actions to address the decline from 83% to 22% and to improve compliance with regard to medical refusals.</p> <p>Using the DMH Medical Emergency Response Evaluation, PSH assessed its compliance based on a sample of 100% of mock codes (total of 192) performed during the review period (November 2010 - April 2011):</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
		2.	<i>Did the first responder provide appropriate CPR procedures?</i>	93%
		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	99%
		4.	<i>Did the first responder provide Heimlich procedures?</i>	100%
		5.	<i>Did the first responder provide appropriate BFA procedures?</i>	97%
		6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%
		7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
		8.	<i>Did the MD respond within 15 minutes?</i>	87%
		9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	97%
		10.	<i>Was the unit milieu appropriately managed?</i>	99%
		11.	<i>Was all required equipment available?</i>	88%
		12.	<i>Was all required equipment in working order?</i>	96%
		13.	<i>Were all medical supplies available?</i>	96%
		14.	<i>Were all medications available?</i>	100%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	96%
		16.	<i>Did all the staff perform according to assigned roles?</i>	99%
		17.	<i>Was staff competent in operating equipment?</i>	100%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	N/A
		19.	<i>Was all required documentation completed?</i>	100%
		20.	<i>Was EMS able to access the site in a timely manner?</i>	N/A
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	N/A

Section F: Specific Therapeutic and Rehabilitation Services

The following table shows changes in compliance since the last review (compliance remained at rates of at least 90% for all other items):

	Previous period	Current period
Mean compliance rate		
2.	69%	93%
4.	N/A	100%
8.	89%	87%
11.	83%	88%
13	89%	96%
14.	85%	100%
15.	88%	96%
18.	100%	N/A

Using the same form, PSH assessed its compliance based on a sample of 100% of actual medical emergencies (#9) during the review period (November 2010 - April 2011):

1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%
3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
4.	<i>Did the first responder provide Heimlich procedures?</i>	100%
5.	<i>Did the first responder provide appropriate BFA procedures?</i>	100%
6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%
7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>8.</td> <td><i>Did the MD respond within 15 minutes?</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Was the unit milieu appropriately managed?</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Was all required equipment available?</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>Was all required equipment in working order?</i></td> <td>89%</td> </tr> <tr> <td>13.</td> <td><i>Were all medical supplies available?</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Were all medications available?</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Was the overall response organized in a manner that led to the best outcome for the individual?</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Did all the staff perform according to assigned roles?</i></td> <td>96%</td> </tr> <tr> <td>17.</td> <td><i>Was staff competent in operating equipment?</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Was the announcement "Code Blue" timely and clear?</i></td> <td>67%</td> </tr> <tr> <td>19.</td> <td><i>Was all required documentation completed?</i></td> <td>88%</td> </tr> <tr> <td>20.</td> <td><i>Was EMS able to access the site in a timely manner?</i></td> <td>100%</td> </tr> <tr> <td>21.</td> <td><i>Was the equipment restocking completed within 8 hours?</i></td> <td>100%</td> </tr> </table>	8.	<i>Did the MD respond within 15 minutes?</i>	100%	9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	100%	10.	<i>Was the unit milieu appropriately managed?</i>	100%	11.	<i>Was all required equipment available?</i>	100%	12.	<i>Was all required equipment in working order?</i>	89%	13.	<i>Were all medical supplies available?</i>	100%	14.	<i>Were all medications available?</i>	100%	15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%	16.	<i>Did all the staff perform according to assigned roles?</i>	96%	17.	<i>Was staff competent in operating equipment?</i>	100%	18.	<i>Was the announcement "Code Blue" timely and clear?</i>	67%	19.	<i>Was all required documentation completed?</i>	88%	20.	<i>Was EMS able to access the site in a timely manner?</i>	100%	21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%	
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1-3, 5-11, 13-17 and 20-21 (item 4 was N/A in the previous period). Declines were noted in the other items as follows:</p>																																											
		<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>12.</td> <td>93%</td> <td>89%</td> </tr> <tr> <td>18.</td> <td>100%</td> <td>67%</td> </tr> <tr> <td>19</td> <td>100%</td> <td>88%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			12.	93%	89%	18.	100%	67%	19	100%	88%																												
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: At the request of this monitor, PSH presented a summary outline of all issues in need of performance improvement that were identified during the performance of emergency drills and actual emergencies. The report included corresponding corrective and follow-up actions. Based on a review of this document, this monitor found that the facility has maintained an adequate system that identifies actual and potential breakdown points and that provides appropriate corrective and follow-up actions.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Implement the processes and strategies outlined to improve compliance regarding medical refusals. 3. The WRPTs need to develop, regularly review, and revise adequate and appropriate WRPs in alignment with the designated risk levels of refusals. 4. Continue to provide summary of all areas of concern identified during performance of emergency drills and actual emergencies, including corresponding corrective and follow up actions.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH has continued its practice.</p> <p>The duties and responsibilities of primary care physicians are adequately</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>defined in the current policies, procedures and administrative directives regarding medical (and nursing) assessments and care.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH has continued its practice.</p> <p>Other findings: Review of the schedule of on-call coverage found that both a primary care physician and a psychiatrist provided after-hours coverage.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: The facility presented data based on a 92% sample of individuals returning from outside medical treatment during the review period (November 2010 - April 2011), tracking whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 91%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor's chart reviews (see F.7.a) found that necessary medical records from outside hospitals were available in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • The facility may reduce the sample sizes for the above-mentioned data to no less than 10% in order to free some resources for self-assessment of other areas (e.g. preventive and cardiac care). <p>Findings: PSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples ranged from 10% to 11% of individuals diagnosed with these disorders during the review period (November 2010 - April 2011). The following tables summarize the</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>95%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td>99%</td> </tr> <tr> <td>11.</td> <td><i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i></td> <td>96%</td> </tr> <tr> <td>12.</td> <td><i>Podiatry care was provided by a podiatrist at least annually.</i></td> <td>99%</td> </tr> <tr> <td>13.</td> <td><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Diabetes is addressed in Focus 6 of the WRP.</i></td> <td>99%</td> </tr> <tr> <td>15.</td> <td><i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at</p>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	97%	2.	<i>HgbA1C was ordered quarterly.</i>	98%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%	4.	<i>Blood sugar is monitored regularly.</i>	99%	5.	<i>Urinary micro albumin is monitored annually.</i>	96%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	99%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i>	99%	9.	<i>Blood pressure is monitored weekly.</i>	95%	10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	99%	11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	96%	12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	99%	13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%	14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	99%	15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>least 90% from the previous review period for all items.</p> <p><u>Hypertension</u></p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td>96%</td> </tr> <tr> <td>5.</td> <td><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i></td> <td>97%</td> </tr> <tr> <td>9.</td> <td><i>An exercise program has been initiated.</i></td> <td>98%</td> </tr> <tr> <td>10.</td> <td><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Dyslipidemia</u></p> <table border="1"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>A lipid panel was ordered at least quarterly.</i></td> <td>98%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	96%	2.	<i>Blood pressure is monitored weekly.</i>	100%	3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	100%	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	96%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	100%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	99%	7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	100%	8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	97%	9.	<i>An exercise program has been initiated.</i>	98%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	93%	2.	<i>A lipid panel was ordered at least quarterly.</i>	98%
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Section F: Specific Therapeutic and Rehabilitation Services

		3.	<i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i>	100%
		4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%
		5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	100%
		6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	99%
		7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	99%
		8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	99%
		9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	97%
		10.	<i>An exercise program has been initiated.</i>	99%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Asthma/COPD</u></p>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	94%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	99%
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	98%
		4.	<i>If the individual is currently a smoker, a smoking</i>	100%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 188 1887 532"> <tr> <td data-bbox="991 188 1087 266"></td> <td data-bbox="1087 188 1793 266"><i>cessation program has been discussed and included in the WRP.</i></td> <td data-bbox="1793 188 1887 266"></td> </tr> <tr> <td data-bbox="991 266 1087 305">5.</td> <td data-bbox="1087 266 1793 305"><i>Asthma or COPD is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1793 266 1887 305">99%</td> </tr> <tr> <td data-bbox="991 305 1087 383">6.</td> <td data-bbox="1087 305 1793 383"><i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i></td> <td data-bbox="1793 305 1887 383">98%</td> </tr> <tr> <td data-bbox="991 383 1087 422">7.</td> <td data-bbox="1087 383 1793 422"><i>The individual has been assessed for a flu vaccination.</i></td> <td data-bbox="1793 383 1887 422">96%</td> </tr> <tr> <td data-bbox="991 422 1087 532">8.</td> <td data-bbox="1087 422 1793 532"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1793 422 1887 532">94%</td> </tr> </table> <p data-bbox="991 574 1887 643">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 685 1140 753">Compliance: Substantial.</p> <p data-bbox="991 795 1325 824">Current recommendations:</p> <ol data-bbox="991 834 1860 977" style="list-style-type: none"> 1. Continue to monitor this requirement. 2. The facility may reduce the sample sizes for the above-mentioned audits to free resources for self-assessment of other areas (e.g. preventive and cardiac care). 		<i>cessation program has been discussed and included in the WRP.</i>		5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	99%	6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	98%	7.	<i>The individual has been assessed for a flu vaccination.</i>	96%	8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	94%
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F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	<p data-bbox="991 1019 1591 1049">Current findings on previous recommendations:</p> <p data-bbox="991 1091 1560 1120">Recommendations 1 and 2, December 2010:</p> <ul data-bbox="991 1130 1887 1344" style="list-style-type: none"> • Continue to provide data on process and clinical outcomes of medical care. • Utilize the outcome data regarding medical care to inform the facility's performance improvement efforts and the oversight function of the facility's Quality Council, as indicated (same as in Section I.2). 															

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: PSH provided process and clinical outcome data for the current review period, including comparisons with the previous review period. The following is a summary outline of the data:</p> <ol style="list-style-type: none">1. Process outcomes:<ol style="list-style-type: none">a. Number of individuals newly diagnosed with Diabetes Mellitus;b. Number of new diagnoses of Diabetes Mellitus in individuals receiving new generation antipsychotics;c. Percentage of individuals whose BMI is tracked monthly;d. Percentage of individuals receiving clozapine and prescribed high fiber diet (or documentation of diet is refused);e. Percentage of individuals receiving clozapine and enrolled in exercise program;f. Number of individuals with 3+ falls in 30 days;g. Total number of falls;h. Number of individuals with cognitive disorders and receiving older anticonvulsant agents;i. Adequate documentation of seizure activity;j. Documentation of medical, neurological and neuropsychological referrals/assessments/consultations for individuals with seizure disorders;k. Documentation of appropriate anticonvulsant medication selection for individuals with seizure disorders;l. Number of individuals with metabolic syndrome;m. Number of individuals with metabolic syndrome who had cardiac disease;n. Number of individuals with metabolic syndrome who had cardiac disease and were hospitalized (or had ER visits)o. Timeliness and appropriateness of external consultations;p. Number of unexpected mortalities andq. Review process for unexpected deaths.
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>2. Clinical outcomes:</p> <ul style="list-style-type: none"> a. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus; b. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics; c. Percentage of individuals with dyslipidemia with LDL <130; d. Percentage of individuals with diabetes mellitus with LDL <100; e. Number/percentage of individuals with BMI >25; f. Percentage of individuals with hypertension with blood pressure < 140/90; g. Percentage of individuals with diabetes mellitus and blood pressure <130/80; h. Number of individuals hospitalized for bowel dysfunction; i. Individuals with falls resulting in major injury; j. Number of individuals diagnosed with aspiration pneumonia; k. Number of individuals with refractory seizures and l. Number of individuals with status epilepticus. <p>Review of the outcome data found that the facility has, in general, maintained positive outcomes of its medical services.</p> <p>Many of the above outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators presented in the appendix of this report. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see section I.2). The facility reported that its Medical Risk Management Committee has reviewed the process and clinical outcome data to assess overall performance.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Other findings: The facility presented the following peer review aggregated data, based on a 100% sample of primary care physicians:</p> <table border="1"> <tr> <td>1.</td> <td><i>Quality of care</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Timeliness of care</i></td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>WRP planning and documentation</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Appropriate consultations ordered</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate consultations reviewed</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate labs/diagnostics ordered</i></td> <td>95%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate labs/diagnostics reviewed</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>During the review period, all Physicians and Physicians who were scheduled for reprivileging (#9) as per the facility's procedure were repriviledged. The criteria used in this process were reviewed in previous reports.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide information regarding the facility's review of the performance (and reprivileging) of Physicians and Surgeons based on objective indicators. 2. Continue to provide process and clinical outcomes of medical service with comparison to previous review period. 	1.	<i>Quality of care</i>	99%	2.	<i>Timeliness of care</i>	96%	3.	<i>WRP planning and documentation</i>	100%	4.	<i>Appropriate consultations ordered</i>	100%	5.	<i>Appropriate consultations reviewed</i>	99%	6.	<i>Appropriate labs/diagnostics ordered</i>	95%	7.	<i>Appropriate labs/diagnostics reviewed</i>	97%
1.	<i>Quality of care</i>	99%																					
2.	<i>Timeliness of care</i>	96%																					
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4.	<i>Appropriate consultations ordered</i>	100%																					
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6.	<i>Appropriate labs/diagnostics ordered</i>	95%																					
7.	<i>Appropriate labs/diagnostics reviewed</i>	97%																					

Section F: Specific Therapeutic and Rehabilitation Services

8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cindy Blaire, RN 2. Donna Rowe, PHN II 3. Richard Morrissey, MD 4. Sandra Doerner, RN, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH IC Admission PPD summary data, November 2010 - April 2011 2. PSH IC Annual PPD Audit summary data, November 2010 - April 2011 3. PSH IC Hepatitis C Audit summary data, November 2010 - April 2011 4. PSH IC HIV Positive Audit summary data, November 2010 - April 2011 5. PSH IC Immunization Audit summary data, November 2010 - April 2011 6. PSH IC Immunization Refusal Audit summary data, November 2010 - April 2011 7. PSH IC MRSA Audit summary data, November 2010 - April 2011 8. PSH IC Positive PPD Audit summary data, November 2010 - April 2011 9. PSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, November 2010 - April 2011 10. PSH IC Sexually Transmitted Disease (STD) Audit summary data, November 2010 - April 2011 11. Department of Medicine meeting minutes for 11/3/10, 12/1/10, 1/5/11, 2/2/11, 3/2/11 and 4/6/11 12. Joint Department of Medicine/Psychiatry meeting minutes dated 1/26/11 and 4/26/11 13. PSH Enhancement Plan of Action Team Leader meeting minutes dated 10/15/10, 1/21/11, 2/18/11 and 3/18/11 14. Infection Control Committee meeting minutes dated 11/18/10, 12/16/10, 1/13/11, 2/17/11, 3/10/11 and 4/14/11

Section F: Specific Therapeutic and Rehabilitation Services

		<p>15. Quality Council meeting minutes dated 11/2/10, 12/14/10, 2/1/11, 4/13/11 and 4/27/11</p> <p>16. PSH Key Indicator data for Infection Control</p> <p>17. Medical records for the following 88 individuals: AAT, AC, AFR, AJT, ALK, ALS, AW, AWT, BIL, BJ, BJN, CC, CLJ, CLV, CMB, CMP, CUP, DDA, DDG, DMA, DRW, EAH, EC, EDL, EDT, EFS, EGG, EJM, EL, FID, FMV, FRL, GEP, GO, GSS, HP, JD, JEB, JEW, JF, JJL, JJM, JMM, JRR, JSN, JTH, JTW, JWA, KC, KE, KIH, LBC, LK, LM, MA, MH, MHK, MKT, MMH, MOP, MS, MW, NGG, NJC, OC, OV, PCN, PS, QH, RBK, RHT, RLA, SAL, SCM, SDH, SH, SL, SLL, SMC, SML, TCD, THE, TM, UML, VEK, WH, WM and WT</p>
F.8.a	Each State hospital shall establish an effective infection control program that:	<p>Compliance: Substantial.</p>
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Ensure that WRPs are individual-specific and that the reasons for the refusals are included in the WRPs and addressed in the objectives and interventions.</p> <p>Findings: Since the last review period, PSH implemented the use of RN mentors assigned to each Program to address issues related to nursing and nursing documentation, which includes WRPs. In addition, in February 2011, the facility began reviewing issues regarding refusals in the Quality Council meetings as verified in the meeting minutes for February and April 2011.</p> <p>Recommendation 2, December 2010: Ensure that the facility's data regarding individuals who have Hepatitis C is accurate.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Individuals at PSH who are Polymerase Chain Reaction (PCR) positive are appropriately reported as Hepatitis C positive and are included in the facility's Key Indicator report.</p> <p>Recommendation 3, December 2010: Continue to monitor this requirement.</p> <p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, PSH assessed its compliance based on an average sample of 43% of individuals admitted to the hospital with a negative PPD in the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 820 1887 1198"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 14 individuals admitted during the review period (AC, AW, AWT, CC, CLJ, CLV, EAH, EJM, KC, NGG, OV, QH, RLA and WH) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, PSH assessed its compliance based on an average sample of 23% of individuals needing an annual PPD during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 930 1887 1232"> <tr> <td data-bbox="991 930 1087 1005">1.</td> <td data-bbox="1087 930 1793 1005"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 930 1887 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1079">2.</td> <td data-bbox="1087 1005 1793 1079"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 1005 1887 1079">98%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">3.</td> <td data-bbox="1087 1079 1793 1154"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 1079 1887 1154">98%</td> </tr> <tr> <td data-bbox="991 1154 1087 1232">4.</td> <td data-bbox="1087 1154 1793 1232"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1154 1887 1232">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	98%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	98%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	97%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 13 individuals requiring an annual PPD during the review period (AFR, BIL, CUP, DMA, FID, HP, JJL, LK, MOP, SLL, SML, VEK and WT) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, PSH assessed its compliance based on an average sample of 100% of individuals admitted to the hospital in the review months (November 2010 - April 2011) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 1040 1887 1414"> <tr> <td data-bbox="991 1040 1087 1154">1.</td> <td data-bbox="1087 1040 1793 1154"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 1040 1887 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1268">2.</td> <td data-bbox="1087 1154 1793 1268"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1154 1887 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1382">3.</td> <td data-bbox="1087 1268 1793 1382"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 1268 1887 1382">100%</td> </tr> <tr> <td data-bbox="991 1382 1087 1414">4.</td> <td data-bbox="1087 1382 1793 1414"><i>The individual's medication plan was evaluated and</i></td> <td data-bbox="1793 1382 1887 1414">98%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and</i>	98%
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>immunizations for Hepatitis A and B were considered.</i></td> <td></td> </tr> <tr> <td>5.</td> <td><i>A Focus 6 is opened for Hepatitis C.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td>100%</td> </tr> </table>		<i>immunizations for Hepatitis A and B were considered.</i>		5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%
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<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 10 individuals who were admitted Hepatitis C positive during the review period (DDG, DRW, GEP, JD, JTH, JWA, LBC, LM, SDH and TM) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, PSH assessed its compliance based on a 100% sample (four individuals) of individuals who were positive for</p>														

