REPORT 5

METROPOLITAN STATE HOSPITAL

September 8-12, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Metropolitan 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 Metropolitan State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Acronyms Used in This Report

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CA	Clinical Administrator
CASAS	Comprehensive Adult Student Assessment Systems
CET	Consistent Enduring Team
CEU	Continuing Education Units
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
CPR	Cardio-pulmonary resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy

DCAT	Developmental and Cognitive Abilities Team (check)
DMH	Department of Mental Health
DOJ	Department of Justice
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTR	Dietetic Technician, Registered
DUE	Drug Utilization Evaluation
EIOR	Emergency Intervention Overnight Report
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
FRP	Forensic Review Panel
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
IDN	Inter-Disciplinary Note
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan

MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MOD	Medical Officer of the Day
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NP	Nursing Policy
NPO	Nulla per Os (nothing by mouth)
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
PBS	Positive Behavior Support
PC	Penal Code
PFA	Psychology Focused Assessment
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior

POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physicians Progress Note
PRA	Patients' Rights Advocate
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)
P&T	Pharmacy and Therapeutics [Committee]
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Records Management System
RN	Registered nurse
RNA	Restorative Nursing Assistant
S&R	Seclusion and Restraint
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SSI	Supervising Special Investigator

TB	Tuberculosis
TD	Tardive dyskinesia
WaRMSS	Wellness and Recovery Model Support System
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 Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from September 8 to 12, 2008 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 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 Enhancement Plan (EP) that 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 in any way it chooses to the recommendations 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 are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be 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 Monitor 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. 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)

As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates.

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

The key indicator data provided by the facility are graphed and presented in the Appendix. The following observations are made:

a. Incidents of restraint have been very few in the most recent review period, and seclusion was not used.
b. Aggression to self has declined approximately 50% from the second-quarter peak.
c. On a rolling 12-month basis, non-adherence to WRP has declined more than 20%.
d. There has been an overall decline in the use of older anticonvulsants.
e. Episodes of both hypo- and hyperglycemia are fewer in number.
f. Suicidal threats/ideations spiked in the last six months, and suicide attempts were unusually high in August.

g. The number of individuals diagnosed with MRSA increased during the review period. This increase warrants vigilant attention to infection control practices, with special attention to areas for improvement identified by the facility's auditing data.

2. Monitoring, mentoring and self-evaluation

MSH has made further progress in self-monitoring, data gathering, aggregation and analysis and mentoring since the previous assessment. The following observations are relevant to this area:

a. MSH has developed most of the structures and processes that are required for implementation of the EP. The facility still needs to formalize the process of systemic and periodic review of the self-assessment data and this monitor's findings to ensure consistent feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions.
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. MSH has presented data comparing the compliance rates from this review period to the previous period and from the month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable.
d. MSH has begun to gather process outcome data regarding substance recovery program.
e. With few exceptions, MSH has utilized the DMH standardized auditing tools for all applicable sections of the EP.
h. MSH has improved the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
i. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in

earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

j. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. Since the last review period, MSH has made progress as follows:
   i. Improved the process of the WRPCs.
   ii. Improved the timely implementation of the WRP reviews.
   iii. Achieved substantial compliance with the staffing ratios on both the admissions and long-term units.
   iv. Improved the content of the WRPs in some areas, including the present status section of the case formulation and the inclusion of an enrichment focus.
   v. Developed a Substance Abuse Program Plan of Improvement that is well-aligned with current generally accepted standards (in collaboration with PSH).
   vi. Increased the number of recovery and medication education groups.
   vii. Made some progress in the finalization of diagnosis that were initially listed as NOS and/or R/O, as clinically appropriate.
   viii. Made recent progress in the structure and quality of admission psychiatric assessments.
   ix. Made some progress in the structure of the monthly psychiatric progress notes.
   x. Achieved substantial compliance with the requirements regarding court reports for individuals admitted under PC 1026 and PC 1370 commitments.

b. MSH has yet to implement mechanisms to improve nursing and medical attention to changes in the physical status of individuals and nurse-physician communications regarding ongoing care and follow up care upon return of individuals from outside hospitalization. The DMH is developing medical and nursing care protocols. If properly implemented, these protocols can correct many of the process deficiencies in medical services (see other findings in F.7.a).

c. MSH needs to take administrative steps to address the lack of progress in medication management (see F.1) during this review period.

d. MSH has yet to make significant progress in the current incident and risk management systems. The facility needs to implement an updated system, including identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow up mechanisms. The interventions and follow up should include, but not be limited, to the following:

i. First-level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
ii. Second-level review by clinical leadership;
iii. Outside consultations, if necessary; and
iv. An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects.

e. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
f. Functional/clinical outcomes of the current structural changes have yet to be finalized and implemented to guide further implementation.
g. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
   i. Mall hours: Several disciplines in the acute service provided the required number of facilitation/therapy hours on average during the review period, as did several non-clinical classifications. Progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing. Nursing hours of service provided in the Mall were minimal, even taking the nursing position vacancy rate into account.

      The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

      (Please see next page)

DMH PSR MALL HOURS REQUIREMENTS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities
8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours		
After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities		

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10
RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as mall group facilitator	
Other hospital staff	As determined locally at each hospital	

The Long-Term staff mall hours are also specified in the DMH Long Term Care Services Division Strategic Plan FY 2007-2009. The hours have been reduced for the Admissions clinical staff because of the heavy assessment workload and increased number of Wellness and Recovery Planning Conferences (WRPCs) that are held during the first 60 days of admission. There is no reduction in the required 20 hours of mall services provided to the individuals.

It is expected that during fixed mall hours, the Program/Units will be closed and all unit and clinical staff will provide services at the PSR Mall. Each hospital should develop and implement an Administrative Directive (AD) regarding the provision of emergency or temporary medical care during mall hours.

ii. **Progress notes**: MSH has yet to ensure that providers of mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

iii. **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

iv. **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.

v. **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the staffing pattern at MSH as of July 31, 2008. These data were provided by the facility. The table shows that there continues to be shortages of staff in several key areas: senior psychiatrists and psychologists, registered nurses and clinical social workers.