Section F: Specific Therapeutic and Rehabilitation Services

		<p>HIV antibody in the review months (November 2010 - April 2011):</p> <table border="1"> <tr> <td data-bbox="991 264 1087 375">1.</td> <td data-bbox="1087 264 1793 375"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 264 1887 375">100%</td> </tr> <tr> <td data-bbox="991 375 1087 487">2.</td> <td data-bbox="1087 375 1793 487"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 375 1887 487">100%</td> </tr> <tr> <td data-bbox="991 487 1087 599">3.</td> <td data-bbox="1087 487 1793 599"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 487 1887 599">100%</td> </tr> <tr> <td data-bbox="991 599 1087 711">4.</td> <td data-bbox="1087 599 1793 711"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 599 1887 711">N/A</td> </tr> <tr> <td data-bbox="991 711 1087 859">5.</td> <td data-bbox="1087 711 1793 859"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 711 1887 859">100%</td> </tr> <tr> <td data-bbox="991 859 1087 902">6.</td> <td data-bbox="1087 859 1793 902"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 859 1887 902">100%</td> </tr> <tr> <td data-bbox="991 902 1087 977">7.</td> <td data-bbox="1087 902 1793 977"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 902 1887 977">100%</td> </tr> <tr> <td data-bbox="991 977 1087 1016">8.</td> <td data-bbox="1087 977 1793 1016"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 977 1887 1016">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%	6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%	7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%	8.	<i>Appropriate interventions are written.</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of four individuals who were admitted during the review period with HIV (AJT, EFS, RBK and SL) found that all were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, PSH assessed its compliance based on an average sample of 28% of individuals admitted to the hospital during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 782 1890 1122"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 14 individuals (AC, AW, AWT, CC, CLJ, CLV, EAH, EJM, KC, NGG, OV, QH, RLA and WH) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, PSH assessed its compliance based on a 100% sample (72 individuals) of individuals in the hospital who refused to take their immunizations during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 966 1890 1416"> <tr> <td data-bbox="991 966 1087 1079">1.</td> <td data-bbox="1087 966 1795 1079"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1795 966 1890 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">2.</td> <td data-bbox="1087 1079 1795 1154"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1795 1079 1890 1154">96%</td> </tr> <tr> <td data-bbox="991 1154 1087 1229">3.</td> <td data-bbox="1087 1154 1795 1229"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 1154 1890 1229">96%</td> </tr> <tr> <td data-bbox="991 1229 1087 1343">4.</td> <td data-bbox="1087 1229 1795 1343"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 1229 1890 1343">96%</td> </tr> <tr> <td data-bbox="991 1343 1087 1416">5.</td> <td data-bbox="1087 1343 1795 1416"><i>The unit notified the Infection Control Department when the individual consented and received the</i></td> <td data-bbox="1795 1343 1890 1416">N/A</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	96%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	96%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	96%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the</i>	N/A
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2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	96%															
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	96%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	96%															
5.	<i>The unit notified the Infection Control Department when the individual consented and received the</i>	N/A															

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 80%;"><i>immunization(s).</i></td> <td style="width: 10%;"></td> </tr> <tr> <td colspan="3"> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 12 individuals who refused immunizations during the review period (ALK, CC, EDT, FRL, JEB, JEW, JMM, MA, MH, MW, NJC and OC) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 100% sample (23 individuals) of individuals in the hospital who tested positive for MRSA during the review months (November 2010 - April 2011):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%;">100%</td> </tr> <tr> <td>2.</td> <td>Notification by the lab was made to the unit housing</td> <td>100%</td> </tr> </table> </td> </tr> </table>		<i>immunization(s).</i>		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 12 individuals who refused immunizations during the review period (ALK, CC, EDT, FRL, JEB, JEW, JMM, MA, MH, MW, NJC and OC) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 100% sample (23 individuals) of individuals in the hospital who tested positive for MRSA during the review months (November 2010 - April 2011):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%;">100%</td> </tr> <tr> <td>2.</td> <td>Notification by the lab was made to the unit housing</td> <td>100%</td> </tr> </table>			1.	Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.	100%	2.	Notification by the lab was made to the unit housing	100%
	<i>immunization(s).</i>													
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 12 individuals who refused immunizations during the review period (ALK, CC, EDT, FRL, JEB, JEW, JMM, MA, MH, MW, NJC and OC) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 100% sample (23 individuals) of individuals in the hospital who tested positive for MRSA during the review months (November 2010 - April 2011):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">1.</td> <td style="width: 85%;">Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</td> <td style="width: 10%;">100%</td> </tr> <tr> <td>2.</td> <td>Notification by the lab was made to the unit housing</td> <td>100%</td> </tr> </table>			1.	Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.	100%	2.	Notification by the lab was made to the unit housing	100%						
1.	Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.	100%												
2.	Notification by the lab was made to the unit housing	100%												

Section F: Specific Therapeutic and Rehabilitation Services

			<i>the individual that a positive culture for MRSA was obtained</i>	
		3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%
		4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%
		5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%
		6.	<i>A Focus 6 is opened for MRSA.</i>	100%
		7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%
		8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 10 individuals with MRSA (EC, GO, JRR, MHK, MS, PS, RHT, SAL, SMC and THE) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate</p>		

Section F: Specific Therapeutic and Rehabilitation Services

		<p>antibiotic; and all WRPs contained appropriate objectives and interventions.</p> <p><u>Positive PPD</u> Using the DMH IC Positive PPD Audit, PSH assessed its compliance based on an average sample of 75% of individuals in the hospital who had a positive PPD test during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 488 1887 1052"> <tr> <td data-bbox="991 488 1087 565">1.</td> <td data-bbox="1087 488 1793 565"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 488 1887 565">100%</td> </tr> <tr> <td data-bbox="991 565 1087 602">2.</td> <td data-bbox="1087 565 1793 602"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1793 565 1887 602">100%</td> </tr> <tr> <td data-bbox="991 602 1087 678">3.</td> <td data-bbox="1087 602 1793 678"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1793 602 1887 678">100%</td> </tr> <tr> <td data-bbox="991 678 1087 792">4.</td> <td data-bbox="1087 678 1793 792"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1793 678 1887 792">N/A</td> </tr> <tr> <td data-bbox="991 792 1087 829">5.</td> <td data-bbox="1087 792 1793 829"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1793 792 1887 829">95%</td> </tr> <tr> <td data-bbox="991 829 1087 938">6.</td> <td data-bbox="1087 829 1793 938"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1793 829 1887 938">95%</td> </tr> <tr> <td data-bbox="991 938 1087 1052">7.</td> <td data-bbox="1087 938 1793 1052"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 938 1887 1052">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	95%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	95%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	95%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of eight individuals who had a positive PPD (AAT, AWT, CMP, EL, FMV, JJM, SH and TCD) found that all individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, PSH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 930 1887 1307"> <tr> <td data-bbox="991 930 1087 1079">1.</td> <td data-bbox="1087 930 1793 1079"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 930 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1156">2.</td> <td data-bbox="1087 1079 1793 1156"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 1079 1887 1156">98%</td> </tr> <tr> <td data-bbox="991 1156 1087 1232">3.</td> <td data-bbox="1087 1156 1793 1232"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1156 1887 1232">98%</td> </tr> <tr> <td data-bbox="991 1232 1087 1307">4.</td> <td data-bbox="1087 1232 1793 1307"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1232 1887 1307">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	98%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	98%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	98%
1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%												
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Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 15 individuals who refused admitting or annual labs/diagnostics (BJ, BJN, CMB, DDA, EDL, GSS, JF, JSN, JTW, KE, LM, MMH, PCN, UML and WM) found that all refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> Using the DMH IC Sexually Transmitted Disease (STD) Audit, PSH assessed its compliance based on an average sample of 100% of individuals in the hospital who tested positive for an STD during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 1079 1890 1416"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>An RPR is ordered during the admission process for each individual.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A Chlamydia and Gonorrhea test are ordered during</i></td> <td>100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%															
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>the admission process for all female individuals</i></td> <td></td> </tr> <tr> <td>6.</td> <td><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td>N/A</td> </tr> <tr> <td>7.</td> <td><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate objective(s) are written.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Appropriate interventions are written.</i></td> <td>100%</td> </tr> </table>		<i>the admission process for all female individuals</i>		6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 6 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of five individuals with diagnosed STDs (ALS, EGG, KIH, MKT and SCM) found that the appropriate lab work indicating a positive STD was obtained in all cases and the STD was adequately addressed in the WRP in all cases.</p> <p>Compliance: Substantial.</p>
	<i>the admission process for all female individuals</i>																	
6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A																
7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																
8.	<i>Appropriate objective(s) are written.</i>	100%																
9.	<i>Appropriate interventions are written.</i>	100%																

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH's key indicator data accurately reflected the infection control trends from the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Review of the minutes of PSH's meetings verified that IC data are discussed monthly at the meetings of the Infection Control Committee, the Joint Department of Medicine and Psychiatry, the Department of Medicine and the Enhancement Plan Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, RN, Nurse Auditor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Dental Services Audit summary data, November 2010 - April 2011 2. PSH's dental appointment logs 3. "High Concern Medical Refuser Response" document (not dated) 4. Nursing Policy & Procedure: 500-A, Refusal of Medical/Dental Appointments and/or Procedures 5. Medical records for the following 74 individuals: AC, ACC, AFR, AFR, AGA, AHS, AW, AWT, BB, BIL, BSH, CEC, CHC, CLB, CLJ, CLV, CUP, DAR, DDG, DH, DLL, DMA, DUL, EAH, EJL, EJM, EL, ES, FID, FJP, GA, GAJ, GD, GPS, HP, JBB, JJ, JJL, JJS, KC, KHM, KT, LEL, LK, LMA, MB, MM, MOP, MPM, NGG, NLP, OV, QH, QL, RA, RIZ, RLA, RS, SBB, SCM, SG, SLL, SMB, SML, SMW, ST, TB, TM, TWB, UPD, VEK, VM, WH and WT
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The number of full-time staff in the Dental Department remained unchanged from the last review period. The facility had conducted interviews for an additional Dental Assistant and a selection had been made pending approval.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 48% mean sample of individuals scheduled for comprehensive dental exams during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="989 933 1892 974"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals (AC, AW, AWT, CHC, CLV, EAH, EJM, KC, NGG, OV, QH, RLA, CLJ and WH) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 50% mean sample of individuals who have been in the hospital for 90 days or less during the review period (November 2010 - April 2011):</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="989 224 1887 266"> <tr> <td data-bbox="989 224 1087 266">1.b</td> <td data-bbox="1087 224 1793 266"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 224 1887 266">95%</td> </tr> </table> <p data-bbox="989 305 1887 380">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 418 1913 526">A review of the records of 14 individuals (AC, AW, AWT, CHC, CLV, EAH, EJM, KC, NGG, OV, QH, RLA, CLJ and WH) found that all individuals were timely seen for their admission exams.</p> <p data-bbox="989 565 1887 672">Using the DMH Dental Services Audit, PSH assessed its compliance based on a 20% mean sample of individuals due for annual routine dental examinations during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="989 711 1887 786"> <tr> <td data-bbox="989 711 1087 786">1.c</td> <td data-bbox="1087 711 1793 786"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 711 1887 786">95%</td> </tr> </table> <p data-bbox="989 824 1887 899">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 938 1892 1045">A review of the records of 13 individuals (AFR, BIL, CUP, DMA, FID, HP, J JL, LK, MOP, SLL, SML, VEK and WT) found that all annual exams were timely completed.</p> <p data-bbox="989 1084 1887 1224">Using the DMH Dental Services Audit, PSH assessed its compliance based on a 82% mean sample of individuals with dental problems identified on admission or annual examination during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="989 1263 1887 1386"> <tr> <td data-bbox="989 1263 1087 1386">1.d</td> <td data-bbox="1087 1263 1793 1386"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1263 1887 1386">100%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</i>	95%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	95%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%
1.b	<i>If admission examination date was 90 days or less</i>	95%									
1.c	<i>Annual date of examination was within anniversary month of admission</i>	95%									
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 27 individuals (AC, AFR, AW, AWT, BIL, CHC, CLJ, CLV, CUP, DMA, EAH, EJM, FID, HP, J JL, KC, LK, MOP, NGG, OV, QH, RLA, SLL, SML, VEK, WH and WT) found that all individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 51% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="993 672 1887 821"> <tr> <td data-bbox="993 672 1087 821">1.e</td> <td data-bbox="1087 672 1793 821"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 672 1887 821">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 16 individuals (AFR, BSH, CLB, DAR, DH, FJP, GPS, JJ, KHM, LMA, NLP, RLA, SCM, SMB, SMW and TB) found that all individuals received timely follow-up care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 32% mean sample of individuals scheduled for follow-up dental care during the review months (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 27 individuals (AC, AFR, AW, AWT, BIL, CHC, CLJ, CLV, CUP, DMA, EAH, EJM, FID, HP, JJJ, KC, LK, MOP, NGG, OV, QH, RLA, SLL, SML, VEK, WH and WT) found compliance with the documentation requirements in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 47% mean sample of individuals due for annual routine dental examinations during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1154 1887 1268"> <tr> <td data-bbox="993 1154 1087 1268">3.a</td> <td data-bbox="1087 1154 1793 1268"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 1154 1887 1268">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of nine individuals (AGA, BB, JJS, KT, MB, RA, SBB, ST and UPD) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="993 488 1890 565"> <tr> <td data-bbox="993 488 1087 565">3.c</td> <td data-bbox="1087 488 1793 565"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 488 1890 565">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 16 individuals (AFR, BSH, CLB, DAR, DH, FJP, GPS, JJ, KHM, LMA, NLP, RLA, SCM, SMB, SMW and TB) found that all individuals received restorative care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals who had tooth extractions during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="993 1344 1890 1414"> <tr> <td data-bbox="993 1344 1087 1414">4.</td> <td data-bbox="1087 1344 1793 1414"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i></td> <td data-bbox="1793 1344 1890 1414">100%</td> </tr> </table>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></p> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals (ACC, CEC, DDG, DLL, EJJ, EL, GA, GD, JBB, LEL, MM, MPM, QL, RS, SG, TM, TWB and VM) found that all records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 53% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (November 2010 - April 2011) and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 27 individuals (AC, AFR, AW, AWT, BIL, CHC, CLJ, CLV, CUP, DMA, EAH, EJM, FID, HP, JJL, KC, LK, MOP, NGG, OV, QH, RLA, SLL, SML, VEK, WH and WT) found that all records were in compliance with the documentation requirements.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																											
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals scheduled for dental appointments during the review months (November 2010 - April 2011):</p> <table border="1" data-bbox="991 821 1892 898"> <tr> <td data-bbox="991 821 1087 898">6.a</td> <td data-bbox="1087 821 1793 898"><i>Transportation and staffing issues do not preclude the individual attending the scheduled appointment</i></td> <td data-bbox="1793 821 1892 898">95%</td> </tr> </table> <p>Comparative data indicated an increase in compliance from 72% in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 1120 1818 1424"> <thead> <tr> <th data-bbox="997 1120 1129 1234">Month</th> <th data-bbox="1129 1120 1360 1234">Refused to come to appt</th> <th data-bbox="1360 1120 1591 1234">Unit staff procedural problem</th> <th data-bbox="1591 1120 1818 1234">Transportation problem</th> </tr> </thead> <tbody> <tr> <td data-bbox="997 1234 1129 1271">Nov 10</td> <td data-bbox="1129 1234 1360 1271">84</td> <td data-bbox="1360 1234 1591 1271">4</td> <td data-bbox="1591 1234 1818 1271">0</td> </tr> <tr> <td data-bbox="997 1271 1129 1308">Dec 10</td> <td data-bbox="1129 1271 1360 1308">74</td> <td data-bbox="1360 1271 1591 1308">43</td> <td data-bbox="1591 1271 1818 1308">1</td> </tr> <tr> <td data-bbox="997 1308 1129 1346">Jan 11</td> <td data-bbox="1129 1308 1360 1346">95</td> <td data-bbox="1360 1308 1591 1346">7</td> <td data-bbox="1591 1308 1818 1346">3</td> </tr> <tr> <td data-bbox="997 1346 1129 1383">Feb 11</td> <td data-bbox="1129 1346 1360 1383">75</td> <td data-bbox="1360 1346 1591 1383">31</td> <td data-bbox="1591 1346 1818 1383">3</td> </tr> <tr> <td data-bbox="997 1383 1129 1424">Mar 11</td> <td data-bbox="1129 1383 1360 1424">82</td> <td data-bbox="1360 1383 1591 1424">7</td> <td data-bbox="1591 1383 1818 1424">2</td> </tr> </tbody> </table>	6.a	<i>Transportation and staffing issues do not preclude the individual attending the scheduled appointment</i>	95%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	Nov 10	84	4	0	Dec 10	74	43	1	Jan 11	95	7	3	Feb 11	75	31	3	Mar 11	82	7	2
6.a	<i>Transportation and staffing issues do not preclude the individual attending the scheduled appointment</i>	95%																											
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Jan 11	95	7	3																										
Feb 11	75	31	3																										
Mar 11	82	7	2																										

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="997 190 1816 230"> <tr> <td data-bbox="997 190 1131 230">Apr 11</td> <td data-bbox="1131 190 1360 230">73</td> <td data-bbox="1360 190 1589 230">26</td> <td data-bbox="1589 190 1816 230">0</td> </tr> </table> <p data-bbox="989 272 1877 378">A review of PSH's dental logs found that staff or transportation issues were not the major issues precluding individuals from attending dental appointments. See F.9.e for findings regarding dental refusals.</p> <p data-bbox="989 420 1140 485">Compliance: Substantial.</p> <p data-bbox="989 531 1457 596">Current recommendation: Continue to monitor this requirement.</p>	Apr 11	73	26	0
Apr 11	73	26	0			
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p data-bbox="989 644 1591 673">Current findings on previous recommendations:</p> <p data-bbox="989 717 1871 782">Recommendation 1, December 2010: Continue to implement the policy/guidelines addressing dental refusals.</p> <p data-bbox="989 828 1906 1190">Findings: PSH indicated that low and moderate risk refusals were addressed in Quality Council. However, the progress report did not address if a policy/procedure addressing the process for high risk dental refusals had been implemented. The facility provided a document, "High Concern Medical Refuser Response," that identified problematic issues the facility found upon auditing high risk medical refusals and identified a new process that was implemented to address these issues. However, it was not clear from the document if high risk dental refusals were included in the new process described.</p> <p data-bbox="989 1235 1843 1336">Recommendation 2, December 2010: Develop and implement a system for the Dental Department to track individuals' refusal risk levels.</p>				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: An interview with Amy Santimalapong, DDS, Chief Dentist found that since the last review, the Dental Department began tracking individuals' refusal risk levels.</p> <p>Recommendation 3, December 2010: Ensure that WRPs are individualized and include the reasons for the refusals and interventions addressing these reasons.</p> <p>Findings: Since the last review, PSH had assigned Nursing mentors to each Program to assist the nursing staff with a number of issues, including developing adequate WRPs.</p> <p>Recommendation 4, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit (Refusals), PSH assessed its compliance based on a 100% sample of individuals (six individuals) scheduled for but refusing to attend dental appointments and designated as high risk refusals during the review months (November 2010 - April 2011) and reported a mean compliance rate of 58%.</p> <p>A review of the records of five individuals (AHS, DUL, ES, GAJ and RIZ) found that all had the dental refusal documented in the Present Status section of the WRP; however, there was no mention that these refusals were designated as high risk and the reason why they were designated as high risk. Of the five individuals, one ultimately attended the dental appointment (ES), and one had an open focus with appropriate interventions addressing refusals included in the WRP (DUL). The remaining three WRPs (AHS, GAJ and RIZ) did not adequately address</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>the high risk dental refusal. The interventions listed in these WRPs were generic and their implementation was noted to be monthly, which was not reflective of the clinical intensity warranted for a high risk dental refusal designation assigned by a dentist.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to implement the policy/guidelines addressing dental refusals.2. Ensure that WRPs addressing refusals adequately reflect the designated risk level of the refusal, are individualized, and include the reasons for the refusals and interventions addressing these reasons.3. Continue to monitor this requirement.
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Section G: Documentation

G. Documentation		
G	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress PSH has made towards aligning documentation practices with the requirements of the EP.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress: PSH has maintained substantial compliance with all requirements of this section.</p>
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Harry Oreol, Assistant Clinical Administrator 2. Nitin Kulkarni, MD, PhD, Assistant Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Seclusion/Restraint Audit summary data, November 2010 - April 2011 2. PSH's training rosters 3. PSH's Assault Reduction Analysis dated June 2011 4. PRC Review minutes for the following individuals: KAM, OC, JD, JLD and OC 5. Seclusion or Restraint Administrative Reviews for the following individuals: JD, OC, PH and SWK 6. Medical records for the following 31 individuals: AC, DDH, DJT, DLJ, DRL, GR, IG, JAM, JAO, JD, JJJ, JLD, JS, JTL, KAH, KAM, KC, KT, MBA, NM, OC, PH, PHH, RMM, RMR, RP, RPJ, SRD, SWK, TWB and VN
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints,	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: No incidents of prone restraint, containment or transportation were</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	<p>prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>found during this review.</p> <p>Other findings: A review of Restraint/Seclusion data from the initial review period of November 2006 - April 2007 to the current review period indicated the changes in philosophy that PSH has made regarding the use of restrictive measures. Specifically:</p> <ul style="list-style-type: none"> • Mean duration of a restraint event decreased from 6.51 hours to 4.65 hours; • Mean monthly total hours of restraint decreased from 485.22 to 184.40; • Mean number of restraint monthly events decreased from 74.50 to 39.67; and • Mean number of individuals in restraint decreased from 33.2 to 24.2. <p>Overall, PSH's data indicated that there were 145 different individuals who required the emergency use of restraints during this review period for a total of 1106 hours. Four individuals accounted for 584 of those restraint hours (52.8%). In addition, there were eight individuals who required the emergency use of seclusion. One of these individuals accounted for 87% of the total number of emergency seclusion hours.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>H.2</p>	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p>Compliance: Substantial.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

<p>H.2.a</p>	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (eight total seclusion episodes) of initial seclusion orders each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 597 1887 824"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improved compliance from the previous review period:</p> <table border="1" data-bbox="991 971 1887 1198"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>64%</td> <td>100%</td> </tr> <tr> <td>2.</td> <td>93%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>71%</td> <td>100%</td> </tr> </tbody> </table> <p>Please refer to this cell in Report 9 for a description of the unusual circumstances that resulted in less than 90% compliance in the previous review period.</p> <p>A review of seven episodes of seclusion for six individuals (DJT, DLJ,</p>	1.	<i>Seclusion is used in a documented manner.</i>	100%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%		Previous period	Current period	Mean compliance rate			1.	64%	100%	2.	93%	100%	3.	71%	100%
1.	<i>Seclusion is used in a documented manner.</i>	100%																								
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%																								
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1.	64%	100%																								
2.	93%	100%																								
3.	71%	100%																								

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>KAH, NM, RMM and TWB) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 99% mean sample (221 out of a total of 222 episodes) of initial restraint orders each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 561 1890 789"> <tr> <td>1.</td> <td><i>Restraint is used in a documented manner.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained compliance rates of at least 90% from the previous review period for all items.</p> <p>A review of 34 episodes of restraint for 20 individuals (DDH, IG, JAM, JAO, JD, JJL, JLD, JS, KAM, KC, MBA, OC, PH, PHH, RMM, RMR, RP, RPJ, SWK and VN) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Restraint is used in a documented manner.</i>	99%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%
1.	<i>Restraint is used in a documented manner.</i>	99%									
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%									
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%									
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	Current findings on previous recommendation:									

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 487 1890 1010"> <tr> <td data-bbox="991 487 1087 561">4.</td> <td data-bbox="1087 487 1793 561"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 487 1890 561">88%</td> </tr> <tr> <td data-bbox="991 561 1087 786">5.</td> <td data-bbox="1087 561 1793 786"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 561 1890 786">100%</td> </tr> <tr> <td data-bbox="991 786 1087 1010">6.</td> <td data-bbox="1087 786 1793 1010"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 786 1890 1010">100%</td> </tr> </table> <p>Comparative data indicated mixed changes in compliance from the previous review period:</p> <table border="1" data-bbox="991 1156 1890 1386"> <thead> <tr> <th data-bbox="991 1156 1520 1234"></th> <th data-bbox="1520 1156 1713 1234">Previous period</th> <th data-bbox="1713 1156 1890 1234">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1234 1890 1273">Mean compliance rate</td> <td data-bbox="1520 1234 1713 1273"></td> <td data-bbox="1713 1234 1890 1273"></td> </tr> <tr> <td data-bbox="991 1273 1520 1312">4.</td> <td data-bbox="1520 1273 1713 1312">100%</td> <td data-bbox="1713 1273 1890 1312">88%</td> </tr> <tr> <td data-bbox="991 1312 1520 1351">5.</td> <td data-bbox="1520 1312 1713 1351">86%</td> <td data-bbox="1713 1312 1890 1351">100%</td> </tr> <tr> <td data-bbox="991 1351 1520 1386">6.</td> <td data-bbox="1520 1351 1713 1386">80%</td> <td data-bbox="1713 1351 1890 1386">100%</td> </tr> </tbody> </table>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	88%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%		Previous period	Current period	Mean compliance rate			4.	100%	88%	5.	86%	100%	6.	80%	100%
4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	88%																								
5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%																								
6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%																								
	Previous period	Current period																								
Mean compliance rate																										
4.	100%	88%																								
5.	86%	100%																								
6.	80%	100%																								

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>A review of seven episodes of seclusion for six individuals (DJT, DLJ, KAH, NM, RMM and TWB) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm or in alignment with specific designated exit criteria.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 99% mean sample of initial restraint orders each month during the review period (November 2010 - April 2011):</p> <table border="1" data-bbox="991 561 1887 1084"> <tr> <td data-bbox="991 561 1087 636">4.</td> <td data-bbox="1087 561 1793 636"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 561 1887 636">95%</td> </tr> <tr> <td data-bbox="991 636 1087 862">5.</td> <td data-bbox="1087 636 1793 862"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 636 1887 862">100%</td> </tr> <tr> <td data-bbox="991 862 1087 1084">6.</td> <td data-bbox="1087 862 1793 1084"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 862 1887 1084">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained compliance rates of at least 90% from the previous review period for all items.</p> <p>A review of 34 episodes of restraint for 20 individuals (DDH, IG, JAM, JAO, JD, JIL, JLD, JS, KAM, KC, MBA, OC, PH, PHH, RMM, RMR, RP, RPJ, SWK and VN) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm or in alignment with</p>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	95%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
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6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%									

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>specific designated exit criteria.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.2.c	<p>are not used as part of a behavioral intervention; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendations: See F.2.c.iv.</p>
H.2.d	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of seclusion each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained compliance rates of at least 90% from the previous review period. See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 99% mean sample of episodes of restraint each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 89%. Comparative data indicated that PSH maintained</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>compliance rates of at least 90% from the previous review period. See H.2.b for review findings.</p> <p>Other findings: In March 2011, one individual accounted for 162 of the total of 275 restraint hours used (59%). In April 2011, two individuals accounted for 311 of the total 529 restraint hours used (59%). These three individuals accounted for 473 of the total of 1106 emergency restraint hours (43%). A review of the documentation found that there were detailed notes addressing the history and behaviors of these individuals as well as thorough programmatic and administrative reviews conducted. At the time of the review, these individuals were no longer at the facility.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance with the one-hour requirement based on a 100% mean sample of initial seclusion orders each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 92%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of seven episodes of seclusion for six individuals (DJT, DLJ, KAH, NM, RMM and TWB) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in five episodes.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Using the DMH Seclusion/Restraint Audit, PSH also assessed its compliance with the one-hour requirement based on a 99% mean sample of initial restraint orders each month during the review period (November 2010 - April 2011) and reported a mean compliance rate of 96%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 34 episodes of restraint for 20 individuals (DDH, IG, JAM, JAO, JD, J JL, JLD, JS, KAM, KC, MBA, OC, PH, PHH, RMM, RMR, RP, RPJ, SWK and VN) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in all episodes.</p> <p>PSH's training rosters indicated that 94% of existing staff and newly hired staff that were required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: PSH continues to use the same procedures to ensure the accuracy of the data for the use of restraints, seclusion, psychiatric PRN medication, or Stat medications. A review of the PRN/Stat medications and seclusion</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>and restraint lists provided found no incidents that were not included in the PSH databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: There were no instances of individuals in seclusion more than three times in four weeks during the review period.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH also assessed its compliance based on a 100% sample of individuals who were in restraint more than three times in 30 days during the review period (November 2010 - April 2011) and reported a mean compliance rate of 71% with the three-day review requirement, the same as in the previous review period.</p> <p>A review of the records of five individuals who were in restraint more than three times in 30 days during the review period (JD, JLD, JS, MBA and OC) found that there was significant clinical documentation in the records and regular and ongoing reviews of the cases.</p> <p>Compliance: Substantial.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Current recommendation: Continue current practice.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Recommendation, December 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendations: See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation	<p>Current findings on previous recommendation:</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: See F.3.h.i and H.3.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.8	Each State hospital shall:	<p>Compliance: Not applicable.</p>
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor this requirement.</p> <p>Findings: There were no instances of side rails used as a restraint during the review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms,	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: See H.8.a.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

	and strategies to reduce the use of side rails, if appropriate.	Findings: See H.8.a. Current recommendation: See H.8.a.
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The decision by OSI to concentrate on investigations of A/N/E has reduced the Office's caseload and improved the timely completion of investigations. The quality of the investigations also shows improvement. For example, the investigations reviewed documented the investigators' attempts to ensure that all persons who might have seen or heard the incident were interviewed. 2. A crucial effort in the facility's work to reduce violence is the Intensive Case Analysis completed after each incident of aggression that results in serious injury. These analyses identify contributing factors, areas of needed improvement, and present plans of action for remediation. The written report of each analysis is discussed at a Quality Council meeting. 3. A sample of other measures enacted by the facility to reduce violence include focused work on Unit 32, which was the site of a disproportionate number of violent incidents; a meeting with local DAs to improve the likelihood of charges being brought for serious assaults; the expansion of on-duty psychologist hours; and the conversion of side rooms to soothing rooms on a pilot basis. For a more complete listing of the work completed to reduce violence, please see I.2.c. 4. The facility has restructured and revitalized the Quality Council. Membership has been increased, and meetings are longer and more frequent as dictated by the agenda. A standard template was developed for committees and workgroups to use in submitting proposals and a Standards Compliance staff member has been designated to track recommendations to completion. 5. The facility will soon present a Strategic Plan for Assault Reduction built on the shoulders of the PSH intensive strategic planning exercises in May 2011 that were modeled on the Statewide Assault Reduction Planning Meetings in March. 6. In response to Risk Management Committee recommendations to enroll specific individuals in RISE (for individuals with cognitive impairments)

		<p>and SAFE—both of which have a limited capacity--the facility has expanded RISE to the East/Central compounds and is exploring ways to expand the SAFE program.</p> <ol style="list-style-type: none"> 7. The Medical Director, assisted by two colleagues, produced the Assault Reduction Analysis document that reports the number of assaults for each month during the 16-month period January 2010 through April 2011 and analyzes assaults by unit type and assault type. In the Analysis and Use of Aggression Data section and the two other sections of the report, Organizational Factors and Individual Factors, the authors presented the relevant data, identified the Actions Implemented during the review period to address the findings and the Actions Planned to address the findings when time and resources permit. 8. The WRPs of a sample of individuals on high risk lists, of individuals who have reached triggers, and of those who have been reviewed by second- and third-level risk management committees show attention to the risk behavior or condition. This positive finding is consistent with the facility's findings as well. 9. The facility leadership has identified some operational changes it needs to make in the implementation of the risk management committee structure. DMH has acknowledged that it will review any changes proposed by a facility to meet its specific needs. 10. The facility needs to ensure that HR is aware of all disciplinary measures taken in response to A/N/E incidents. Further, the facility needs to ensure that failure to report A/N/E is addressed with progressive discipline in all instances. 11. Finally, it would be advisable for the OSI Supervisor and the IRC to closely review the rationales for determinations to ensure that they address the definition of the incident type under review and evidence a fair and objective weighing of the evidence. <p><i>Areas of need include:</i></p> <ol style="list-style-type: none"> 1. <i>Finalize and fully implement PSH Strategic Plan for Assault Reduction and ensure that the implementation is aligned with the DMH Statewide</i>
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Section I: Protection from Harm

		<p><i>Assault Reduction Planning.</i></p> <ol style="list-style-type: none">2. <i>Ensure adequate implementation of other planned actions that were initiated or recommended as per the facility's report regarding Assault Reduction Analysis.</i>3. <i>Ensure that all corrective actions that were recommended in the Post-Assault Intensive Cases Analyses are reviewed by the Quality Council for implementation, as needed.</i>
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Sherer, Hospital Administrator and Chair of Incident Review Committee 2. E. Loo, OSI Director 3. J. D'Braunstein, Standards Compliance Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Fifteen investigations 2. SIRs for three assaults still under investigation 3. IRC minutes (October 2010-April 2011) 4. Selected personnel and training information for 14 staff members 5. Rights notifications for 16 individuals for signature 6. Documents related to the deaths of three individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to be alert in identifying staff members who fail to report allegations of A/N/E.</p> <p>Findings: Please see I.1.a.ix for an instance in the sampled investigations of failure to report in the manner prescribed in policy, causing a significant delay in the</p>

Section I: Protection from Harm

		<p>initiation of an investigation.</p> <p>Current recommendation: Take appropriate action, considering the consequences and length of the delay, in response to a staff member's failure to report an allegation of A/N/E in a timely manner.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Ensure that all aspects of an allegation are covered in the preliminary investigation for cases brought for review by the Case Review Group. Continue the IRC review of all determinations made by the Case Review Group.</p> <p>Findings: The IRC minutes make only one reference to the involvement of the Case Review Group. The November 30, 2010 minutes indicate that on 9/28/10, BF alleged that on 8/4/10 she requested to be put on bed rest because she had been stabbed with swords. Her request was denied when the physician determined that she did not have a condition that required bed rest. The minutes further state that BF frequently asks for bed rest after coming from grounds where she is known to prostitute herself with several men. It concludes with the statement that BF has been counseled regarding her sexual promiscuity but continues her behavior. This case was reviewed by the Case Review Group prior to the assignment to an investigator. The IRC minutes do not document a recommendation regarding the allegations of inappropriate sexual activity and subsequent minutes do not document any follow-up.</p> <p>Current recommendation: IRC should make recommendations to refer cases in which additional efforts are needed to enhance the safety of an individual to the Medical Director or</p>

Section I: Protection from Harm

		Clinical Administrator as appropriate.
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue review of reassignment decisions by the IRC.</p> <p>Findings: The IRC minutes document the reassignment (or lack thereof) of staff members alleged to have engaged in A/N/E for each investigation reviewed. The April 12, 2011 minutes document the procedures for removing or reassigning staff members: "In the case of an allegation of physical abuse, pending a recommendation from Program Management and the approval of the Clinical Administrator, the employee is assigned outside the security compound. In the case of an allegation of verbal abuse, pending a recommendation from Program Management and the approval of the Clinical Administrator, the employee is assigned to a different treatment unit."</p> <p>Other findings: In the investigations reviewed, removal or reassignment occurred as follows:</p> <ul style="list-style-type: none"> • Verbal abuse (reported 1/6/11)—no removal or reassignment • Neglect cases (12/8/10, 12/7/10)—no removal or reassignment • Physical abuse (reported 2/22/11)—no removal or reassignment • Intimidation (3/3/11)—staff member removed • Psychological abuse (reported 12/15/10)—staff member removed • Sexual abuse (2/3/11)—no removal or reassignment <p>All of the decisions regarding removal and reassignment are documented as having been made in collaboration with the Clinical Administrator.</p> <p>Current recommendation: Ensure that the facility's procedures for removing staff conform with SO</p>