Identified Clinical Positions at MSH	Established	Caseload Allocations	Filled	Vacant	Vacancy Rate
Nursing Classifications					
Hospital Worker	6.00	6.00	5.00	1.00	16.67%
Licensed Vocational Nurse	45.00	44.00	41.00	3.00	6.82%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT *	362.80	295.68	295.00	0.68	0.23%
Sr. Psychiatric Technician	50.00	46.00	40.00	6.00	13.04%
Registered Nurse *	173.00	195.84	143.00	52.84	26.98%
Supervising Registered Nurse	9.00	9.00	7.00	2.00	22.22%
Unit Supervisor	21.00	17.00	15.00	2.00	11.76%
Nurse Practitioner	1.00	1.00	1.00	0.00	0.00%
LOC Professional					
Physician & Surgeon	19.20	19.20	19.00	0.20	1.04%
Psychologist-HF, (Safety)	41.30	37.33	35.00	2.33	6.24%
Rehabilitation Therapist	48.00	44.04	42.60	1.44	3.27%
Clinical Social Worker	50.80	47.89	34.50	13.39	27.96%
Sr. Psychiatrist	12.50	12.50	6.00	6.50	52.00%

Identified Clinical Positions at MSH	Established	Caseload Allocations	Filled	Vacant	Vacancy Rate
Sr. Psychologist (Spvr and Spec)	10.00	10.00	5.00	5.00	50.00%
Staff Psychiatrist	47.20	41.51	40.25	1.26	3.04%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00	0.00%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00	0.00%
Other					
Assistant Coordinator of Nursing Services	5.00	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	3.00	3.00	2.00	1.00	33.33%
Audiologist	0.00	0.00	0.00	0.00	0.00%
Chief Dentist	0.00	0.00	0.00	0.00	0.00%
Chief, Central Program Services	1.00	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	1.00	100.00%
Chief Psychologist	1.00	1.00	1.00	0.00	0.00%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	9.00	9.00	7.00	2.00	22.22%
Clinical Laboratory Technologist	4.00	4.00	4.00	0.00	0.00%
Coordinator of Nursing Services	1.00	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	2.00	0.00	0.00%
Dentist	2.00	2.00	2.00	0.00	0.00%
Dietetic Technician	2.00	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	1.00	0.00	0.00%
Food Service Technician I and II	79.00	79.00	70.50	8.50	10.76%
Hospital Police Lieutenant	2.00	2.00	2.00	0.00	0.00%
Hospital Police Sergeant	6.00	6.00	6.00	0.00	0.00%
Hospital Police Officer	52.00	52.00	48.00	4.00	7.69%

Identified Clinical Positions at MSH	Established	Caseload Allocations	Filled	Vacant	Vacancy Rate
Hospital Worker	6.00	6.00	5.00	1.00	16.67%
Health Record Technician I	26.00	26.00	23.00	3.00	11.54%
Health Record Techn II Sp	6.00	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	2.00	1.00	33.33%
Health Record Techn III	2.00	2.00	2.00	0.00	0.00%
Health Services Specialist	34.00	34.00	34.00	0.00	0.00%
Institution Artist Facilitator	1.00	1.00	0.00	1.00	100.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00	0.00%
Medical Transcriber	5.00	5.00	3.00	2.00	40.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	0.00	0.00	0.00	0.00	0.00%
Nurse Instructor	4.00	4.00	4.00	0.00	0.00%
Nursing Coordinator	6.00	6.00	6.00	0.00	0.00%
Office Technician	41.50	41.50	37.00	4.50	10.84%
Pathologist	0.00	0.00	0.00	0.00	0.00%
Pharmacist I	17.60	17.60	15.60	2.00	11.36%
Pharmacist II	2.00	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	13.60	12.00	1.60	11.76%
Podiatrist	1.00	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00	0.00%
Program Assistant	7.00	7.00	5.00	2.00	28.57%
Program Consultant (RT, PSW)	2.00	2.00	1.00	1.00	50.00%
Program Director	6.00	6.00	6.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	1.00	0.00	0.00%

Identified Clinical Positions at MSH	Established	Caseload Allocations	Filled	Vacant	Vacancy Rate
Psychiatric Technician Instructor	1.00	1.00	0.00	1.00	100.00%
Public Health Nurse II/I	2.00	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	1.00	0.00	0.00%
Special Investigator	1.00	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.10	3.10	3.00	0.10	3.23%
Speech Pathologist I	0.00	0.00	0.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	1.00	0.00	0.00%
(Sr.) Voc. Rehab. Counselor	0.00	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	7.00	7.00	7.00	0.00	0.00%
Teaching Assistant	2.00	0.00	0.00	0.00	0.00%
Unit Supervisor	21.00	17.00	15.00	2.00	11.76%
Vocational Services Instructor	2.00	2.00	1.00	1.00	50.00%

Notes on staffing table:

1. *The Hourly Intermittent FTE is not included in filled column.*
   ** Plus, Registered Nurse - 10.17 FTE*
   ** Plus, Psychiatric Technician - 14.5 FTE*
   **Plus, Psychiatric Technician Trainee - 4.0 FTE*
   **Plus, Psychiatric Technician Assistant - 4.0 FTE*
2. *Caseload allocations are based on client population.*

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be

added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be 35-40% RNs and 60-65% Psychiatric Technicians and/or LVNs. Additionally, there should be a sufficient number of nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

Finally, there is a shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan. Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