Section I: Protection from Harm

		263.																																																																															
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Address attendance at mandatory training through the current practice of including attendance in performance evaluations.</p> <p>Findings: As indicated in the table below, nine of the 14 staff members sampled had completed A/N training within the last 12 months. Three of the five staff members not in compliance were three or more years in arrears.</p> <table border="1" data-bbox="953 672 1822 1360"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_Z</td> <td>10/1/08</td> <td>9/3/08</td> <td>10/1/08</td> <td>3/10/11</td> </tr> <tr> <td>_C</td> <td>3/3/08</td> <td>10/25/07</td> <td>3/3/08</td> <td>3/10/11</td> </tr> <tr> <td>_T</td> <td>1/4/10</td> <td>12/1/09</td> <td>1/6/10</td> <td>1/11/11</td> </tr> <tr> <td>_V</td> <td>10/22/01</td> <td>9/25/01</td> <td>10/22/01</td> <td>11/13/10</td> </tr> <tr> <td>_H</td> <td>5/31/01</td> <td>4/14/01</td> <td>5/31/01</td> <td>11/10/10</td> </tr> <tr> <td>_M</td> <td>3/1/97</td> <td>4/9/97</td> <td>3/3/97</td> <td>9/23/10</td> </tr> <tr> <td>_M</td> <td>5/13/02</td> <td>4/24/02</td> <td>1/25/90</td> <td>7/6/10</td> </tr> <tr> <td>_C</td> <td>4/1/09</td> <td>2/23/09</td> <td>4/1/09</td> <td>6/24/10</td> </tr> <tr> <td>_G</td> <td>10/1/86</td> <td>12/26/78</td> <td>9/4/07</td> <td>5/26/10</td> </tr> <tr> <td>_C</td> <td>4/2/90</td> <td>7/26/05</td> <td>3/28/08</td> <td>1/8/10</td> </tr> <tr> <td>_L</td> <td>1/2/98</td> <td>8/12/98</td> <td>10/2/98</td> <td>9/10/09</td> </tr> <tr> <td>_R</td> <td>10/2/06</td> <td>9/21/06</td> <td>10/2/06</td> <td>3/11/08</td> </tr> <tr> <td>_A</td> <td>1/18/05</td> <td>12/23/04</td> <td>1/18/05</td> <td>12/15/07</td> </tr> <tr> <td>_F</td> <td>1/31/91</td> <td>10/23/89</td> <td>1/31/91</td> <td>8/28/07</td> </tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_Z	10/1/08	9/3/08	10/1/08	3/10/11	_C	3/3/08	10/25/07	3/3/08	3/10/11	_T	1/4/10	12/1/09	1/6/10	1/11/11	_V	10/22/01	9/25/01	10/22/01	11/13/10	_H	5/31/01	4/14/01	5/31/01	11/10/10	_M	3/1/97	4/9/97	3/3/97	9/23/10	_M	5/13/02	4/24/02	1/25/90	7/6/10	_C	4/1/09	2/23/09	4/1/09	6/24/10	_G	10/1/86	12/26/78	9/4/07	5/26/10	_C	4/2/90	7/26/05	3/28/08	1/8/10	_L	1/2/98	8/12/98	10/2/98	9/10/09	_R	10/2/06	9/21/06	10/2/06	3/11/08	_A	1/18/05	12/23/04	1/18/05	12/15/07	_F	1/31/91	10/23/89	1/31/91	8/28/07
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Section I: Protection from Harm

		<p>Current recommendation: Require attendance at annual training be a component of performance improvement plans or take other actions to improve timely attendance.</p>
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: As indicated in the table above, two staff members sampled did not sign the Mandatory Reporter form at the time of hire. One of these staff members was hired in 1986, which may be prior to the requirement. This staff member signed later, an indication of the facility's work in ensuring that all staff have signed the form acknowledging reporting responsibilities.</p> <p>Other findings: See I.1.a.ix for an instance of failure to report in a timely manner.</p> <p>Current recommendation: Continue current practice.</p>
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to monitor the provision of an opportunity to discuss rights on an annual basis.</p> <p>Findings: Of the 16 individuals sampled, documentation indicated that 13 were provided the opportunity to sign the statement of rights within the last 12 months.</p>

Section I: Protection from Harm

		<table border="1" data-bbox="961 228 1415 919"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr><td>PC</td><td>6/6/11</td></tr> <tr><td>CC</td><td>5/5/11 (refused)</td></tr> <tr><td>JH</td><td>5/5/11</td></tr> <tr><td>DW</td><td>5/5/11</td></tr> <tr><td>FG</td><td>5/21/11</td></tr> <tr><td>RH</td><td>5/21/11</td></tr> <tr><td>PB</td><td>5/20/11</td></tr> <tr><td>PL</td><td>5/20/11</td></tr> <tr><td>DC</td><td>5/20/11</td></tr> <tr><td>SV</td><td>5/20/11</td></tr> <tr><td>RM</td><td>3/8/10</td></tr> <tr><td>JC</td><td>3/21/11</td></tr> <tr><td>MB</td><td>12/2/09</td></tr> <tr><td>CC</td><td>11/29/10</td></tr> <tr><td>CG</td><td>Cannot locate</td></tr> <tr><td>RF</td><td>Cannot locate</td></tr> </tbody> </table> <p data-bbox="951 963 1467 1029">Current recommendation: Continue current practice and monitoring.</p>	Individual	Date of most recent signing	PC	6/6/11	CC	5/5/11 (refused)	JH	5/5/11	DW	5/5/11	FG	5/21/11	RH	5/21/11	PB	5/20/11	PL	5/20/11	DC	5/20/11	SV	5/20/11	RM	3/8/10	JC	3/21/11	MB	12/2/09	CC	11/29/10	CG	Cannot locate	RF	Cannot locate
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p data-bbox="951 1073 1541 1105">Current findings on previous recommendation:</p> <p data-bbox="951 1146 1398 1214">Recommendation, December 2010: Continue current practice.</p> <p data-bbox="951 1255 1902 1396">Findings: In all of the units toured, a rights poster with the name and phone number of the Advocate was displayed in a common area. The phones for use by the individuals have a direct line to the Patients Rights Advocate's office.</p>																																		

Section I: Protection from Harm

		<p>Current recommendation: Continue current practice.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Local law enforcement or the District Attorney were notified in several of the investigations reviewed:</p> <ul style="list-style-type: none"> • Following the investigation of peer-to-peer assault on 11/14/10 that resulted in serious injury to the victim, the aggressor was arrested and transported to West Valley Detention Center. • The peer aggressor who seriously injured the victim in the 11/25/10 assault was arrested and booked on 11/29/10. • In the investigation of psychological abuse in which a staff member was alleged to have shown what might have been pornographic material to individuals, the OSI contacted the San Bernardino police about possible child pornography. <p>Current recommendation: Continue current practice.</p>
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: In the investigation of the allegation of verbal abuse of RS, the reporting</p>

Section I: Protection from Harm

	<p>reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>party did not report the allegation until nearly a month after the event. When questioned about the delay, the staff member responded that he "was thinking of his safety and possible retaliation" and was on vacation for three weeks. No disciplinary action was taken with regard to this failure to report in the manner prescribed in policy, as reported by HR. Rather, the fact that the employee reported at all was cited as grounds for sustaining the allegation. For further information, see I.1.b.iv.3(viii).</p> <p>Current recommendation: Take appropriate action in response to a staff member's failure to report an allegation of A/N/E in a timely manner.</p>
<p>I.1.b</p>	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial, but showing improvement over the last review period.</p>
<p>I.1.b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue current practice in reviewing mortalities.</p> <p>Findings: The deaths of three individuals were reviewed by the MIRC during the review period:</p> <ul style="list-style-type: none"> • CR, a 43-year-old woman, died on 11/6/10 at San Bernardino Medical Center, where she was admitted on 11/4/10 after being found unresponsive in the side room at PSH. The death was determined "Unexpected." The Interdisciplinary Death Summary identified problems in charting and the unit's response to the medical emergency and made five recommendations for improving medical care. The autopsy

		<p>(3/31/11) determined the cause of death to be Small Bowel Infarction with contributing causes of diabetes mellitus-type 2, obesity and bi-polar disorder.</p> <ul style="list-style-type: none"> • SF was 76 years old when she died at San Bernardino Hospital on 10/8/10 where she was admitted on 9/13/10. This was determined an expected death. The physician-determined cause of death was respiratory failure, bilateral pneumonia and multi-organ failure. The MIRC noted the gaps in performance that were first identified in the Nursing Death Summary. • RM's death was determined an Unexpected Death-Level II. This 68-year-old man died at the Community Hospital of San Bernardino on 12/18/10. The preliminary autopsy labeled the major finding as a volvulus of the sigmoid colon that was distended, gangrenous, hemorrhagic, and almost 360 degrees rotated. The Internal Interdisciplinary Death Report identified several issues in need of correction. These included use of an ambulance instead of a direct admission, the need to send the KUB x-ray to the hospital with the individual, and the need for changes in clinical attention paid to individuals with signs of constipation. <p>Recommendation 2, December 2010: Consider adopting the practice of immediately referring individuals to ETRC who had previously been referred but were not reviewed because they were no longer in the facility as soon as they return to the facility.</p> <p>Findings: This circumstance was not present in the sampled cases reviewed by the Risk Management Committee.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor the review of deaths to ensure compliance with the Special Order. 2. Track recommendations for improvements in care made in death reviews
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Section I: Protection from Harm

		and monitor (and document) implementation of these measures.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue the practice of HPD officers completing initial investigations, as they generally are able to go to the scene and obtain statements very soon after the incident is reported.</p> <p>Findings: The hospital's HPD has continued to report to the scene of an incident in a timely fashion and begin an initial investigation in the sample of investigations reviewed.</p> <p>Other findings: OSI presently has a staff of four full-time and five part-time investigators—all of whom have had investigator training. HPD officers complete initial investigations and specifically identified members of the HPD investigate felonies.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: All of the investigations reviewed included a taped interview of the known alleged staff perpetrator and the victim (unless he/she refused to cooperate). Several investigations reviewed required the collection and safeguarding of additional evidence. Specifically:</p>

Section I: Protection from Harm

		<ul style="list-style-type: none"> • In the 11/14/10 peer-to-peer assault and battery investigation, the investigator took five photos of the crime scene and two photos of the victim's injuries, which were booked as evidence. • In the investigation of mayhem on 11/25/10, the investigator took 16 photos of injuries and the crime scene and preserved human tissue (bitten from the victim) as evidence. • In the investigation of the felony assault of JH by a peer on 1/16/11, the investigators took 62 photos of the injuries sustained by the two men involved and of the crime scene as evidence. <p>Current recommendation: Continue current practice.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Provide supervision and assistance to investigators to support their ability to complete comprehensive investigations in a timely manner.</p> <p>Findings: The OSI Director said in an interview that he meets weekly with each investigator and reviews his/her caseload.</p> <p>Recommendation 2, December 2010: Consider other options to assist in the investigation of felonies.</p> <p>Findings: Felonies are now investigated by specific members of the HPD. During the review period, there were several peer-to-peer assaults that were still under investigation. Review of the SIRs for three of these assaults indicated the victims suffered serious injuries.</p>

Section I: Protection from Harm

		<ul style="list-style-type: none"> • Assault on 9/27/10 in the dayroom on Unit 73—victim suffered a bloody nose and lost two teeth. • Assault on 4/8/11 on grounds—victim suffered a right inferior orbital wall fracture, right subconjunctival hemorrhage and a closed head injury. • Assault on 3/10/11 in the bathroom of Unit 26—victim suffered a right orbital wall fracture, right maxillary sinus fracture and a head injury. <p>[Other serious bodily injury assaults are cited in the cell above and described in I.1.d.vii.]</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct investigations of serious bodily assaults in a timely manner and take appropriate action with the assailant and victim. 2. As serious assaults are investigated, bear in mind the possibility of neglect and ensure that any cases in which neglect is suspected are reported on a SIR and referred to OSI.
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: In the investigations reviewed, PSH hospital police reached the scene of incidents and began an initial investigation in a timely manner and well within the 24-hour timeframe established by the EP.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material</p>	<p>Current findings on previous recommendations:</p>

Section I: Protection from Harm

	<p>evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Recommendation 1, December 2010: Provide investigators with the supervision and other resources necessary to enable the timely completion of investigation reports.</p> <p>Findings: The OSI has focused on investigations of A/N/E incidents. This has resulted more timely completion of A/N/E investigations. In the sample of investigations reviewed, 80% met the EP timeframe.</p> <table border="1" data-bbox="955 524 1906 1222"> <thead> <tr> <th>Incident type</th> <th>Date reported</th> <th>Date to OSI</th> <th>Date Closed</th> </tr> </thead> <tbody> <tr> <td>Psychological abuse</td> <td>10/20-12/15/10</td> <td>12/15/10</td> <td>12/29/10</td> </tr> <tr> <td>Sexual contact</td> <td>11/3/10</td> <td>11/5/10 to HPD</td> <td>11/6/10</td> </tr> <tr> <td>Assault and battery</td> <td>11/14/10</td> <td>11/14/10 to HPD</td> <td>11/22/10</td> </tr> <tr> <td>Rape</td> <td>11/18/10</td> <td>11/22/10</td> <td>12/23/10</td> </tr> <tr> <td>Assault/mayhem</td> <td>11/25/10</td> <td>11/25/10</td> <td>11/29/10</td> </tr> <tr> <td>Neglect</td> <td>12/7/10</td> <td>12/13/10</td> <td>12/29/10</td> </tr> <tr> <td>Neglect</td> <td>12/8/10</td> <td>12/13/10</td> <td>1/14/11</td> </tr> <tr> <td>Physical abuse</td> <td>12/22/10</td> <td>12/22/10</td> <td>1/13/11</td> </tr> <tr> <td>Verbal abuse</td> <td>1/6/11</td> <td>1/7/11</td> <td>4/22/11</td> </tr> <tr> <td>Felony SBI</td> <td>1/16/11</td> <td>1/16/11</td> <td>1/20/11</td> </tr> <tr> <td>SIB</td> <td>1/16/11</td> <td>1/16/11</td> <td>1/20/11</td> </tr> <tr> <td>Sexual abuse</td> <td>2/3/11</td> <td>2/3/11</td> <td>2/16/11</td> </tr> <tr> <td>Physical abuse</td> <td>2/5/11</td> <td>2/23/11</td> <td>3/24/11</td> </tr> <tr> <td>Neglect</td> <td>3/2/11</td> <td>3/4/11</td> <td>3/24/11</td> </tr> <tr> <td>Intimidation</td> <td>3/3/11</td> <td>3/8/11</td> <td>4/27/11</td> </tr> </tbody> </table> <p>Recommendation 2, December 2010: Conduct internal audits of investigation files on a regular basis to avoid cases being overlooked and not completed.</p>	Incident type	Date reported	Date to OSI	Date Closed	Psychological abuse	10/20-12/15/10	12/15/10	12/29/10	Sexual contact	11/3/10	11/5/10 to HPD	11/6/10	Assault and battery	11/14/10	11/14/10 to HPD	11/22/10	Rape	11/18/10	11/22/10	12/23/10	Assault/mayhem	11/25/10	11/25/10	11/29/10	Neglect	12/7/10	12/13/10	12/29/10	Neglect	12/8/10	12/13/10	1/14/11	Physical abuse	12/22/10	12/22/10	1/13/11	Verbal abuse	1/6/11	1/7/11	4/22/11	Felony SBI	1/16/11	1/16/11	1/20/11	SIB	1/16/11	1/16/11	1/20/11	Sexual abuse	2/3/11	2/3/11	2/16/11	Physical abuse	2/5/11	2/23/11	3/24/11	Neglect	3/2/11	3/4/11	3/24/11	Intimidation	3/3/11	3/8/11	4/27/11
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Section I: Protection from Harm

		<p>Findings: The facility reported that 60% of the investigations closed during the review period met the 30-business-day timeframe set by the EP. Review of the listing of all cases opened and closed in the review period found that 31 investigations were opened before April and were not yet closed at the time of the tour. The oldest were opened in November and December.</p> <p>Current recommendation: Continue efforts to meet the EP timeframes for completing investigations.</p>
<p>I.1.b. iv.3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: In making determinations, link findings of fact with the relevant sections of the SIR definition of the incident type under review.</p> <p>Findings: In the investigation of the 3/3/11 allegation of psychological abuse, the summary of the complaint reads, "Victim is alleging the [named staff member] during a counseling session made threats against his aunt who is his advocate in an effort to intimidate the victim." The investigation established that the named staff member told the individual that he was "going to go to Arizona and I am going to confront her [aunt]." The individual made clear that he viewed this as an attempt to intimidate him—a charge that the staff member denied. In reaching a determination of "not sustained," the investigator moved the focus off the individual and onto the aunt when he stated in the rationale that the named staff member "never threatened to harm the individual's aunt in any way and [the individual] admitted that he did not believe the named staff was going to harm his aunt." No portion of the rationale was directed toward the victim's view that the statement of the intent to "confront" his aunt and advocate was intimidating and thereby constituted psychological abuse. The use of intimidation is expressly identified as an example of psychological abuse in</p>

Section I: Protection from Harm

		<p>the definition.</p> <p>Current recommendation: Link determinations to findings of fact that relate to the definition of the type of incident under review.</p>
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Fully investigate all allegations of staff misconduct that constitute violations of individuals' rights.</p> <p>Findings: During the investigation of the allegation of unwanted sexual contact between peers SM (female victim) and TM (male aggressor), in an interview TM said, "Yeah, I touch females on the unit all the time." When asked which females he touches, TM responded, "I don't know—lots of them." He added that he stops touching, when the female tells him to. There was no documentation of an intention or plan to follow up on these statements to determine if there were any other victims who had not brought their situation forward to staff.</p> <p>Current recommendation: Fully investigate any reasonably credible allegations that surface during the investigation of another incident.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Conduct interviews as near to the date of the incident as possible to avoid individuals and staff members having lost an accurate memory of the circumstances of the incident.</p>

Section I: Protection from Harm

		<p>Findings: IL alleged that on 12/22/10 he was physically abused during a wall and then floor containment when an unidentified staff member put a knee on his chest. Interviews conducted between 12/28/10 and 1/16/11 were unable to identify all of the staff members who engaged in the containment, in part because of the time lapse from the event and the large number of staff involved. The physician recalled the victim complaining of pain and ordered an x-ray (which showed no abnormal findings), an ice pack and Tylenol for pain.</p> <p>Other findings: Please see I.1.b.iv.3(iv) for a description of efforts by investigators to identify and interview witnesses.</p> <p>Current recommendation: Conduct interviews as near as possible to the event in order to record the relevant parties' fresh memories.</p>
<p>I.1.b. iv.3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The investigations reviewed clearly identified the alleged victims and perpetrators.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p>

Section I: Protection from Harm

		<p>Recommendation, December 2010: Supervise investigations in such a manner that the credibility of the investigation is not jeopardized by interviews conducted remote from the incident.</p> <p>Findings: Please see I.1.b.iv.3(viii) for a description of a situation in which the interview of the alleged victim was conducted nearly three months after the incident (but two months after it was reported) and the alleged victim could not remember the incident.</p> <p>Other findings: All of the investigations reviewed identified the names of all persons interviewed and provided the date of the interview and a summary of its contents. Several investigations were noteworthy for the diligence in interviewing all likely parties. In the investigation of verbal abuse of RS that allegedly occurred during a Mall group, the investigator interviewed 10 individuals attending the class to determine who might have heard the offending remark. Similarly, in the investigation of alleged neglect of seven individuals, all of the involved individuals were interviewed. In addition, in several of the investigations reviewed, the investigator documented his/her attempts to identify additional witnesses. These include the investigations of the peer assault on 1/25/10 and the allegations of physical abuse of GE and IL.</p> <p>Current recommendation: Continue current practice of seeking witnesses and documenting these efforts in the investigation reports.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice of providing a summary of each interview</p>

Section I: Protection from Harm

		<p>conducted along with the date of the interview and any other relevant information regarding the circumstances of the interview.</p> <p>Findings: The investigators have consistently provided a summary of each interview conducted along with the date and circumstances.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: All of the investigation reports reviewed identified the documents reviewed by the investigator in the course of the investigation. This is a standard item in the reports that follows the summaries of interviews.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue to document the review of the incident history of the named staff member and alleged victim in the investigation reports of A/N/E incidents.</p> <p>Findings: The investigations reviewed yielded variable findings related to the review of the incident history of the alleged victim and perpetrator. In seven of the nine A/N/E investigations reviewed in which the alleged staff</p>

Section I: Protection from Harm

		<p>perpetrator was identified, the incident history of both the named staff and the individual victim was documented.</p> <p>Recommendation 2, December 2010: Apply the same review criteria to each staff member, i.e. sustained A/N/E cases, adverse actions or prior abuse allegations made against the staff member.</p> <p>Findings: The OSI Director stated in an interview that HR records are the source of information about staff members' previous involvement in incidents. Consequently, investigators are learning only of a staff member's history of sustained violations. In contrast, the incident reporting database is used for past history of allegations made by individuals. This database captures all incidents reported and is not limited to sustained allegations.</p> <p>The March 8, 2011 IRC minutes state that reports concerning all individuals identified as victims of A/N/E are provided to the Chief of Psychology for follow-up by senior psychologists to address with the WRPT as indicated. Reports concerning staff members named in A/N/E incidents are provided to the Clinical Administrator for his referral to the Program Directors group. The February 8, 2011 IRC minutes cite the committee's review of an A/N Victims Report and an A/N Suspect (named staff member) Report.</p> <p>Current recommendation: Make the reports of individuals and the reports of staff members named repeatedly in A/N/E allegations available to the IRC on a periodic basis. Document the discussion of these materials in the minutes.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Ensure that the summary of the findings provided to support the</p>

Section I: Protection from Harm

	<p>requirements;</p>	<p>determination is accurate.</p> <p>Findings: The findings of fact do not support the "substantiated" determination of verbal abuse of RS on 12/8/10. The incident: Two staff members were facilitating a Mall group of about 12 individuals. One staff member alleged that the other, facing away from him, addressed seriously offensive language to one of the individuals in class. The staff member reported the verbal abuse allegation nearly one month after the event on 1/6/11—the lateness explained by his fear of retaliation and his three-week vacation. On 3/3/11, the investigator interviewed the alleged victim, who did not remember the offensive remark and interviewed 10 other individuals in the group on 2/7/11—all of whom said they did not hear the remark. The named staff member denied the allegation. The rationale for the determination of substantiation reads, "Credibility does lend itself to the reporting party for coming forward and discussing the issue after his return to duty. And just because the alleged victim and the individuals interviewed from the Mall group did not hear the statement, does not mean it was not said. Therefore, this case is being sustained for verbal abuse."</p> <p>In short, using the same logic, all allegations reported by a staff member, whether timely or not, should be sustained. The allegation by the staff member outweighed the testimony of 10 individuals in the Mall group and the victim that they did not hear the remark. This is, at best, a questionable weighing of the preponderance of the evidence.</p> <p>Other findings: Several investigations reviewed addressed staff members' violations of policy in addition to the allegation of A/N/E. In the investigation of neglect of JO (12/8/10), the named staff member was found to have neglected JO and was additionally found to have violated several Administrative Directives: AD 15.08 governing the 1:1 observation of individuals, AD 1.08 prohibiting employees bringing cameras, camera cell phones, and filming</p>
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Section I: Protection from Harm

		<p>equipment on the hospital grounds, and AD 6.08 regarding an employee's duty to wear his/her ID badge while on grounds. Similarly, in the investigation of the alleged sharing of what may have been pornographic pictures, the named staff member was found to have violated AD 1.08 in having the pictures on his cell phone and minicomputer in the facility.</p> <p>Current recommendation: The Supervising Special Investigator and the IRC need to be attentive to the rationales for determinations, ensuring that they are defensible and evidence the even-handed application of the preponderance of the evidence standard of proof.</p>
1	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Acknowledge conflicting evidence and take additional investigatory steps to reconcile the disparities whenever possible.</p> <p>Findings: See the cell above for an investigation that failed to satisfactorily address conflicting evidence in reaching the determination.</p> <p>Current recommendation: When irreconcilable differences in testimony persist despite efforts to gain additional evidence, ensure that the determination is drawn from a fair and equitable weighing of the evidence.</p>
I.1.b. iv.4	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Provide supervision/mentoring to investigators to ensure that investigations are complete.</p>

Section I: Protection from Harm

	<p>further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings: The areas requiring improvement in the investigations reviewed were not identified by the Supervising Special Investigator. The IRC had not yet reviewed the investigations cited as in need of improvement.</p> <p>Current recommendation: Continue to monitor compliance with this section of the EP. This duty will fall heavily on the IRC as well as the Supervising Special Investigator.</p>
<p>I.1.c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Facility HR reported that personnel actions were taken in three of the six investigations reviewed where such action was warranted. Specifically:</p> <ul style="list-style-type: none"> • In the case of a sustained allegation of verbal abuse (reported 1/6/11), the HR Department did not report any personnel action. • In the investigation that found that the staff member had waited nearly a month to report an allegation of verbal abuse, no HR action was reported. • In the sustained case of neglect (12/8/10), the pay of the named staff member was reduced. • In the sustained case of neglect (12/7/10), the named staff member was provided a letter of instruction. • In the sustained case of psychological abuse (reported 12/15/10), the named staff member received a notice of adverse action for dismissal. • In the sustained case of neglect (3/2/11) HR did not report any personnel action taken or planned.

Section I: Protection from Harm

		<p>Other findings: No recommendations were made in the investigations reviewed beyond referral as appropriate to HR for personnel action. In contrast, see the corrective actions recommended in the Intensive Case Analyses completed after serious injury assaults described in I.1.d.vii.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Take measures to ensure that HR takes and/or is advised of personnel actions taken in response to sustained cases of mistreatment and failure to report allegations of A/N/E as required by policy. 2. Continue to monitor compliance with this section of the EP. 			
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Substantial.</p>			
I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to provide incident, trigger and aggression data to the IRC and the Quality Council and other parties who need it to address the facility's goal of reducing violence.</p> <p>Findings: The data provided below show a substantial decrease in the number of allegations of verbal and psychological abuse during the current review period.</p> <table border="1" data-bbox="966 1339 1717 1414"> <tr> <td data-bbox="966 1339 1213 1414">Abuse type</td> <td data-bbox="1213 1339 1465 1414">May-October 2010</td> <td data-bbox="1465 1339 1717 1414">November 2010 - April 2011</td> </tr> </table>	Abuse type	May-October 2010	November 2010 - April 2011
Abuse type	May-October 2010	November 2010 - April 2011			

Section I: Protection from Harm

		<table border="1"> <tr> <td>Physical</td> <td>43</td> <td>40</td> </tr> <tr> <td>Verbal</td> <td>38</td> <td>16</td> </tr> <tr> <td>Psychological</td> <td>16</td> <td>7</td> </tr> <tr> <td>Sexual</td> <td>8</td> <td>Not provided</td> </tr> <tr> <td>Neglect</td> <td>28</td> <td>28</td> </tr> <tr> <td>Exploitation</td> <td>4</td> <td>0</td> </tr> <tr> <td>Other</td> <td>1</td> <td>Not provided</td> </tr> <tr> <td>Total</td> <td>138</td> <td>91 (estimated)</td> </tr> </table>	Physical	43	40	Verbal	38	16	Psychological	16	7	Sexual	8	Not provided	Neglect	28	28	Exploitation	4	0	Other	1	Not provided	Total	138	91 (estimated)	
Physical	43	40																									
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Psychological	16	7																									
Sexual	8	Not provided																									
Neglect	28	28																									
Exploitation	4	0																									
Other	1	Not provided																									
Total	138	91 (estimated)																									
I.1.d.ii	staff involved and staff present;	<p>Other findings: The Assault Reduction Analysis document reports the number of assaults for each month during the 16-month period January 2010 through April 2011. The monthly number of assaults ranged from 127 (September 2010) to 222 (April 2010). The number of assaults exceeded 150 in 13 months.</p> <p>The report indicates that for the same review period, peer-to-peer assaults with major injury have ranged from one in March 2010 to nine in February 2011. In one-half of the months in the sample, the count of peer assaults with major injury was seven or more. During the same review period, there is a downward trend in the two key indicators that measure repeat assaults: two or more assaults in seven days and four or more assaults in 30 days. The downward trend suggests that interventions after the first assault are reducing the number of subsequent assaults.</p> <p>Current recommendation: Continue current practice of presenting and analyzing data in a manner that guides an effective response by the Quality Council.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Ensure that all investigations address the incident history of the named staff member.</p>																								

Section I: Protection from Harm

		<p>Findings: The OSI investigation reports reviewed addressed the staff member's history of substantiated abuse/neglect findings by review of the staff member's HR personnel file. According to the OSI Director, this process limits the incident review for staff members to substantiated cases only.</p> <p>Current recommendation: Consider using the SIR database or the RMS database to enable investigators to report substantiated and not substantiated A/N/E cases, as this more complete information would be helpful in identifying staff members with patterns of involvement in incidents that raise concern or questions.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: A summary of the incident history of individuals named as victims was most often, but not in all cases, provided in the investigation reports reviewed. For example, the incident history of the victim was not provided in the investigation report of the allegation of sexual abuse reported on 2/11/11.</p> <p>Current recommendation: Include the incident history of the alleged victim in A/N/E investigation reports unless the number makes this impractical, e.g. a whole unit or Mall group is the victim.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p>

Section I: Protection from Harm

		<p>Recommendation, December 2010: Continue current practice of gathering and distributing data.</p> <p>Findings: The Assault Reduction Analysis determined that the rate of assaults per bed is highest on the admissions units (4.53) and lowest on the specialty units (1.15). In terms of numbers of assaults, in the period June 1, 2009-May 1, 2011 (23 months), admission units saw on average 62 assaults per month, intermediate and long-term units saw 87 assaults per month on average, and specialty units saw 11 assaults per month on average.</p> <p>Current recommendation: Continue current practice of assembling and analyzing assault data and presenting it to Quality Council for discussion and action.</p>
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice of gathering and distributing data.</p> <p>Findings: The facility's data indicate that during the review period, Saturdays saw the fewest number of incidents with 88. Tuesdays saw the highest number with 105.</p> <p>Current recommendation: Continue current practice of gathering and analyzing data.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p>

Section I: Protection from Harm

		<p>Findings: Please see the cell below for a discussion of the Intensive Case Analyses that are conducted following serious injury incidents related to aggression. These analyses identify factors that contributed to the incident and identify areas in need of improvement. They are shared with the Quality Council.</p> <p>Current recommendation: Continue current practice of engaging in Intensive Case Analyses or their equivalent.</p>
<p>I.1.d. vii</p>	<p>outcome of investigation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Provide supervision and guidance to investigators so that timeliness issues do not negatively impact the quality of investigations and raise questions about the determinations (outcomes).</p> <p>Findings: As noted in earlier sections, with the focus of OSI on A/N/E investigations and with selected hospital police officers conducting felony investigations, the timeliness of completing investigations has improved.</p> <p>Other findings: Following several serious assaults, the facility conducted Intensive Case Analyses, each of which raised issues requiring correction and presented an Action Plan. The following examples demonstrate the facility's work in identifying systemic issues and pursuing favorable outcomes:</p> <ul style="list-style-type: none"> • 10/4/10 assault that resulted in one individual losing the sight in one eye. <u>Selected Issues Identified:</u> Sub-optimal medication dosing, inadequate violence risk assessment, individuals were assembled for count procedures in a manner that left them unsupervised and able to engage

Section I: Protection from Harm

		<p>in an altercation. <u>Action Plan:</u> Senior psychiatrists reviewed the robust dosing guidelines (STOP-A) with all psychiatrists.</p> <ul style="list-style-type: none"> • An expanded violence risk assessment was added to the admission assessment for individuals gone less than 90 days. AD 6.12 Count Procedures was revised to ensure that all bedrooms and bathrooms are cleared before individuals are assembled. • 1/16/11 assault that caused multiple facial contusions, black eye, lip laceration, nasal fracture, left orbital and facial swelling and displaced fracture of the C6 spinous process on the victim. <u>Selected Issues Identified:</u> Speculation and rumors about dangerousness were not given appropriate follow-up. Individual may endanger the milieu because the cause of the assault is unclear and there is speculation about possible retaliation. <u>Action Plan:</u> Consult with the hospital police force on how best to address suspicion of criminal activity. The Clinical Team will refer the individual for transfer to another DMH hospital for further assessment and management. • 2/23/11 assault that resulted in a staff member sustaining a sprained neck, cuts and bruising to her head and face and loss of several clumps of hair. <u>Selected Issues Identified:</u> The individual was a victim of violence and was not assessed after the incident. The individual had allegedly engaged in bartering activities with prescription medication. <u>Action Plan:</u> Departments of Psychiatry, Psychology and the Medical Executive Committee will develop clinically appropriate expectations when individuals are victims of violence. Analyze current use of Wellbutrin and Seroquel and provide education on abuse. <p>The Special Investigations Case Log contains a listing of 118 Abuse and Neglect investigations opened during the review period. Abuse (verbal, psychological, sexual and physical) investigations closed: 48, sustained: 1. Neglect cases opened: 25, closed: 13, sustained: 5.</p> <p>Current recommendation: Expand the intensive case analysis protocol and documentation to all</p>
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Section I: Protection from Harm

		<p>incidents that result in very serious injuries. This is to recommend the same level of intense review, not to suggest that the same staff members should be responsible for all of these reviews.</p>
<p>I.1.e</p>	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: As shown in I.1.a.iv, 11 of the 14 staff members sampled had cleared the background check prior to assuming work duties.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

Section I: Protection from Harm

2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Andrew Blaine, MD, Chief of Medical Staff (QC) 2. Arthur Martinez, Program Director (QC) 3. B. Holmes, RN, Standards Compliance 4. Blanche Sherer, Hospital Administrator (QC) 5. Carlos Luna, Executive Director, Quality Council (QC) Chairperson 6. Darold Dahse, Acting Program Director (QC) 7. David Haimson, PhD, Chief of Psychology (QC) 8. Dien Mach, MD, Chief Physician and Surgeon (QC) 9. Gari-Lyn Richardson, Standards Compliance Director (QC) 10. George Christison, MD, Medical Director (QC) 11. George Proctor, MD, Senior Psychiatry Supervisor, P&T Committee Chair (QC) 12. Ginny Gibialante, Program Director (QC) 13. Greg Siples, Chief of Rehabilitation Therapy (QC) 14. Harry Oreol, Assistant Clinical Administrator (QC) 15. Jana Christ, Registered Nurse (QC) 16. Javier Diaz, SRN (Medical Services) QC 17. Jessica D'Braunstein, Standards Compliance Coordinator, (QC) 1. Joseph Malancharuvil, PhD, Clinical Administrator 18. Ken Reust, Program Director (QC) 19. Laura Yao, Business Manager II (QC) 20. Mark Camero, Program Director (QC) 21. Michael Gomes, Acting Program Director (QC) 22. Mohamed Amr Hafez, MD, F7 Section Leader (QC) 23. Nitin Kulkarni, MD, Assistant Medical Director 24. Rebecca Kornbluh, MD, Acting Chief of Psychiatry (QC) 25. Rogene Sears, Data Processing Manager II (QC) 26. Sandra Doerner, Nurse Administrator (QC) 27. Sean Evans, PhD, Risk Manager (QC)

Section I: Protection from Harm

		<p>28. Shannon Bader, PhD, Risk Manager (QC) 29. Shobha George, Program Director (QC) 30. Susan Velasquez, PhD, Senior Psychology Supervisor (QC) 31. Trang Tran, MD, Physician and Surgeon 32. Veronica Kaufman, Program Director (QC) 33. WRP Team Risk Management Trigger Event case review for MA, Unit 73 <u>Team Members:</u> Carolyn Stewart, Acting Unit Supervisor/Senior Psychiatric Technician Shanell Green, Registered Nurse Marchelle Moss, Psychiatric Technician Debra Taylor-Tatum, Rehabilitation Therapist Ishea Brown, Clinical Social Worker Elmer Bajet, Registered Nurse Dennis Wallstrom, PhD, Senior Psychologist David Bernhardt, Supervising Social Worker Sarah White, PhD, Unit Psychologist Alejandro Fernandez, Supervising Rehabilitation Therapist Uqbah Taksh, MD, Staff Psychiatrist Mark Camero, Program Director Jyotila Singh, MD, Senior Psychiatrist</p> <p>34. WRP Team Risk Management Trigger Event case review for DB, Unit 72 <u>Team Members:</u> Karen Ban, Psychiatric Technician Marietta Picar, Registered Nurse John MacDonald, Licensed Clinical Social Worker Mike Sterling, Unit Supervisor Dennis Wallstrom, PhD, Senior Psychologist David Bernhardt, Supervising Social Worker Jisanu Gajaseni, Rehabilitation Therapist Martin Lloyd, PhD, Unit Psychologist Meerabai Mohapatra, MD, Staff Psychiatrist Jyotila Singh, MD, Senior Psychiatrist Mark Camero, Program Director</p>
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Section I: Protection from Harm

		<p>Nitin Kulkarni, MD, Assistant Medical Director</p> <p>35. WRP Team Risk Management Trigger Event case review for BA, Unit EB04</p> <p><u>Team Members:</u></p> <p>Josie Giantonio, Registered Nurse</p> <p>Marcia Olave, Psychiatric Technician</p> <p>Faye Owen, MD, Staff Psychiatrist</p> <p>Ken Reust, Program Director</p> <p>Jesus Rodriguez, PhD, Unit Psychologist</p> <p>Edward Hayes, Unit Supervisor</p> <p>Deyanira Gibson, Rehabilitation Therapist</p> <p>Yuki Suzuki, Rehabilitation Therapist</p> <p>Deedra Corona, Licensed Clinical Social Worker</p> <p>Stan Hyding, Supervising Rehabilitation Therapist</p> <p>Tiffany Rector, Supervising Social Worker</p> <p>Bhupinder Nakai, MD, Senior Psychiatric Supervisor</p> <p>36. WRP Team Risk Management Trigger Event case review for RF, Unit 31</p> <p><u>Team Members:</u></p> <p>Charles Ma, MD, Senior Psychiatrist</p> <p>Sjoekje Sasbone, Licensed Clinical Social Worker</p> <p>Robbin Huff-Musgrove, PhD, Senior Psychologist</p> <p>Darold Dahse, Acting Program Director</p> <p>Wendy Chan, PsyD, Unit Psychologist</p> <p>Deborah Bratti, Psychiatric Technician</p> <p>Mary Mattappalli, Registered Nurse</p> <p>Diana Bernhardt, Licensed Clinical Social Worker</p> <p>Randi Redditt, Rehabilitation Therapist</p> <p>Patrick Allen, Acting Unit Supervisor</p> <p>Krishna Murthy, MD, Staff Psychiatrist</p> <p>Sarah Gutierrez, Acting Supervising Rehabilitation Therapist</p> <p>37. WRP Team Risk Management Trigger Event case review for CMR, Unit N25/32</p> <p><u>Team Members:</u></p>
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Section I: Protection from Harm