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 individuals, 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. At least two of the hospitals (i.e., PSH and ASH) have reached substantial compliance in one section of the EP. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18

consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, 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 assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Metropolitan State Hospital March 9-13, 2009 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital October 20-24, 2008.
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		
	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.	**Summary of Progress:** 1. MSH has made further progress in the process of WRP reviews during the WRPCs. 2. MSH has maintained compliance with the required staffing ratios on the long-term units. 3. MSH has achieved compliance with the required staffing ratios on the admission units for MDs, PhDs, RTs, RNs and PTs, and is close to compliance for SWs on these units. 4. MSH has improved the timely implementation of WRP reviews after the first seven days of hospitalization. 5. MSH has improved the content of the WRPs in some areas, including the present status section of the case formulation and the inclusion of an enrichment focus. 6. In collaboration with PSH, MSH has developed a Substance Abuse Program Plan of Improvement that is well aligned with current generally accepted standards. 7. MSH has increased the number of recovery and medication education groups.
1. Interdisciplinary Teams		
C.1	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:	**Methodology:** <u>Interviewed</u>: 1. Donna Gillard, Program Director, Assistant to Clinical Administrator 2. Kenneth Layman, Treatment Enhancement Coordinator <u>Reviewed</u>: 1. MSH WRPT member training database 2. MSH outline of WRP eight-hour training sessions 3. MSH outline of WRP update training 4. MSH WRP mentoring assignments

		5. DMH WRP Process Observation Monitoring Form 6. DMH WRP Process Observation Monitoring Form Instructions 7. MSH WRP Process Observation Monitoring summary data (2008) 8. DMH Clinical Chart Auditing Form 9. DMH Clinical Chart Auditing Form Instructions 10. MSH Clinical Chart Auditing Form summary data (2008) 11. DMH WRP Psychiatry Team Leadership Monitoring Form 12. DMH WRP Psychiatry Team Leadership Monitoring Form Instructions 13. MSH WRP Psychiatry Team Leadership summary data (2008) 14. MSH data regarding staffing ratios on admissions and long-term units <u>Observed</u>: 1. WRPC (Program I, unit 410) for 14-day review of BM 2. WRPC (Program II, unit 412) for monthly review of SW 3. WRPC (Program II, unit 412) for monthly review of YB 4. WRPC (Program III, unit 407) for monthly review of JRB 5. WRPC (Program III, unit 415) for monthly review of RG 6. WRPC (Program IV, unit 405) for 14-day review of ES 7. WRPC (Program V, unit 403) for monthly review of DC 8. WRPC (Program V, unit 411) for quarterly review of FO 9. WRPC (Program VI, unit 418) for quarterly review of TP
C.1.a	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	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. **Findings:** MSH has maintained the structures and functions of its WRP training program and has not made changes in the curricula of the five modules.

	determination and independence.	During this review period, MSH has provided the following training activities: 1. WRP training of core WRPT members, non-core nursing staff who are assigned to the units and new employees: a. Training consisted of eight-hour sessions that were provided on three occasions in April, May and July 2008. b. Training used the curricula of the MSH five modules (engagement, diagnosis and case formulation, discharge planning, foci and objectives, and interventions and mall integration). c. Training was provided by competent and enduring WRP trainers from the disciplines of Psychiatry, Social Work, Rehab and Nursing. d. Training utilized the WRP Knowledge Assessment test to measure competency. 2. Update WRP training of WRPT core members: a. Training consisted of four-hour update sessions that were provided twice (in April and July 2008). b. Training focused on findings from various sections of the CM's previous report regarding WRP process and content of documentation. c. Training was provided by competent, consistent and enduring WRP trainers. 3. WRP mentoring process utilizing senior clinicians from the classifications of MD, PhD, SW, RT, RN, and PT: a. A total of 41 senior clinicians from all core disciplines were assigned to mentor and/or co-mentor teams. b. Each WRPT at the facility has received mentoring from a designated senior clinician. c. The mentors have provided in-vivo feedback to the WRPTs. d. The mentors, WRP Master Trainers, and program managers have met on several occasions to discuss PLATO data outcomes for each WRPT, performance expectations, challenges and plans to

address performance issues. The information was derived from the process observation and chart auditing data.

MSH has yet to formalize a process of systemic and periodic review of WRP training data to ensure that the WRPTs receive consistent feedback from the mentors, that trends and patterns are identified and that targeted corrective actions are provided.

Recommendation 2, March 2008:
Provide documentation of WRP competencies of WRPTs.

Findings:
MSH presented information regarding the number of staff who attended the eight-hour full training and the four-hour update training. However, the data did not include the number of staff who were required to attend these trainings and thus are difficult to interpret.

The facility also presented data showing that 94% of staff from all core disciplines met the facility's competency threshold (a score of 95% or higher on the knowledge assessment test). The testing reportedly was provided to new employees who will be WRPT members and members who had not previously obtained a score of 95%. The following table outlines the competency by discipline:

Discipline	Percent of staff competent as of July 2008
MD	94%
PhD	100%
SW	100%
RT	94%
RN	94%
PT	83%

The data showed a mild drop in competency from the rate reported for January 2008 (96%). The facility attributed this drop to staff turnover, particularly among PTs. The interpretation of these data is limited because of the following:

1. It is unclear whether current employees who met the competency threshold and received the four-hour update training sessions were included in the facility's data.
2. The facility failed to present the competency rates for the entire review period.

Other findings:
MSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement. The facility reviewed an average sample of 12% of the quarterly and annual WRPs due each month (February to July 2008). The following are the indicators and corresponding compliance rates:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care*	76%
2.	*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*	86%

The facility's data analysis showed that the mean compliance rate has increased from the last month of the previous review period, January 2008, to the last month of this review period, July 2008, as follows:

1. Item 1: from 64% to 78%; and

		2. Item 2: from 72% to 100%. The monitor attended nine WRPCs and observed evidence of further progress in the overall process of the team meetings. The following are examples: 1. With few exceptions, the meetings started on time. 2. The team psychiatrists have improved their facilitation of the required sequence of tasks. 3. Attendance and participation by PTs have improved. 4. The presentation of the summary of the assessment data was utilized in updating the present status section of the case formulation. 5. The review of risk factors and identification of key questions prior to the individual's arrival was more consistent. 6. The WRPTs have improved the process of engagement of the individuals during the meetings. 7. When the individual was unable to participate actively during the meeting, the WRPT made a good effort to explain the WRP to the individual. 8. The WRPT's review of the diagnosis, objectives and interventions with the individual has improved. 9. The teams updated the life goals during the meeting. 10. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. 11. The teams reviewed the By Choice participation and point allocation with the individual. However, the meetings showed the following process deficiencies: 1. There was no mechanism to conduct data-based review of the individual's progress in Mall groups and to ensure linkage between Mall groups and the WRP objectives.