		<p>Tammy Swafford, Clinical Social Worker Leigh Lindsey, MD, Staff Psychiatrist Robbin Huff-Musgrove, PhD, Senior Psychologist Sjoekje Sasbone, Licensed Clinical Social Worker Kenjie Nwosu, Rehabilitation Therapist Susanne Endicott, Unit Supervisor Darold Dahse, Acting Program Director Yvonne Duran, Registered Nurse and Shift Lead Lauren Stevenson, PsyD, Unit Psychologist Sarah Gutierrez, Acting Supervising Rehabilitation Therapist Lorraine Jiminez, Clinical Social Worker</p> <p>38. WRP Team Risk Management Trigger Event case review for TM, Unit N20</p> <p><u>Team Members:</u> Rocio Urbina, Supervising Social Worker Rachel Cox, Rehabilitation Therapist Ramila Duwal, MD, Staff Psychiatrist Nimfa Baraero, Registered Nurse Bruce Karp, PhD, ABPP, Unit Psychologist Holly Melvin, Licensed Clinical Social Worker Cathy Sink, PhD, Senior Psychologist Kathleen McIntire, Rehabilitation Therapist Art Morales, Program Director Maria Haro, Psychiatric Technician Paul Malko, Unit Supervisor Fred Falvo, Senior Psychiatrist</p> <p>39. WRP Team Risk Management Trigger Event case review for MB, Unit N21</p> <p><u>Team Members:</u> Joshua Horsley, Staff Psychiatrist Rocio Urbina, Supervising Social Worker Miyoko Oaks, Licensed Clinical Social Worker Alice Benson, Psychiatric Technician</p>
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Section I: Protection from Harm

		<p>Alex Anguren, Registered Nurse Vicki McWain, PhD, Unit Psychologist Cathy Sink, PhD, Senior Psychologist Art Morales, Program Director Chris Keierleber, Supervising Rehabilitation Therapist Erin Cross, Rehabilitation Therapist Fred Falvo, Senior Psychiatrist Mark Imafidon, Acting Unit Supervisor</p> <p>40. WRP Team Risk Management Trigger Event case review for PH, Unit EB10</p> <p><u>Team Members:</u> James Jordan, Unit Supervisor Louyza Siringoringo, Registered Nurse Monica Breitel, Psychiatric Technician Jonathan Ly, Registered Nurse Chris Thompson, Psychiatric Technician Michael Gomes, Acting Program Director Kitasha (Kia) Martin, Supervising Social Worker Mona Mosk, PhD, Unit Psychologist Norm Kerbel, PhD, Senior Psychologist Joy Tilton, MD, Staff Psychiatrist Arlyne Witczak, Staff Services Analyst Barbara Emmons, Licensed Clinical Social Worker Daniel Padua, MD, Senior Psychiatrist Tom Thomsen, MD, Senior Psychiatrist Floyd Jackson, Rehabilitation Therapist Kathy Wood, Psychiatric Technician, Nursing Coordinator</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Quality Council minutes for the meetings of 2/1/11, 4/13/11, 4/21/11, 4/27/11 and 6/1/11 2. ETRC/PSSC meeting minutes 3. WRPs of 10 individuals for response to ETRC/PSSC recommendations
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Section I: Protection from Harm

		<ol style="list-style-type: none"> 4. WRPs of 14 individuals for responses to Key Indicators 5. WRPs of 5 individuals on high risk lists 6. Trigger data identifying specific individuals 7. Clinical documents related to 22 individuals on medical high risk lists or reaching medical triggers (reviewed by M. Jackman Risk Management Database for incidents/triggers) 8. Post-Assault Intensive Case Analysis - Incident Dates: 10/4/10, 11/25/10, 1/16/11, 2/23/11, 3/2/11, 3/20/11 and 3/23/11 9. PSH Assault Reduction Analysis Data, Actions Taken and Actions Planned, June 2011 10. Mortality Review documents for individual CR: <ul style="list-style-type: none"> • Post autopsy Internal Review dated 5/13/11 • Independent external medical review by Dr. Jeffrey Zwerin dated 12/28/10 • Internal discipline services review addendum, post-autopsy report, dated 5/13/11 11. Mortality Review documents for individual RM: <ul style="list-style-type: none"> • Special Investigator Report, dated 12/23/10 • Medical Death Summary Report, dated 12/28/10 • Nursing Death Summary Report, dated 12/31/10 • Initial MIRC Summary Report, date 12/31/10 • Internal Disciplinary/Summary Death Report, dated 1/11/11 12. Strategic Planning Conference: Statewide Aggression reduction, March 28, 2011, revised May 31, 2011. <p><u>Observed:</u> Quality Council meeting</p>
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	Compliance: Substantial.

Section I: Protection from Harm

I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: As demonstrated in the tables below, the facility has the technological capacity to identify various categories of high-risk situations.</p> <table border="1" data-bbox="955 524 1841 1015"> <thead> <tr> <th></th> <th>May-Oct 2010</th> <th>Nov 2010-Apr 2011</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>29</td> <td>37</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>73</td> <td>31</td> </tr> <tr> <td>Individuals with two or more aggressive acts to self or others in seven days</td> <td>129</td> <td>119</td> </tr> <tr> <td>Individuals with four or more aggressive acts to others in 30 days</td> <td>45</td> <td>29</td> </tr> <tr> <td>SIB resulting in major injury</td> <td>22</td> <td>14</td> </tr> </tbody> </table> <table border="1" data-bbox="955 1088 1885 1393"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Total</th> <th colspan="2">Mean</th> </tr> <tr> <th>Previous period</th> <th>Current period</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Peer altercations</td> <td>559</td> <td>474</td> <td>93</td> <td>79</td> </tr> <tr> <td>Individuals involved-victims and aggressors</td> <td>818</td> <td>979</td> <td>136</td> <td>163</td> </tr> <tr> <td>1:1</td> <td>453</td> <td>385</td> <td>76</td> <td>72</td> </tr> <tr> <td>2:1</td> <td>68</td> <td>61</td> <td>11</td> <td>10</td> </tr> </tbody> </table>		May-Oct 2010	Nov 2010-Apr 2011	Peer-to-peer aggression resulting in major injury	29	37	Aggression to staff resulting in major injury	73	31	Individuals with two or more aggressive acts to self or others in seven days	129	119	Individuals with four or more aggressive acts to others in 30 days	45	29	SIB resulting in major injury	22	14		Total		Mean		Previous period	Current period	Previous period	Current period	Peer altercations	559	474	93	79	Individuals involved-victims and aggressors	818	979	136	163	1:1	453	385	76	72	2:1	68	61	11	10
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2:1	68	61	11	10																																													

Section I: Protection from Harm

		<p>Review of the WRPs of five individuals on the high-risk list for victimization yielded variable but principally negative findings related to treatment directed at this risk factor:</p> <table border="1" data-bbox="955 341 1906 609"> <thead> <tr> <th>Individual</th> <th>Cited in Risk Factors?</th> <th>Focus of treatment?</th> </tr> </thead> <tbody> <tr> <td>AIR</td> <td>WRP 5/6--Yes</td> <td>Addressed in attendance at DCAT and RISE</td> </tr> <tr> <td>AR</td> <td>WRP 6/1--Yes</td> <td>Addressed in Focus 1.2</td> </tr> <tr> <td>DJ</td> <td>WRP 3/17--Yes</td> <td>Not addressed in an open focus</td> </tr> <tr> <td>FD</td> <td>WRP 6/3--Yes</td> <td>Not addressed in an open focus</td> </tr> <tr> <td>RE</td> <td>WRP 5/17--No</td> <td>Not addressed in an open focus</td> </tr> </tbody> </table> <p>Current recommendation: Guide WRPTs in developing treatment objectives related to victimization.</p>	Individual	Cited in Risk Factors?	Focus of treatment?	AIR	WRP 5/6--Yes	Addressed in attendance at DCAT and RISE	AR	WRP 6/1--Yes	Addressed in Focus 1.2	DJ	WRP 3/17--Yes	Not addressed in an open focus	FD	WRP 6/3--Yes	Not addressed in an open focus	RE	WRP 5/17--No	Not addressed in an open focus
Individual	Cited in Risk Factors?	Focus of treatment?																		
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FD	WRP 6/3--Yes	Not addressed in an open focus																		
RE	WRP 5/17--No	Not addressed in an open focus																		
I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: Review of individuals who reached behavioral triggers during the review period yielded the finding that some of the same individuals responsible for frequent acts of aggression are also responsible for aggression that seriously injures others.</p> <ul style="list-style-type: none"> • Seven individuals who reached the two or more aggressive acts in seven days trigger also reached the peer assault resulting in major injury trigger. The seven individuals engaged in 17 aggressive incidents, eight of which resulted in major injuries. • Four individuals who reached the four or more aggressive acts in 30 days trigger also reached the peer assault resulting in major injury trigger. The four individuals engaged in nine aggressive incidents, two of which 																		

Section I: Protection from Harm

resulted in major injuries.

- Seventeen individuals who reached the two in seven aggressive acts trigger continued over the next days and weeks to reach the four in 30 days trigger. They are:

Individual	Trigger months	Individual	Trigger months
JD-1	November	GH	March
MA	November	RV	March
GA	Nov/Dec	SK	March
RF	Dec/Jan	OC	Mar/Apr
RW	Dec/Jan	RG	Mar/Apr
HM	January	RP	Mar/Apr
PL	January	JD-2	April
TW	January	LJ	April
KM	February		

Other findings:

A review of documents related to medical triggers for 12 individuals found that the WRPs of each cited the medical trigger, and that 11 of the 12 individuals received referrals and assessments as indicated.

	Issue	WRP documentation
KMS	Met trigger 7.2 for three or more falls in 30 days	WRP dated 2/24/11 discussed fall history and listed individual as at high fall risk. Open focus 6.10 for fall risk with nursing, Risk Prevention Group (RPG) and PT objectives and interventions in place focusing on education, utilization of fall risk strategies and improvement of gait and balance. Individual receiving Physical Therapy services to address underlying factors related to fall risk. Individual was referred to RPG following third fall in 30 days, and referral was made for physical

Section I: Protection from Harm

			therapy following second fall. Physical therapy assessment dated 12/12/10 addressed factors underlying mobility-related fall risk, and individual enrolled in direct PT treatment for gait training, balance and strengthening exercises.
		MGM	4/08/11- met trigger 7.1 for fall with major injury Incident documented and reviewed in WRP dated 4/26/11, although individual not in facility during time of conference, so no focus of treatment opened at that time. It does not appear that he truly met the criteria for fall according to definition in the special order, as he fell secondary to critical aortic stenosis. He received a valve replacement on 4/29/11. WRP on 5/13/11 had open focus 6.3 to address care s/p aortic valve placement.
		RB	3/04/11- met trigger 7.1 for fall with major injury Incident documented and reviewed in WRP dated 4/04/11. It does not appear that he truly met the criteria for fall according to definition in the special order, as he fell secondary to syncope secondary to orthostatic hypotension. Open focus 6.19 for fall risk due to syncope noted with nursing education and prevention related objective and interventions.
		WC	1/13/11- met trigger 7.1 for fall with major injury Incident documented and reviewed in WRP dated 5/04/11 (no other WRPs following incident in chart). Open focus 6.33 for fracture but not fall risk. It does not appear that PT and/or OT assessments or open focus for fall risk were indicated.
		FR	New diagnosis of diabetes Diagnosed with diabetes on 4/07/11. Physician ordered Nutrition consultation on 4/07/11. Nutrition assessment 4/12/11 and addressed symptoms of diabetes; recommendations made for

Section I: Protection from Harm

			<p>monitoring of weight and labs, and NST level was changed to 4 (monthly review). No new recommendations for interventions to address new diagnosis were made, although it was documented that the individual refused nutrition education, and that the dietitian would follow up and attempt to provide nutrition education. The WRP dated 5/10/11 has DM listed as an Axis III diagnosis; focus 6.5 nursing objectives and intervention in place for verbalizing ways that he can reduce his blood sugar to nursing staff, verbalizing signs and symptoms of low and high blood sugar to case manager, and participating in nutrition education with dietitian.</p>
		CJL	<p>New diagnosis of diabetes</p> <p>DM diagnosed on 1/13/11 and individual referred to Diabetes Management Team and consultation written for diabetes education. Nutrition assessment completed on 2/4/11 with recommendations for nutrition education plan to teach meal planning by carbohydrate counting. The WRP dated 3/09/11 listed DM as Axis III diagnosis; focus 6.3 objectives and interventions in place to normalize blood sugar, and for education with RD and participation in Diabetes Management group. Individual previously reviewed as NST 3 (quarterly), but following diagnosis was changed to NST 4 and was followed up monthly for nutrition assessment updates.</p>
		DJ	<p>New diagnosis of diabetes</p> <p>DM diagnosed on 2/23/11, and individual referred for Nutrition assessment. Nutrition assessment completed on 2/25/11 and made recommendations for diabetes education. Individual seen for diabetes education on 3/03/11. WRP dated</p>

Section I: Protection from Harm

			3/08/11 listed DM as Axis III diagnosis; focus 6.4 for DM included objective and intervention recommended by dietitian. Following diagnosis, individual was changed to NST 4 (monthly follow-up.)
		RD	New diagnosis of diabetes DM diagnosed on 4/4/11, WRP attachment dated 4/4/11 listed DM diagnosis and had open focus 6.20 with nursing objective and education intervention in place. No Nutrition referral was written for consultation and assessment following DM diagnosis.
		GK	Choking incident 3/23/11 WRP dated 4/21/11 listed choking risk, choking incident and open focus 6.7 with objectives and interventions related to decreasing choking risk by eating slowly and reducing talking during eating. Individual was assessed by speech therapist following incident on 3/29/11, and therapeutic diet texture recommendation made.
		RLR	Choking incidents 12/25/10 and 12/29/10 WRP dated 1/24/11 listed choking risk, choking incidents and open focus 6.25 with objectives and interventions related to decreasing choking risk by naming dysphagia risk factors. Individual was assessed by speech therapist following incident on 1/04/11; recommended MBSS, which occurred on 2/09/11. Direct speech therapy sessions were initiated to provide laryngeal strengthening exercises following MBSS. Dilatation was performed. A 24-hour support plan was developed 2/9/11 and implemented to provide staff with instructions to improve safety during mealtime, with revisions made as indicated.
		JBD	Stage 2 decubitus WRP dated 1/19/11 listed decubitus and open focus 6.2 with objective and interventions related to

Section I: Protection from Harm

			ulcer upon admission 1/12/11	verbalizing ways to prevent further pressure ulcers. Physical and/or occupational therapy focused assessment did not appear to be clinically indicated, as no mobility and/or positioning issues were identified.
		GS	Stage 2 decubitus ulcer identified 3/09/11	WRP dated 5/9/11 listed decubitus and risk for impaired skin integrity with open focus 6.21 for decubitus prevention and 6.26 for decubitus with objective and interventions related to verbalizing ways to prevent further pressure ulcers. Individual receiving direct occupational and physical therapy treatment at time of discovery of decubitus, with 24-hour support plan in place to address ADL participation and fall and choking risk. However, 24-hour support plan did not include strategies for positioning for pressure relief. Physical and/or occupational therapy focused assessment did not appear to be clinically indicated, as no mobility or positioning issues were identified.
		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice and monitoring of the medical triggers cited above. 2. Continue to provide senior clinician reviews of individuals whose aggression is marked by high frequency and high intensity resulting in serious injury to others. 		
I.2.a. iii	identification of systemic trends and patterns of high risk situations.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p>		

		<p>Findings:</p> <p>The minutes of the Quality Council meetings document the review of systemic issues related to various safety issues at the facility. Many are accompanied by proposals for additional study or recommendations for corrective actions, such as the following examples:</p> <p>The February Quality Council minutes state that the ED provided a summary of aggression data over the past seven years that found:</p> <ul style="list-style-type: none"> • Aggression toward peers had increased while aggression toward staff had remained relatively stable. • There was a slight downward trend in aggression in the last two years. • Individuals residing at PSH for less than 90 days engage in more aggression than their peers. The highest rate of aggression is among individuals with a PC 2684 commitment (revocation from Conrep). <p>A review of factors associated with repeat restraint usage on the same individual was presented in the revised March QC minutes. The study found that 145 different individuals required restraint in the period November 2010 -April 2011. Four of those individuals accounted for over 50% of the restraint hours. The report identified the need for preventive measures for individuals whose behaviors warrant the use of restraint most frequently.</p> <p>The May QC minutes note that the Employee Assistance Plan, in coordination with the Medical Director, is implementing a support system for staff who have been injured while on duty. The minutes also state that Psychology is structuring a training program to ensure that all psychologists are trained in the necessary forensic assessment tools, including malingering assessment tools. The May minutes provide a short description of the results of data collection at ASH and Patton of the characteristics of individuals who would be appropriate for the use of the STOP-A medication protocol (designed to hasten stabilization of individuals with specific diagnoses who are prone to</p>
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Section I: Protection from Harm

		<p>psychomotor agitation).</p> <p>Three Intensive Case Analyses completed following assaults resulting in serious injuries were presented at the June QC meeting.</p> <p>Current recommendation: Continue operation of the restructured Quality Council.</p>			
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Substantial.</p>			
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue to address high risk medical issues with appropriate objectives and interventions.</p> <p>Findings: As demonstrated in the table below, the WRPs of nine of the 10 sampled individuals addressed the high risk condition.</p> <table border="1" data-bbox="953 1044 1898 1416"> <tr> <td>CA</td> <td>At high risk for metabolic syndrome</td> <td>WRP dated 5/25/11 listed high risk for metabolic syndrome under risk factors. Open focus 6.2 for obesity, and 6.4 for dyslipidemia noted, with nursing and dietitian objectives and interventions in place. Nutrition admission assessment dated 03/15/11 addressed dyslipidemia and obesity and provided subsequent nutrition education regarding these risk factors. No specific clinical recommendations were made regarding risk factors, although it was recommended that indi-</td> </tr> </table>	CA	At high risk for metabolic syndrome	WRP dated 5/25/11 listed high risk for metabolic syndrome under risk factors. Open focus 6.2 for obesity, and 6.4 for dyslipidemia noted, with nursing and dietitian objectives and interventions in place. Nutrition admission assessment dated 03/15/11 addressed dyslipidemia and obesity and provided subsequent nutrition education regarding these risk factors. No specific clinical recommendations were made regarding risk factors, although it was recommended that indi-
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Section I: Protection from Harm

			vidual remain on current calorie-restricted diet.
		THH	At high risk for metabolic syndrome WRP dated 5/16/11 listed high risk for metabolic syndrome under risk factors. Open focus 6.1 for obesity, and 6.2 for dyslipidemia noted, with nursing and dietitian objectives and interventions in place. Nutrition admission assessment dated 03/08/11 addressed dyslipidemia, but it appears that the assessment listed a weight and subsequent BMI that was inconsistent with weight listed in the Computrition database, as well as BMI measurements listed in WaRMSS. As a result, no nutrition diagnosis, goals or recommendations were made regarding the obesity component of metabolic syndrome.
		AD	At high risk for metabolic syndrome High risk identified in the Present Status of the most recent WRP dated 5/10/11; open focus 6.1 for obesity, and 6.2 for hypertension; met criteria for metabolic syndrome due to elevated BMI, waist circumference, and HTN, with nursing and dietitian objectives in place related to education. Last Nutrition assessment dated 12/23/10, with obesity and hypertension risk factors addressed and nutrition education provided, but no additional recommendations made despite further weight gain noted. However, individual's current weight reflects loss since last Nutrition assessment.
		AH	At high risk for metabolic syndrome High risk identified in the Present Status of the WRP dated 04/11/11. Open focus 6.2 for obesity, 6.3 for diabetes, 6.4 for hyperlipidemia, and 6.8 for HTN, with nursing, rehabilitation therapy and dietitian objectives and interventions in place to address risk. Nutrition assess-

Section I: Protection from Harm

			ment dated 4/14/11 addressed factors underlying metabolic syndrome risk, with documentation that individual has been making progress towards goals. Subsequently, individual was changed on 4/14/11 from an NST 4 (monthly follow-up) to an NST 3 (quarterly follow-up).
		JT	At high risk for metabolic syndrome High risk not identified in the Present Status of the most recent WRP dated 5/23/11; open focus 6.2 for obesity and 6.3 for hyperlipidemia, with nursing objectives and interventions in place. Nutrition admission assessment dated 3/4/11 addressed obesity, high waist circumference and hyperlipidemia, with relevant nutrition education provided, but no clinical recommendations made.
		TC	At high risk for falls Most recent WRP dated 3/18/11 and draft for June conference lists low fall risk, with fall risk score of 2.
		LJS	At high risk for falls High risk identified in the Present Status of the most recent WRP dated 5/9/11; open focus 6.24 for dizziness and individual was placed on 1:1 due to symptoms of dizziness. PT referral made and completed on 11/12/10 that addressed high fall risk, lower extremity weakness, and unsteadiness with transitions. Individual enrolled in direct physical therapy treatment to address risk factors underlying fall risk, and was seen for two months and then discharged after documentation of meeting his objectives.
		JRH	At high risk for falls High risk identified in the Present Status of the most recent WRP finalized 4/22/11. Open focus and objective 6.5 for fall risk. Individual seen in physical therapy during previous review period, and discharged. Being seen in OT treatment to

Section I: Protection from Harm

		<table border="1"> <tr> <td data-bbox="949 191 1045 451"></td> <td data-bbox="1045 191 1255 451"></td> <td data-bbox="1255 191 1921 451"> <p>address ADL limitation due to shoulder DJD and Parkinson's, but no 24-hour support plan has been developed and implemented to promote safety and independence due to unsteady gait and during ADLs. Individual had a fall with major injury in 2/11, but it does not appear that treatment plan or supports were changed following incident.</p> </td> </tr> <tr> <td data-bbox="949 451 1045 748">SRF</td> <td data-bbox="1045 451 1255 748">At high risk for impaired skin integrity</td> <td data-bbox="1255 451 1921 748"> <p>High risk identified in the Present Status of the most recent WRP dated 03/15/11; open focus 6.22 to address incontinence. No pressure-related concerns are noted due to issues with mobility and/or positioning that would clinically indicate a POST assessment, although individual may benefit from a 24-hour plan to improve independence with toileting.</p> </td> </tr> <tr> <td data-bbox="949 748 1045 1045">MJP</td> <td data-bbox="1045 748 1255 1045">At high risk for impaired skin integrity</td> <td data-bbox="1255 748 1921 1045"> <p>High risk identified in the Present Status of the most recent WRP dated 4/18/11; open foci 6.4 and 6.6 to address risk due to impaired mobility and neurogenic bladder with educational and physical therapy objectives and interventions. Individual is currently receiving direct physical therapy treatment to address mobility and to teach and provide pressure relief exercises.</p> </td> </tr> </table> <p>Current recommendation: Continue to monitor WRPs address of high risk situations in compliance with the intent of the EP.</p>			<p>address ADL limitation due to shoulder DJD and Parkinson's, but no 24-hour support plan has been developed and implemented to promote safety and independence due to unsteady gait and during ADLs. Individual had a fall with major injury in 2/11, but it does not appear that treatment plan or supports were changed following incident.</p>	SRF	At high risk for impaired skin integrity	<p>High risk identified in the Present Status of the most recent WRP dated 03/15/11; open focus 6.22 to address incontinence. No pressure-related concerns are noted due to issues with mobility and/or positioning that would clinically indicate a POST assessment, although individual may benefit from a 24-hour plan to improve independence with toileting.</p>	MJP	At high risk for impaired skin integrity	<p>High risk identified in the Present Status of the most recent WRP dated 4/18/11; open foci 6.4 and 6.6 to address risk due to impaired mobility and neurogenic bladder with educational and physical therapy objectives and interventions. Individual is currently receiving direct physical therapy treatment to address mobility and to teach and provide pressure relief exercises.</p>
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I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: Continue current practice of monitoring implementation of proposed responses to triggers.</p>									

		<p>Findings: The facility's data indicates that during the review period, implementation of the WRPTs' proposed actions in response to triggers occurred in 86% of the sample of 158 actions. This is a slight decrease from 90% compliance during the previous review period.</p> <p>Recommendation 2, December 2010: Improve response to triggers related to suicide threats and attempts.</p> <p>Findings: The WRPs of three individuals in the list below who had threatened suicide or who were severely depressed addressed the issue.</p> <p>Other findings: As indicated below, the WRPs of nine of the 10 individuals sampled addressed the recommendations made by the ETRC/PSSC.</p> <table border="1" data-bbox="953 857 1885 1421"> <thead> <tr> <th>Individual</th> <th>Recommendation</th> <th>Response</th> </tr> </thead> <tbody> <tr> <td>MH</td> <td>Trigger: Aggression Complete Behavior Assessment</td> <td>WRP 6/3 BA found aggression derived from panic attacks and agoraphobia. Focus 3.1 addresses impulsivity resulting in aggression and SIB.</td> </tr> <tr> <td>RH</td> <td>Review Behavior Assessment Refer for neuropsych testing</td> <td>WRPs 4/29 and 6/3 mention the recommendation but do not reference neuropsych testing as in progress, planned or completed.</td> </tr> <tr> <td>RG</td> <td>Trigger: Peer aggression with major injury</td> <td>WRP 6/1 No PBS interventions needed. In water intoxication program. Prevention strategies completed and sent to unit</td> </tr> </tbody> </table>	Individual	Recommendation	Response	MH	Trigger: Aggression Complete Behavior Assessment	WRP 6/3 BA found aggression derived from panic attacks and agoraphobia. Focus 3.1 addresses impulsivity resulting in aggression and SIB.	RH	Review Behavior Assessment Refer for neuropsych testing	WRPs 4/29 and 6/3 mention the recommendation but do not reference neuropsych testing as in progress, planned or completed.	RG	Trigger: Peer aggression with major injury	WRP 6/1 No PBS interventions needed. In water intoxication program. Prevention strategies completed and sent to unit
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Section I: Protection from Harm

			PBS to reevaluate— look at Behavior Assessment and update	psychologist for review.
		WW	Trigger: Suicide threat Need to revise BGs	Behavior Change Agent recommend- ed for AM and PM shift as a result of PBS consult. Focus 3.1 addresses suicidality.
		GE	MD request for review PBS will check with staff	WRP 5/6 No behavioral interventions needed. Focus 1.1 addresses depression and suicidality.
		AC	Trigger: Multiple PRNs Refer to RISE	WRP 6/2 Referred to FREE— program for individuals with brain injury.
		DB	Trigger: Suicide threat DCAT plan needs to be reimplemented	WRP 6/9 Attending cognitive remediation groups Focus 1.2 addresses borderline intellectual functioning.
		DD	Trigger: Peer aggression with major injury Refer to RISE	WRP 5/15 Attending cognitive remediation groups for two hours/ week. Focus 1.1 addresses impaired intellectual functioning
		TW	Trigger: Aggression Complete Behavior Assessment. Is aggression Axis I or Axis II related?	WRP 6/3 PBS consulted; no plan indicated. Aggression determined to be Axis II related.
		SC	PBS to possibly set up BGs	WRP 6/1 Behavior program revised to be more formalized with daily

Section I: Protection from Harm

		<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;">checklist for him.</td> </tr> </table> <p>Current recommendation: Continue current practice and monitoring.</p>		checklist for him.
	checklist for him.			
I.2.b. iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Make any changes to the ETRC meeting structure that will facilitate the identification of recommendations and discipline responsible.</p> <p>Findings: There was no difficulty in identifying recommendations made at the ETRC meetings during this tour.</p> <p>Other findings: The facility has effectively used technology to notify WRPs of high-risk situations, including individuals on high-risk lists, individuals who have reached triggers, and individuals for whom second- and third-level risk management committees have made recommendations, as demonstrated in this section of the report. The WRPs had addressed the high-risk situation in most of the cases reviewed.</p> <p>Current recommendation: Continue current practice and monitoring.</p>		
I.2.b. iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: As shown in the table below, the WRPs of each of the 14 sampled individuals</p>		

Section I: Protection from Harm

cited the incidents that constituted the triggers and addressed the aggressive behaviors with treatment objectives.		
Individual	Approximate date of trigger	Addressed/cited in WRP?
Trigger: Aggression to self resulting in major injury		
JD	3/15 and 4/23	WRP 4/26 Behavior is listed in risk factors and is addressed in Focus 3.1.
GG	3/20	WRP 5/3 Incident specifically mentioned and behavior addressed in Focus 1.1.
RS	11/16/10	WRP 3/8 Incident specifically mentioned and behavior addressed in Focus 3.3.
NM	3/27 and 4/24	WRP 6/9 Incident (4/24) specifically mentioned and behavior addressed in Focus 3.2.
Trigger: Peer aggression resulting in major injury		
JA	2/13	WRP 6/2 Incident specifically mentioned and behavior addressed in Focus 3.1.
DC	1/14 and 3/20	WRP 5/24 specifically mentions both incidents and addresses the behavior in Focus 1.1.
RG	3/17	WRP 6/1 Incident specifically mentioned and behavior addressed in Focus 3.1
RH	1/2 and 2/20	WRP 4/29 mentions both incidents and addresses aggression in Focus 3.1. Individual in SAFE and DBT.
GH	3/28	WRP 4/7 specifically addresses the incident and addresses behavior in Focus 3.4 with referral to RISE and consideration of involuntary medication.
JH	4/8	WRP 5/31 specifically mentions incident and addresses behavior in Focus 3.3 with functional assessment by PBS.

Section I: Protection from Harm

		<table border="1"> <tr> <th colspan="3" data-bbox="953 196 1885 232">Trigger: 4 or more aggressive acts in 30 days or 2 such acts in 7 days</th> </tr> <tr> <td data-bbox="953 232 1115 342">RG</td> <td data-bbox="1115 232 1339 342">3/23,3/29,4/8, 4/9, 4/12</td> <td data-bbox="1339 232 1885 342">WRP 4/26 cites aggression in Risk Factors and addresses behavior in Focus 3.1.</td> </tr> <tr> <td data-bbox="953 342 1115 418">JS</td> <td data-bbox="1115 342 1339 418">3/26, 4/6,4/11, 4/23, 4/24</td> <td data-bbox="1339 342 1885 418">WRP 6/3 cites aggression in Risk Factors and addresses the behavior in Focus 3.1.</td> </tr> <tr> <td data-bbox="953 418 1115 529">AB</td> <td data-bbox="1115 418 1339 529">4/26, 4/29</td> <td data-bbox="1339 418 1885 529">WRP 6/6 cites aggression in Risk Factors and addresses behavior in Focus 3.1 through revision of BGs by PBS team.</td> </tr> <tr> <td data-bbox="953 529 1115 639">SC</td> <td data-bbox="1115 529 1339 639">2/16 (x2)</td> <td data-bbox="1339 529 1885 639">WRP 4/22 mentions the specific incidents and addresses the behavior in Focus 3.1.</td> </tr> </table> <p data-bbox="953 688 1921 792">Current recommendation: Continue current practice and monitoring.</p>	Trigger: 4 or more aggressive acts in 30 days or 2 such acts in 7 days			RG	3/23,3/29,4/8, 4/9, 4/12	WRP 4/26 cites aggression in Risk Factors and addresses behavior in Focus 3.1.	JS	3/26, 4/6,4/11, 4/23, 4/24	WRP 6/3 cites aggression in Risk Factors and addresses the behavior in Focus 3.1.	AB	4/26, 4/29	WRP 6/6 cites aggression in Risk Factors and addresses behavior in Focus 3.1 through revision of BGs by PBS team.	SC	2/16 (x2)	WRP 4/22 mentions the specific incidents and addresses the behavior in Focus 3.1.
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SC	2/16 (x2)	WRP 4/22 mentions the specific incidents and addresses the behavior in Focus 3.1.															
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p data-bbox="953 802 1921 834">Current findings on previous recommendation:</p> <p data-bbox="953 873 1921 938">Recommendation, December 2010: Continue current practice, including monitoring.</p> <p data-bbox="953 980 1921 1198">Findings: As demonstrated in the cells above, the review of the WRPs of a sample of individuals on high-risk lists, of individuals who have reached triggers, and of those who have been reviewed by second- and third-level risk management committees show attention to the risk behavior or condition. This finding is consistent with the facility's findings as well.</p> <p data-bbox="953 1240 1921 1414">Other findings: The minutes of the second- and third-level risk management committees cite instances in which the individual's problematic behavior is traceable to a single set of circumstances and is no longer a problem when the individual's case is reviewed by the committee. The facility and DMH are aware that</p>															

Section I: Protection from Harm

		<p>there may need to be changes in the implementation of the Special Order by each hospital tailored to its needs. Any changes must ensure the risk management system meets its objectives while using clinical resources wisely.</p> <p>The Court Monitor and his psychology/behavioral expert conducted an evaluation of PSH's implementation of its risk management process. The charts of eight individuals (BA, CMR, DB, MA, MB, PH, RF and TM) were reviewed and the WRPT members who provided care to these individuals were interviewed. The individuals had met a variety of high-risk triggers/thresholds during this review period, including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions (seclusion/restraint).</p> <p>This review found general evidence of adequate implementation of the risk management procedure, including acceptable practice in the following areas:</p> <ol style="list-style-type: none">1. Timely and appropriate documentation of the incident;2. Review of the incident by the treating, covering or on-call psychiatrists within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individuals and/or others;3. Attention by the WRPT to the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;4. Timely and adequate behavioral assessments and interventions (see further details below);5. Tracking by risk management staff of the incidents that constitute triggers or thresholds requiring progressive levels of reviews;6. Review and recommendations by the Facility Review Committee of situations that require this level;7. Timely and adequate behavioral assessments and interventions; and8. Positive clinical outcomes in response to adequate practice in the above
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		<p>areas.</p> <p>The following summarizes findings in the area of behavioral assessments and interventions:</p> <ol style="list-style-type: none">1. In all eight cases, the PBS team and/or the unit psychologist in collaboration with the WRPT initiated behavioral assessments and where appropriate implemented behavioral interventions even before the trigger threshold was met. When the individual met trigger threshold, the PBS teams and unit psychologists followed up with the review committees' advice. However, in a number of cases the review teams had few or no recommendations for the WRPTs as the problem was being appropriately handled or the problem had been ameliorated by the WRPTs and PBS teams.2. The behavioral assessments revealed that the psychologists had conducted structural and functional assessments prior to developing and implementing intervention plans. In general, the assessments were of acceptable quality.3. A review of the behavioral intervention plans found that many were well developed. However, a number of them were deficient in the way the functions were hypothesized, the way predictive variables and de-escalation strategies were used, and the way "active strategies if behavior escalates" were applied. In one plan (MLB), the active strategy relating to aggression was not relevant to the individual's targeted self-injurious behavior. However, the WRP/PBS team members provided the correct information when asked during the Risk Management review meeting, an indication of a lack of focus at the writing stage. Furthermore, unit staff responsible for implementing the plans correctly stated the intervention strategies of the behavioral plans.4. The outcome data presented showed that there had been a reduction in the frequency of the challenging behaviors since the implementation of the behavioral intervention plans and other therapeutic interventions.
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Section I: Protection from Harm

		<p>Current recommendation: DMH should entertain recommendations from the hospitals to make operational changes in the risk management system.</p>
I.2.c	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2010: The facility's Quality Council must review and analyze facility-wide trends and patterns, in key indicator data, including but not limited to, aggression at the facility. This review and analysis must include systemic corrective measures both at the facility and DMH levels, as indicated and must address and coordinate other facility-wide interdisciplinary performance improvement activities.</p> <p>Findings: The facility presented to the Quality Council a report entitled <i>Assault Reduction Analysis: Data, Actions Taken, Actions Planned</i>. This report presents violence data with analysis and includes actions already implemented and actions planned. Actions that have been implemented to reduce violence include:</p> <ul style="list-style-type: none"> • Expansion and re-conceptualization of the Quality Council where institutional violence is a standing agenda item. An Executive Council pre-meeting winnows and prioritizes proposals and reports prior to their reaching the QC; • Institution of an electronic suggestion box by which staff members can make suggestions directly to executive leadership; • Initiation of a Strategic Plan for Assault Reduction built on the shoulders of the PSH intensive strategic planning exercises in May 2011 that were modeled on the Statewide Assault Reduction Planning Meetings in March; • Piloting Monday-Friday morning meetings in which clinical staff are informed by unit and level of care staff regarding new or evolving high-

Section I: Protection from Harm

		<p>risk situations;</p> <ul style="list-style-type: none">• Post Assault Intensive Analysis following incidents that result in significant injuries to individuals or staff with the objective of raising awareness of multiple issues that increase assault risk and identifying strategies to address these factors;• Expansion of the RISE program for individuals with cognitive disabilities and exploration of means for expanding SAFE, a specialized treatment program addressing high risk violent behaviors;• Expansion of weeknight, weekend and holiday hours of the on-duty psychologists;• Introduction of STOP-A, a prescribing protocol for high starting dosages for use with high-risk individuals;• Multiple initiatives and guidance for Unit 32 in an effort to reduce its disproportionately high number of assaults;• Provision on an admission unit of staff training in empathic approaches;• Change in count procedures to require that all bedrooms and bathrooms be cleared and individuals assembled in a designated place before beginning count procedures. <p>The report also contained a variety of planned actions, including but not limited to the following:</p> <ul style="list-style-type: none">• Finalization and implementation of PSH Strategic Plan for Assault Reduction;• Researching (and addressing) the contribution of psychopathic individuals/malingers to assault rates;• Addressing barriers to implementation of STOP-A;• Evaluating the sensitivity and specificity of the expanded Admission Violence Risk Assessment;• Creation of two soothing rooms, and• Improving the therapeutic environment of existing seclusion rooms. <p>This monitor reviewed the DMH document <i>Strategic Planning Conference:</i></p>
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		<p><i>Statewide Aggression Reduction, March 28, 2011, revised May 31, 2011.</i> The document was comprehensive, included adequate goals, objectives and implementation steps that addressed multiple domains that influence violence at the state level (medical/administrative leadership, legislation, clinical leadership, data systems and outcome monitoring, training, violence risk assessment, specialty units (that treat aggression specifically). Full implementation of this plan should have positive outcomes in aggression reduction at the facilities.</p> <p>Recommendation 2, December 2010: Move those proposals that are believed most likely to reduce violence and for which resources are available to implementation stage. Keep data to use in evaluating the effectiveness.</p> <p>Findings: As described in several cells, the deliberations of the QC, the Intensive Case Analyses following serious assaults and the Assault Reduction Analysis show the implementation of initiatives to reduce violence.</p> <p>Other findings: The monitor reviewed the Post-Assault Intensive Case Analyses that were completed for seven incidents during this review period (10/4/10, 11/25/10, 1/16/11, 2/23/11, 3/2/11, 3/20/11 and 3/23/11). The analysis addressed incidents of serious aggression that did not reach the threshold for sentinel events. The reviews, led by Rebecca Kornbluh, MD, employed adequate methodology and appropriately identified a variety of systemic issues, some of which required immediate corrective actions. Some of the corrective actions have been initiated following a review by the Quality Council. However, review of the minutes of the Council found that a number of the systemic issues identified in these analyses were not captured by the Council.</p> <p>This monitor reviewed the facility's Mortality Review documents pertaining</p>
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Section I: Protection from Harm