		2. The WRPTs did not revise/update the case formulation, foci, objectives and interventions as a result of the discussion with the individuals. 3. The WRPTs did not utilize the updated life goals and the individual's strengths in the WRP. . 4. The reviews of diagnosis, foci, objectives and interventions were not consistently informed by the assessments/consultations and the case formulation. 5. The reviews of the discharge criteria were either generic or did not occur, and the teams did not consistently discuss with the individual progress needed to meet each criterion. The above deficiencies must be corrected to achieve substantial compliance with EP requirements regarding the process of WRP. **Compliance:** Partial. **Current recommendations**: 1. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 2. Provide documentation of WRP training competencies of WRPT members, including a. Information regarding numbers of staff who attended both types of training sessions vs. those who were required to attend; b. Clarification of whether and how the competency data are based on both types of training for current employees (e.g. employees who achieved the required competency are receiving the four-hour update; and c. The rates for the entire review period; 3. Formalize a process of systemic and periodic review of WRP training data to ensure that the WRPTs receive consistent feedback from

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<tr><td></td><td></td><td>the mentors, that trends and patterns are identified and that targeted corrective actions are provided. The reviews must occur at least monthly.
4. Monitor this requirement using the DMH Clinical Chart Auditing Form based on a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.1.b</td><td>Be led by a clinical professional who is involved in the care of the individual.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, March 2008:
• Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used the DMH WRP Observation Monitoring Form to assess compliance (February to July 2008), based on an average sample of 14% of all WRPCs due each month.

<table>
<tr><td>1.</td><td>Each team is led by a clinical professional who is involved in the care of the individual:</td><td></td></tr>
<tr><td>1.a</td><td>The clinical professional is a core team member for the individual.</td><td>98%</td></tr>
<tr><td>1.b</td><td>This person is the identified facilitator or the team leader appointed a team facilitator.</td><td>99%</td></tr>
</table>

The mean compliance rate for this requirement was 96% in the last review period compared to 97% in the current review period.</td></tr>
</table>

		The facility used the DMH WRP Psychiatry Team Leadership Monitoring Form to assess compliance. However, the facility did not present data for the first four months of this reporting period and the average sample used (1%) was too small to permit meaningful review and analysis. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement using the DMH WRP Process Observation Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH used the DMH WRP Observation Monitoring Form (February to July 2008) to assess compliance with this requirement based on an average sample of 14% of the WPRCs due each month. The following is a summary of the compliance data:

2.	*Each team functions in an interdisciplinary fashion.*	
2.a	*The core team members participate by presenting or updating discipline-specific and or holistic assessment data*	43%
2.b	*The team reviews and updates the DMH WRPC Task Tracking form.*	83%
2.c	*Team members present their assessments and consultations as listed in the task tracking form*	78%
2.d.	*Team members discuss the individual's specific outcomes for the WRP review period.*	50%

The facility presented data analysis showing that the mean compliance rate for the reporting period has increased from 21% during the last review to 30% during this review. The mean compliance rate has changed from the last month of the prior review period, January 2008, to the last month of the current review period, July 2008, as follows:

1. Item 2.a: from 35% to 40%;
2. Item 2.c: from 66% to 79%; and
3. Item 2.d: decreased from 29% to 43%.

The mean compliance rate for item 2.b has remained unchanged at 84%.

The facility reported that WRPTs need to improve discussion of specific outcomes during the WRPC and that nursing staff has been inconsistent in using the newly developed RN and PT Conference Worksheets prior to the WRPC in order to have correct assessment data to present. Other disciplines were also inconsistent in providing assessment data. The facility presented a targeted plan of correction including a mandatory two-hour training as well as systemic follow-up with review of WRP Observation data by discipline supervisors.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 12% of quarterly and annual WRPs due for the month (February to July 2008). The following is a summary of the data: 1. *Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.* 1.a *The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)* — 98%

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<tr><td>1.b</td><td>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)</td><td>77%</td></tr>
</table>

Data analysis by MSH showed that the mean compliance rate has increased from 43% during the last review to 76% during this review. The mean compliance rates for the sub-items have increased from January 2008 to July 2008 as follows:

1. Item 1.a: from 79% to 96%; and
2. Item 1.b: from 66% to 78%.

The facility reported that the WRPTs were inconsistent in their reviews of Mall facilitator monthly progress notes and integration of the data into the WRPs. The plan for improvement included a review of the data and follow up by the WRP mentors, discipline chiefs and program managers.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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<tr>
<td>C.1.e</td>
<td>Ensure that each member of the team participates appropriately in competently and knowledgeably</td>
<td>Recommendations 1 and 2, March 2008:
1. Monitor this requirement using the WRP Observation Monitoring</td>
</tr>
</table>

	assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH used the DMH WRP Observation Monitoring Form to assess compliance, based on an average sample of 22% of the WRPCs held each month. The following is a summary of the data (January to May 2008): 3. *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 rehabilitative services.* 3.a *Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.* 3% 3.b *Team members present their assessments and consultations as listed in the Task Tracking Form.* 10% 3.c *Team members discuss the individual's specific outcomes for the WRP review period.* 5% MSH's data analysis showed the following changes in compliance rates from the last month of the prior review period, January 2007, to the last month of the current review period, July 2008: 1. Item 3.a: from 1% to 3%; 2. Item 3.b: from 7% to 14%; and 3. Item 3.c: From 11% to 6%.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.f	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.	**Recommendations 1 and 2, March 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH used the DMH Observation Monitoring Form to assess compliance, reporting a compliance rate of 25% for this review period compared to 22% for the previous review period. The mean compliance rate for the final month of each reporting period (January vs. July 2008) remained unchanged at 22%. The facility's analysis and plan of improvement were the same as in C.1.d. **Compliance**: Partial. **Current recommendations**: 1. Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate

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<tr><td></td><td></td><td>areas of relative improvement.</td></tr>
<tr><td>C.1.g</td><td>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.</td><td>
Recommendations 1 and 2, March 2008:

Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample.
Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.

Findings:
MSH used the WRP observation process to assess compliance (February to July 2008). The following is a summary of the data:
<table>
<tr><td>5.</td><td>The team identified 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.</td><td></td></tr>
<tr><td>5.a</td><td>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.</td><td>89%</td></tr>
<tr><td>5.b</td><td>The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.</td><td>65%</td></tr>
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The mean compliance rate has decreased slightly from 66% during the last review to 64% during this review. The changes in the compliance rate for the sub-items (January vs. July 2008) were as follows:
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		1. Item 5.a: from 95% to 92%; and 2. Item 5.b: from 64% to 63% The facility's data analysis showed that WRPTs were inconsistently obtaining signatures, and filling out the appointment cards during the conference. The plan of improvement will focus on obtaining signatures, filling out appointment cards and the proper use of the task tracking form. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement.
C.1.h	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue current efforts to improve attendance by core members. **Findings:** MSH reported that discipline chiefs have been reviewing the facility's database (PLATO) and assessing workload factors and other barriers to staff attendance at the WRPCs. **Recommendations 2 and 3, March 2008:** • Monitor this requirement using process observation based on at least a 20% sample.

- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH presented data based on the WRP observation process, based on an average sample of 14% of the WRPCs due each month. The following table is a summary of attendance rates by each core member (February to July 2008):

WRPT member	Attendance rate
Individual	96%
Psychiatrist	91%
Psychologist	77%
Social Worker	81%
Rehabilitation Therapist	78%
Registered Nurse	99%
Psychiatric Technician	77%

The mean compliance rate for WRPT attendance was 85% during this review period, compared to 83% in the last review. The compliance rate has increased from January to July 2008 for the following members:

1. Individual: from 91% to 99%;
2. Psychologist: from 79% to 80%;
3. RN: from 97% to 100%; and
4. PT: from 68% to 72%.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using process observation based on at

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<td>least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
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<tr>
<td>C.1.i</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendations 1-3, March 2008:

- Continue current practice on the long-term units.
- Continue efforts to achieve compliance on the admission units.
- Provide data regarding case loads on both the admission and long-term units.

Findings:

The following table is a summary of the facility's data for long-term units. The data showed that facility has maintained compliance with this requirement, with further improvement in the ratios for SWs, RNs and PTs.

<table>
<tr><td></td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>MDs</td><td>1:20</td><td>1:20</td><td>1:20</td><td>1:21</td><td>1:21</td><td>1:21</td><td>1:21</td></tr>
<tr><td>PhDs</td><td>1:24</td><td>1:23</td><td>1:23</td><td>1:24</td><td>1:24</td><td>1:24</td><td>1:24</td></tr>
<tr><td>SWs</td><td>1:23</td><td>1:23</td><td>1:22</td><td>1:22</td><td>1:22</td><td>1:22</td><td>1:22</td></tr>
<tr><td>RTs</td><td>1:20</td><td>1:19</td><td>1:20</td><td>1:20</td><td>1:21</td><td>1:21</td><td>1:20</td></tr>
<tr><td>RNs</td><td>1:22</td><td>1:20</td><td>1:20</td><td>1:19</td><td>1:21</td><td>1:20</td><td>1:20</td></tr>
<tr><td>PTs</td><td>1:22</td><td>1:21</td><td>1:21</td><td>1:20</td><td>1:21</td><td>1:21</td><td>1:21</td></tr>
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The following table summarizes the data for admission units. The data showed that MSH has met the required ratios for MDs, PhDs, RTs, RNs and PTs, with SW ratios improving from 1:19 in the previous period to 1:16 in the current period.

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<table>
<tr><td></td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Mean</td></tr>
<tr><td>MDs</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
<tr><td>PhDs</td><td>1:16</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
<tr><td>SWs</td><td>1:17</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:16</td><td>1:15</td><td>1:16</td></tr>
<tr><td>RTs</td><td>1:16</td><td>1:15</td><td>1:15</td><td>1:14</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
<tr><td>RNs</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
<tr><td>PTs</td><td>1:16</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
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Compliance:
Substantial.

Current recommendations:
1. Ensure compliance with the required ratios for Social Workers on the admission units.
2. Provide data regarding case loads on both the admission and long-term units.
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<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
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Current findings on previous recommendation:

Recommendation, March 2008:
Same as in C.1.a through C.1.f.

Findings:
Same as in C.1.a through C.1.f.

Compliance:
Partial.

Current recommendation:
Same as in C.1.a through C.1.f.
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</table>

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	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:	**Methodology:** Interviewed: 1. The following four individuals: AAH, JU, RM and WS 2. Andrea Cirota, Acting Supervising Rehabilitation Therapist 3. Asha Vij, Occupational Therapist 4. Ashvind Singh, PhD, Psychologist, Substance Recovery Service 5. Brian Parks, PT 6. Christina Marshall, Director of Nutrition Services 7. Cynthia Lusch, Clinical Administrator 8. Denise Nicks, Rehabilitation Therapist 9. Donna Gilland, Program Director, Assistant to the Director 10. Doug Strosnider, Mall Director 11. Edwin Poon, PhD, Psychologist 12. Eric Ruffins, PT 13. Ese Soriano Alvarado, RT 14. Forresteen Forbes, PhD, Psychologist 15. Gretchen Hunt, BY CHOICE Coordinator 16. Jack McClary, Supervisor for Vocational Services 17. Jocelyn Agtarap, RN, Supervisor 18. John Lusch, Program Director 19. Julia Hastings, Physical Therapist 20. Kelly Baker, Acting Supervising Rehabilitation Therapist 21. Kenneth Layman, Treatment Enhancement Coordinator 22. Leah Abarientos, RN 23. Leora Schefres, PhD, Psychologist 24. Lisa Rimland, WRP Trainer 25. Mari Cobb, Rehabilitation Therapy Chief 26. Marilu Tiberi-Vipraioa 27. Marion Paclibar, Physical Therapist 28. Michael Cooper, Chair of PSSC 29. Nakil Desai, CSW, Social Worker