		<p>to the unexpected mortalities that occurred during this review period (CR and RM). The review found general evidence of adequate implementation of the mortality review procedure, including clinical reviews, delineation and analysis of possible contributing factors and recommendations for systemic/clinical corrective actions, as appropriate.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue current practice.2. Finalize and fully implement the PSH Strategic Plan for Assault Reduction and ensure that the implementation is aligned with the DMH Statewide Assault Reduction Planning.3. Ensure adequate implementation of other planned actions that were initiated or recommended in the facility's report regarding Assault Reduction Analysis.4. Ensure that all corrective actions that were recommended in the Post-Assault Intensive Cases Analyses are reviewed by the Quality Council for implementation, as needed.
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Section I: Protection from Harm

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Ray, Health and Safety Officer 2. B. Sherer, Hospital Administrator 3. D. Booth, Chief of Plant Operations 4. E. Halsell, Chief of Plant Operations, III 5. H. Oreol, Assistant Clinical Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH audits of sexual contact incidents 2. Clinical records of seven individuals involved in sexual contact incidents 3. WRPs of nine individuals with the problem of incontinence 4. PSH environmental survey and work order data <p><u>Toured:</u> Units 31, 32, 72 and 75</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, December 2010: Clarify expectations regarding the completion of Safety Checks.</p> <p>Findings: The facility reported that staff are expected to make 30-minute rounds and document these on the unit's daily log.</p> <p>During the tours of Units 72 and 75, we found problems in accounting for individuals left behind on the units when others had left for Mall groups. Both events clearly identified a need for a standard system for accounting for individuals left behind when others have left the unit. Uncorrected, these circumstances present an opportunity for individuals to hurt</p>

Section I: Protection from Harm

		<p>themselves and others with the aggressive acts potentially being undetected for a considerable period of time. The facility immediately assigned the Assistant Clinical Administrator the task of bringing this issue to the Program Directors meeting.</p> <p>On Unit 72, we were told, as we stood in the nurses' station looking into the dayroom, that the three individuals in the dayroom were the only individuals on the unit and that all others had left for Mall groups. Upon walking the hall to exit the unit, we found two other individuals in a bedroom. When questioned about the mechanism for accounting for individuals left behind, we were advised by unit leadership to consult the nurses' log in the medication room and we would find a listing of individuals left behind. Inspection of this log found that it did not contain the names of all five individuals left behind and, upon further questioning, the nurse clarified that the purpose of the log is to identify only those individuals left behind because they need to see a physician or have a medical appointment.</p> <p>On Unit 75, we asked unit leadership how many individuals were on the unit and not attending Mall groups. The initial answer was four—two individuals in the hallway and two in a bedroom. When an individual exited the bathroom a few moments later, it was clear that not four but five individuals had stayed behind.</p> <p>Other findings: The facility reported that Program Management responded back with corrective measures for all areas that were identified as requiring attention as determined by the environmental inspection teams.</p> <table border="1" data-bbox="961 1227 1717 1416"> <thead> <tr> <th>Month</th> <th>Number of areas surveyed</th> <th>Number of individual-occupied areas surveyed</th> </tr> </thead> <tbody> <tr> <td>November</td> <td>10</td> <td>2</td> </tr> <tr> <td>December</td> <td>15</td> <td>8</td> </tr> <tr> <td>January</td> <td>19</td> <td>8</td> </tr> </tbody> </table>	Month	Number of areas surveyed	Number of individual-occupied areas surveyed	November	10	2	December	15	8	January	19	8
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Section I: Protection from Harm

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I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be	<p>During the tours of four units, the facility's continuing efforts to make the physical environment safer were evident:</p> <ul style="list-style-type: none"> • Ventilation screens were exchanged for those with a finer mesh that would not permit the passage of a ligature. • Bathroom cabinetry was being replaced because the particleboard cabinets were falling apart and broken-off pieces could be used as weapons. Plumbing under sinks would be enclosed. • New-style wardrobes with sliding doors, locking mechanisms that do not support a ligature, and slanted tops (that do not provide a platform for standing/jumping) are being installed flush against the wall and secured. • All showers were push button-operated with no protruding fixtures that would support a ligature. Lighting had been upgraded in several bathrooms toured. • On all units visited, a cut-down instrument was in a locked cabinet in the nurses' station to which all licensed staff had a key. • All units visited had working flashlights for night rounds. <p>Compliance: Partial—as related to the absence of a standard system for accounting for individuals left behind when others have left the unit.</p> <p>Current recommendation: Develop, promulgate, implement and monitor standard procedures for accounting for individuals left behind when the others have left the unit.</p> <p>Current findings on previous recommendation:</p>									

Section I: Protection from Harm

	<p>promptly corrected;</p>	<p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: During the tours, all units were a comfortable temperature.</p> <p>Other findings: The facility reported that 965 Urgent Work Orders were received during the review period (work orders related to temperature control are Urgent Work Orders) and that 99.9% were responded to on the same or next day—a response rate almost identical to the 100% response rate during the last review period. More specifically, 99.7% of the Temperature Hot work orders were responded to on the same or next day and 98% of the Temperature Cold work orders were responded to on the same or next day.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>								
<p>I.3.c</p>	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility's internal auditing resulted in the positive findings below.</p> <table border="1" data-bbox="955 1263 1892 1417"> <thead> <tr> <th>Criterion</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>Incontinence status is addressed in Present Status</td> <td>84%</td> </tr> <tr> <td>Incontinence identified in Focus 6</td> <td>100%</td> </tr> <tr> <td>Objectives promote dignity and self-reliance</td> <td>98%</td> </tr> </tbody> </table>	Criterion	Compliance rate	Incontinence status is addressed in Present Status	84%	Incontinence identified in Focus 6	100%	Objectives promote dignity and self-reliance	98%
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Section I: Protection from Harm

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I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2010: Ensure that staff document all services provided to individuals involved in sexual incidents, such as physical and psychological assessments, counseling, education, and support for victims.</p>																																		

Section I: Protection from Harm

	<p>monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Findings: Review of the clinical records of seven individuals involved in sexual contact incidents yielded variable findings. In all instances, the incident was documented, but counseling, comfort or education as appropriate was not provided in all instances. Positive findings are in italics.</p> <table border="1" data-bbox="953 451 1896 1414"> <thead> <tr> <th data-bbox="953 451 1121 565">Individual Incident date</th> <th data-bbox="1121 451 1335 565">Incident type</th> <th data-bbox="1335 451 1896 565">WRPT response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 565 1121 1045">SM 11/5/10</td> <td data-bbox="1121 565 1335 1045">Sexual contact between adults (unwanted)</td> <td data-bbox="1335 565 1896 1045">11/10 Monthly Psychiatry Note states the allegation of unwanted touching and male aggressor's move to another unit. IDNs on 11/5 note SM was placed on 1:1 for protection and then taken off 1:1 when the aggressor was moved to another unit. 11/5 RN change of status note describes the unwanted contact. Said SM felt uncomfortable and denied genital contact or being physically hurt. Full body exam found no marks or bruises. WRP 12/15 lists the incident under triggers. No focus on victimization.</td> </tr> <tr> <td data-bbox="953 1045 1121 1414">ES 11/24/10</td> <td data-bbox="1121 1045 1335 1414">Engaged in unprotected sex</td> <td data-bbox="1335 1045 1896 1414">IDN 11/24 reports that two individuals alleged ES was trading sex for Pepsi and the male partners were known to be active with HIV+ individuals. RN weekly note 11/26 makes no mention of incident. Psychiatry weekly note 12/9/10 reports the allegation and ES's denial. WRP 1/4/11 cites the allegation and that ES has consented to HIV testing. No focus on sexual behavior.</td> </tr> </tbody> </table>	Individual Incident date	Incident type	WRPT response	SM 11/5/10	Sexual contact between adults (unwanted)	11/10 Monthly Psychiatry Note states the allegation of unwanted touching and male aggressor's move to another unit. IDNs on 11/5 note SM was placed on 1:1 for protection and then taken off 1:1 when the aggressor was moved to another unit. 11/5 RN change of status note describes the unwanted contact. Said SM felt uncomfortable and denied genital contact or being physically hurt. Full body exam found no marks or bruises. WRP 12/15 lists the incident under triggers. No focus on victimization.	ES 11/24/10	Engaged in unprotected sex	IDN 11/24 reports that two individuals alleged ES was trading sex for Pepsi and the male partners were known to be active with HIV+ individuals. RN weekly note 11/26 makes no mention of incident. Psychiatry weekly note 12/9/10 reports the allegation and ES's denial. WRP 1/4/11 cites the allegation and that ES has consented to HIV testing. No focus on sexual behavior.
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Section I: Protection from Harm

		<p>TM 11/5/10</p>	<p>Aggressor in sexual contact with SM</p>	<p>IDNs jump from 10/14 to 11/5. Note on 11/5 records administrative transfer to another unit. Psychologist met with him on 11/5, but note makes no mention of the incident. Psychiatry progress note 11/30 states he was found in the female bathroom with a female peer and both were rearranging their clothes.</p>
		<p>CF 11/19/10</p>	<p>Sexual abuse</p>	<p>IDN 11/19 states CF alleged a staff member raped her daily and she has memories from the past. She was medically assessed—no pain or trauma. <i>Psychology note 12/1-met with CF to discuss alleged rape. Focus: potential stress related to being physically/sexually assaulted.</i> WRP 12/23 incident listed as a trigger.</p>
		<p>LM 11/18/10</p>	<p>Sexual contact between adults (unwanted)</p>	<p><i>IDN 11/18 by psychologist. Met with LM for 30 mins. She discussed being groped by a male peer today. I reinforced her willingness to tell grounds presence and unit staff about it. Discussed ways to handle the situation if she runs into this male peer and ways she could feel safer (walking to group with a peer or by a different route).</i> IDN by RN (11/18) reports allegation of inappropriate touching, but LM telling RN, "I am OK." RN Weekly Progress Note—no mention of incident.</p>
		<p>SB 3/26/11</p>	<p>Sexual assault</p>	<p>IDN 3/26-SB reported someone was in her room last night and raped her. Said she woke up undressed. Would not allow</p>

Section I: Protection from Harm

				<p>physical exam. IDN 3/26-Displaying no signs of trauma or fear. Escorted to hospital via medical transport for evaluation. <i>3/29 Psychology note-SB related rapes in homeless shelters. Asked if she is having intrusive memories. Psycho-education provided re: PTSD and related symptoms.</i></p>
<p>SD 11/3/10</p>	<p>Sexual assault of female staff</p>	<p>Multiple IDNs on 11/3 describing behavior of asking staff member on grounds to kiss him, grabbing her arm and pulling her to him. When she resisted, he said, "You ruined my fun time." <i>RN note 11/3-counseled SD regarding unacceptable behavior. SD put on 1:1. WRP 1/27 contains the intervention: Unit staff will daily get a commitment from him that he will not touch female staff or make sexual advances.</i></p>		
<p>Other findings: The facility conducted an audit of the follow-up for all of the sexual contact incidents during the review period. Samples from the 38 audits are presented below and also show variable findings.</p>				
<p>Individual Incident type Incident date</p>	<p>Unit and Program level responses on SIR</p>	<p>PSH Audit Findings</p>		
<p>SB Sexual Assault 3/26/11</p>	<p>WRPT will teach individual skills to cope with overwhelming feelings of being raped, teach skills to manage mood, and teach</p>	<p>No documentation of these interventions in WRP, IDN, psychiatry or psychology notes.</p>		

Section I: Protection from Harm

			skill of self-monitoring behavior.	
		TC Sexual Abuse 12/20/10	Supportive counseling is being provided to TC by the psychologist. TC is being seen by the unit psychologist for emotional support.	Counseling is being documented by the psychologist.
		AA Sexual Assault 1/4/11	WRP Present Status and risk profile updated. Focus 3 opened for aggression.	All responses documented appropriately.
		SD Sexual Assault 11/3/10	WRPT to review WRP and make any necessary changes. WRPT and unit staff will provide supportive counseling.	Incident not documented in WRP. No documentation of supportive counseling to develop coping skills.
		SM Inappropriate sexual behavior 11/5/10	Individual was evaluated by the doctor and counseled. Consensual sex incident as reported. Counseling provided.	No PCP note in this chart for incident. SIR was written for unwanted sexual touching. No documentation of counseling provided.
		EW Inappropriate sexual behavior 11/9/10	Individual was redirected to return to his room and counseled about inappropriate sexual behavior in public. WRP updated.	All responses documented appropriately.

Section I: Protection from Harm

		<p>Compliance: Partial.</p> <p>Current recommendation: Continue internal audits and provide feedback to WRPTs to improve performance in responding to sexual incidents.</p>																											
I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The facility-prepared data in the table below shows nearly perfect compliance:</p> <table border="1" data-bbox="955 784 1827 1166"> <thead> <tr> <th>Course</th> <th>May-November 2010</th> <th>November 2010-April 2011</th> </tr> </thead> <tbody> <tr> <td>PMAB</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>CPR</td> <td>98%</td> <td>98%</td> </tr> <tr> <td>First Aid</td> <td>97%</td> <td>98%</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>93%</td> <td>95%</td> </tr> <tr> <td>By Choice</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Patients Rights</td> <td>98%</td> <td>98%</td> </tr> <tr> <td>Neglect and Abuse</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Mean Compliance Rate</td> <td>97%</td> <td>98%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Course	May-November 2010	November 2010-April 2011	PMAB	99%	99%	CPR	98%	98%	First Aid	97%	98%	Recovery (Chapter 1)	93%	95%	By Choice	99%	99%	Patients Rights	98%	98%	Neglect and Abuse	99%	99%	Mean Compliance Rate	97%	98%
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Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. During a meeting with the Council's senators, the senators clearly expressed their acknowledgement of and appreciation for the response of the facility and DMH to their Top Nine Concerns. Specifically, the senators mentioned the lifting in January 2011 of the \$300 per month spending limit and plans for a second incoming phone line on each unit. 2. The senators expressed their willingness to work hard to develop a policy to provide the foundation for efforts to expand and strengthen unit government through weekly or semi-weekly unit meetings. Unit government is viewed as a means of developing cohesion and team building with the ultimate goal of reducing violence. 3. This is a model Council where standardized processes for bringing issues forward, methods for prioritizing issues and respectful interchange among participants and between participants and the administration mark its operations.
J	<p>Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Council Senators during meeting 2. C. Clark, Administrative Liaison to Individuals 3. Several individuals during unit tours <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. February 2011 survey data 2. Progress report: 2011 Top Nine List of Senate Concerns 3. Hospital analysis of survey results for the period August 2007-February 2011

J		<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2010: Continue current practice.</p> <p>Findings: The survey results for this and the preceding review period show a steady rate of positive responses.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Item</th> <th colspan="2">Percentage of positive responses</th> </tr> <tr> <th>August 2010</th> <th>February 2011</th> </tr> </thead> <tbody> <tr> <td>Feel safe?</td> <td style="text-align: center;">69%</td> <td style="text-align: center;">71%</td> </tr> <tr> <td>Treated with respect?</td> <td style="text-align: center;">72%</td> <td style="text-align: center;">77%</td> </tr> <tr> <td>Environment clean?</td> <td style="text-align: center;">74%</td> <td style="text-align: center;">73%</td> </tr> <tr> <td>Encouraged to be of service to others?</td> <td style="text-align: center;">60%</td> <td style="text-align: center;">58%</td> </tr> <tr> <td>Staff make sure rules are followed?</td> <td style="text-align: center;">75%</td> <td style="text-align: center;">81%</td> </tr> <tr> <td>Unit's rules are fair?</td> <td style="text-align: center;">70%</td> <td style="text-align: center;">70%</td> </tr> <tr> <td>Staff believe I can get better?</td> <td style="text-align: center;">77%</td> <td style="text-align: center;">79%</td> </tr> <tr> <td>I have input into hospital rules and policies.</td> <td style="text-align: center;">57%</td> <td style="text-align: center;">58%</td> </tr> </tbody> </table> <p>The following table tracks the positive response rate to each of these items in August of the noted year:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Item</th> <th>2007</th> <th>2008</th> <th>2009</th> <th>2010</th> </tr> </thead> <tbody> <tr> <td>Feel safe?</td> <td style="text-align: center;">59%</td> <td style="text-align: center;">61%</td> <td style="text-align: center;">71%</td> <td style="text-align: center;">69%</td> </tr> <tr> <td>Treated with respect?</td> <td style="text-align: center;">69%</td> <td style="text-align: center;">68%</td> <td style="text-align: center;">72%</td> <td style="text-align: center;">72%</td> </tr> <tr> <td>Environment clean?</td> <td style="text-align: center;">66%</td> <td style="text-align: center;">64%</td> <td style="text-align: center;">72%</td> <td style="text-align: center;">74%</td> </tr> <tr> <td>Encouraged to be of service to others?</td> <td style="text-align: center;">60%</td> <td style="text-align: center;">61%</td> <td style="text-align: center;">55%</td> <td style="text-align: center;">60%</td> </tr> </tbody> </table>	Item	Percentage of positive responses		August 2010	February 2011	Feel safe?	69%	71%	Treated with respect?	72%	77%	Environment clean?	74%	73%	Encouraged to be of service to others?	60%	58%	Staff make sure rules are followed?	75%	81%	Unit's rules are fair?	70%	70%	Staff believe I can get better?	77%	79%	I have input into hospital rules and policies.	57%	58%	Item	2007	2008	2009	2010	Feel safe?	59%	61%	71%	69%	Treated with respect?	69%	68%	72%	72%	Environment clean?	66%	64%	72%	74%	Encouraged to be of service to others?	60%	61%	55%	60%
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>				