		30. Ninfa Guzman, Hospital Administrative Resident 31. Paul Ananias, MD, Psychiatrist 32. Portia Salvacion, Assistant Director of Nutrition Services 33. Raafat Guirgis, MD, Senior Psychiatrist, Patton State Hospital 34. Rebecca McClary, Rehabilitation Therapy Program Assistant 35. Richard Hartley, PhD, Psychologist 36. Sean Johnson, Assistant BY CHOICE Coordinator 37. Sharon Smith Nevins, Executive Director 38. Sheri Greve, PsyD, Consultant to PSR Mall Services 39. Shirin Karimi, LCSW, Chief of Social Work 40. Swati Roy, PhD, Chief of Psychology, C-Chair of PSSC 41. Tracy Tremayne Bradley, RT <u>Reviewed</u>: 1. The charts of the following 168 individuals: AA, AAA, AB, ABR, AC, AD, AH, AJ, ALC, AM, AMM, AP, ARB, ARD, AS, BAM, BE, BF, BMP, BP, BSK, BU, BY, CAS, CC, CDJ, CG, CH, CMG, CRG, CRO, CRT, CWL, DAC, DE, DF, DLG, DM, DMS, DSH, DT, EN, FG, FM, FR, GB-1, GB-2, GF, GLT, GMH, GR, GS, HC, HVT, IGM, IR, JA, JAC, JAS, JC, JC-2, JCB, JD, JDE, JDR, JEM, JG, JLS, JM, JMA, JMS, JND, JOR, JP, JR, JS, JS-2, JT, JTW, KB, KCY, KD, KEG, KLF, KS, KSC, KTB, KZ, LK, LL, LM, LMC, LMH, LW, MA, MAB, MAF, MAO, MC, MCF, MCL, MD, MDW, MEB, MG, MGF, MH, MJ, MJK, MJM, MR, MRA, MTR, NA, NH, NM, PC, PD, PHS, PS, PW, RAP, RAV, RDU, RF, RGM, RJA, RLH, RML, RMT, RP, RR, RS, RS-2, RT, SB, SCC, SDE, SE, SF, SFY, SG, SH, SL, SM, SMN, SR, SRF, SW, TAN, TDW, TJ, TK, TL, TLF, TLM, TP, TR, VA, VAB, VLG, VP, WH, WO, WP, YB, YFH and YH 2. MSH Lesson Title: Engagement of Individuals in the WRPC 3. MSH Lesson Title: Case Formulation 4. MSH Lesson Title: Foci and Objectives 5. MSH Lesson Title: Interventions and Mall Integration 6. MSH Update training Addressing Discharge Planning

		7. DMH revised template for the Mall Facilitator Monthly Progress Note 8. DMH WRP Observation Monitoring Form 9. DMH WRP Observation Monitoring Form Instructions 10. MSH WRP Observation Monitoring summary data (February to July 2008) 11. DMH Chart Auditing Form 12. DMH Chart Auditing Form Instructions 13. MSH Chart Auditing summary data (February to July 2008) 14. DMH Clinical Chart Auditing Form 15. DMH Clinical Chart Auditing Form Instructions 16. MSH Clinical Chart Auditing Form summary data (February to July 2008) 17. DMH Mall Alignment Monitoring Form 18. DMH Mall Alignment Monitoring Form Instructions 19. MSH Mall Alignment Monitoring summary data (March to July 2008) 20. DMH WRP Substance Abuse Monitoring Form 21. DMH WRP Substance Abuse Monitoring Form Instructions 22. MSH Substance Abuse Monitoring summary data (February to July 2008) 23. Substance Abuse Treatment Program Plan of Improvement (MSH and PSH) and Implementation Plan (PSH) 24. University of Rhode Island Change Assessment (URICA) 25. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) 26. MSH MAPP data regarding active treatment hours scheduled and attended (February to July 2008) 27. A sample of MSH Active Treatment Rosters 28. MSH My Activity and Participation Plan (MAPP), Facilitator's guide "How to Complete a Roster" 29. AD 3465 (Assessment of English Language Learners) 30. Basic Group Leadership Lesson Plans

		31. Basic Group Leadership Training Form 32. BY CHOICE Training Log 33. BY CHOICE Progress Report 34. CASAS Competencies: Essential Life and Work Skills for Youth and Adults 35. English Language Learner List 36. Enrichment Activity List 37. Exercise Group List 38. Family Therapy/Education Letter to Families 39. Home Language Survey Data 40. List of Individuals Assessed to Need Family Therapy 41. Mall Facilitator Monitoring Form 42. Mall Facilitator Training Roster 43. MSH Curriculum Committee Database 44. Progress Note Audit 45. Substance Abuse Recovery Curriculum 46. Substance Abuse Recovery Curriculum Training 47. Substance Abuse Recovery Group Audit Training Roster 48. Substance Abuse Recovery Training Attendance Roster 49. Summary List of Missed Appointments 50. Summary of Scheduled Mall Hours By Discipline <u>Observed</u>: 1. WRPC (Program I, unit 410) for 14-day review of BM 2. WRPC (Program II, unit 412) for monthly review of SW 3. WRPC (Program II, unit 412) for monthly review of YB 4. WRPC (Program III, unit 407) for monthly review of JRB 5. WRPC (Program III, unit 415) for monthly review of RG 6. WRPC (Program IV, unit 405) for 14-Day review of ES 7. WRPC (Program V, unit 403) for monthly review of DC 8. WRPC (Program V, unit 411) for quarterly review of FO 9. WRPC (Program VI, unit 418) for quarterly review of TP 10. PSR Mall group: DBT Skills Introduction

		11. PSR Mall group: ESL 12. PSR Mall group: Healthy Lifestyle 13. PSR Mall group: Legal Issues-Court Preparation 14. PSR Mall group: Mind Over Mood 15. PSR Mall group: Motivational Group 16. PSR Mall group: Reality Orientation 17. PSR Mall group: Recovery Games 18. PSR Mall group: Social Skills 19. PSR Mall group: Sports and Fitness 20. PSR Mall group: Substance Recovery 21. BY CHOICE Incentive Store 22. The following four bed-bound individuals: BP, DE, HS, and JP
C.2.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue current training and mentoring regarding engagement of individuals. **Findings:** Same as in C.1.a. In addition, the facility reported that WRPT-specific reports from the PLATO database were developed to identify teams showing inconsistent performance in this requirement **Recommendations 2 and 3, January 2008:** • Monitor this requirement using the Observation Monitoring Auditing Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH used the DMH Observation Monitoring Form to assess compliance

(February to July 2008) based on an average sample of 14% of WRPCs due each month. The following is a summary of the data:

6.	*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.*	
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	64%
6.b	*When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.*	64%
6.c	*The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.*	72%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual;s WRP objectives and interventions, as relevant.*	68%

The mean compliance rate for this requirement has improved from 46% in the last review period to 49% in the current review period.

The mean compliance rates for sub-items have improved from January to July 2008 as follows:

1. Item 6.a: 9% to 20%;
2. Item 6.b: 4% to 15%; and

		3. Item 6.d: 6% to 35%. The mean compliance rate for item 6.c has remained unchanged at 71%. MSH's data analysis showed that WRPTs were inconsistent in assisting the individual in re-allocation of BY CHOICE points. The facility acknowledged the need to improve sample size and inter-rater agreement process. The plan of improvement for this requirement included the following: 1. The Treatment Enhancement Coordinator (TEC) will improve the process of development of PLATO reports for each WRPT. 2. The WRP trainers, mentors, discipline chiefs and program managers will review teams with low compliance and identify and implement strategies for remediation. 3. Remediation may include extra training in the computer laboratory, mandatory re-enrollment in the eight-hour WRP class, or meeting with direct supervisor for corrective action. 4. Deficit areas will be discussed during the four-hour update training. 5. The data will be administratively reviewed during monthly meetings of the Performance Improvement Committee. 6. The office of the TEC will improve scheduling of WRPCs to ensure adequate sample sizes for each WRPC type. 7. A back-up system will be developed to ensure coverage during auditor vacations. 8. The facility will review the auditing methodology, including revision and implementation of inter-rater agreement processes. **Other findings:** This monitor's observations of the WRPC process are summarized in C.1.a.

		Compliance: Partial. **Current recommendations**: 1. Continue current training and mentoring regarding engagement of individuals. 2. Monitor this requirement using process observation based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice, including self-monitoring. **Findings:** MSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (February to July 2008). Based on an average sample of 15% of admission WRPs that were completed each month, the facility reported a mean compliance rate of 100%. This was the same rate reported for the last review period. The facility's data are presented below in each corresponding cell (C.2.b.ii and C.2.b.iii). **Other findings:**

		This monitor reviewed the charts of 11 individuals (ABR, AD, CRT, DAC, KS, LK, LL, MA, MG, RR and SDE) who were admitted during this reporting period. The reviews found compliance in all cases except one (MG). **Compliance:** Substantial. **Current recommendations**: Continue current practice, including self-monitoring.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice, including self-monitoring. **Findings:** The facility reported a mean compliance rate of 67% for this requirement. This rate has dropped from 95% in the last review. The average sample size was 15% of 7-Day WRPs that were completed each month. During this review period, the compliance rate showed progressive improvement (to 100% in July 2008). The facility recognized that unit supervisors did not ensure that the WRPC schedule was consistently adjusted to 7-day conferences timeliness. Reportedly, this problem has been corrected through training and monthly monitoring. The facility plans to monitor conference scheduling and timeliness data from the PLATO database on a monthly basis, refine the conference scheduling system and ensure timely implementation of the schedule. **Other findings:** Chart reviews by this monitor found compliance in all 11 cases.

<table>
<tr><td></td><td></td><td>Compliance:
Partial.

Current recommendations:
Continue current practice, including self-monitoring.</td></tr>
<tr><td>C.2.b.iii</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1-3, March 2008:
• Monitor this requirement using chart audits based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
• Implement corrective actions to improve compliance.

Findings:
The following summarizes the facility's data:

<table>
<tr><td>WRP Review</td><td>Mean S%</td><td>Mean %C</td></tr>
<tr><td>14-Day</td><td>59%</td><td>51%</td></tr>
<tr><td>Monthly</td><td>15%</td><td>38%</td></tr>
<tr><td>Quarterly</td><td>19%</td><td>39%</td></tr>
<tr><td>Annual</td><td>19%</td><td>49%</td></tr>
</table>

The plan of improvement is the same as in C.2.b.ii.

1. 14-Day WRPCs:
a. The mean compliance rate has improved from 17% for the last review period to 51% for this review period.
b. The mean compliance rate has improved from 25% in January 2008 to 66% in July 2008.</td></tr>
</table>

		2. Monthly WRPCs: a. The mean compliance rate has improved from 15% for the last review period to 38% for this review period. b. The mean compliance rate has improved from 12% in January 2008 to 62% in July 2008. 3. Quarterly WRPCs: a. The mean compliance rate has improved from 7% for the last review period to 39% for this review period. b. The mean compliance rate has improved from 0% in January 2008 to 59% in July 2008. 4. Annual WRPCs: a. The mean compliance rate has improved from 10% for the last review period to 49% for this review period. b. The mean compliance rate has improved from 13% in January 2008 to 60% in July 2008. **Other findings:** This monitor found compliance in eight charts (AD, CRT, KS, LL, MA, MG, RR and SDE), partial compliance in two (DAC and LK) and noncompliance in one (ABR). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using chart audits based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a	**Current findings on previous recommendations:**

	thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Recommendations 1-3 March 2008:** • Monitor this requirement using the Clinical Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Implement corrective actions to address the deficiencies outlined by this monitor above. **Findings:** MSH used the DMH Clinical Chart Auditing Form to assess compliance (February to July 2008). The average sample was 12% of the quarterly and annual WRPs per month. The following is a summary of the data:

2.	*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.*	
2.a	*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.*	88%
2.b	*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.*	91%
2.c	*When a mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.*	84%
2.d	*When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked*	86%

			intervention.	

The mean compliance rate for this requirement has increased from 72% during the last review period to 86% for this review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 2.a: 89% to 100%;
2. Item 2.b: 75% to 100%; and
3. Item 2.c: 33% to 100%

The facility's plan of improvement is the same as in C.2.a.

Other findings:
This monitor reviewed the charts of several individuals diagnosed with a variety of cognitive and seizure disorders. The reviews found some improvement in the following areas:

1. Documentation of foci, objectives and interventions to address the needs of individuals diagnosed with dementing illnesses and seizure disorders;
2. Decreased use of ongoing treatment with anticholinergic medications and benzodiazepines for individuals suffering from dementing illnesses (GB);
3. Documentation of the status of some individuals suffering from seizure disorders (in the present status section of the case formulation);
4. Attempts to develop objectives and interventions based on learning outcomes for some individuals suffering from seizure disorders; and
5. Attempts to utilize individuals' strengths in the development of interventions to address the cognitive impairment (e.g. AC).

		However, the review also found a pattern of persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (AC, AJ, AM, DLG, GB, HC, JMA, KZ, LW and RJA): a. The WRPs did not include focus, objectives or interventions to address the needs of individuals diagnosed with mild Mental Retardation (AJ and KZ) and Cognitive Disorder NOS (LW and RJA). b. The WRPs included objectives and interventions related to a diagnosis of Dementia Due to General Medical Condition with Behavioral Disturbance (AC and DG) that were generic and did not adequately address the cognitive impairment. c. The WRP included a focus statement that was not aligned with the established diagnosis of dementia (AC). d. Some WRPs included learning objectives, but the objectives were not appropriately tailored to the needs of individuals diagnosed with dementing illnesses (e.g. AM). e. The WRPs did not include interventions to assess the risks of ongoing treatment with high-risk medications, including phenytoin (AM and JMA) and lorazepam (LW). f. Some WRPs for individuals diagnosed with dementing illnesses included interventions that did not address the specified objective. For example, the chart of GB included an objective of being able to be prompted by hand to participate in certain groups, but the interventions did not address this issue. g. There was evidence of limited offerings of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. h. The present status sections of the case formulations did not

		address changes in the cognitive status of individuals diagnosed with dementing illnesses (e.g. AC, DLG and HC) or Cognitive Disorder NOS (LW and RJA). i. In general, the WRPs did not include adequate measures/ consultations to assess, determine the etiology of and/or finalize diagnoses of Cognitive Disorder, NOS (e.g. LW and RJA). 2. Individuals diagnosed with seizure disorders (AM, CG, GF, JMA, JMS and MTR): a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in all charts reviewed. b. The WRP included an incomprehensible focus statement (JMS). c. The WRPs included objectives that were not meaningful for some individuals, such as being free of seizure-related injury (JMS). d. The WRP did not include objectives with learning outcomes for individuals (CG, GF and JMS). e. Some WRPs included interventions that did not address the specified objective of learning to recognize and verbalize the signs and symptoms of impending seizure (AM, JMA and MTR). f. The WRPs did not include objectives/interventions to assess the risks of treatment with older anticonvulsant medications and to minimize the impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (GF, JMA, JMS, MA and MTR) and phenobarbital (CG). Some of these individuals had diagnoses of dementing illnesses (AM and JMA), which increase the risk of this treatment for the individuals. **Compliance:** Partial. **Current recommendations**:

		1. Monitor this requirement using the Clinical Chart Auditing Form, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement adequate corrective actions to address the deficiencies outlined by this monitor above.
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:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue training on the Case Formulation Module to all WRPTs and ensure that the training includes clinical case examples. **Findings:** Same as in C.1.a. In addition, the facility has reportedly increased WRP training to include clinical examples during the eight-hour full WRP sessions and during the four-hour updates. **Recommendations 2 and 3, March 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used the DMH Clinical Chart Auditing to assess compliance (January to July 2008). The average sample was 12% of the Quarterly and Annual WRPs due each month. The following is a summary of the data regarding this requirement.

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	
3.a	*All six sections of the case formulation (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) are aligned with the Integrated Assessment and/or additional discipline-specific assessments, including*	96%
3.b	*All six sections of the case formulation indicate interdisciplinary participation and are not written from the point of view of one discipline.*	89%

The mean compliance rate for this requirement has improved from 46% in the last review period to 88% in the current review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 3.a: 74% to 100%; and
2. Item 3.b: 74% to 96%.

The facility found that WRPTs were inconsistent in writing case formulations from an interdisciplinary point of view. The plan of improvement is the same as in C.2.a.

		The facility's compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed as necessary. The plan of improvement is the same as in C.1.a. **Other findings:** Chart reviews and WRPCs attended by this monitor and his consultants demonstrated that MSH has made progress in the organization and content of the present status section of the case formulation, which was in general more comprehensive than in the last review. However, the content of many formulations showed deficiencies that must be corrected to achieve substantial compliance. The following are examples: 1. In some charts (e.g. RJA), the present status section of the case formulation inappropriately included documentation of the activities of the WRPT that had no relevance to the status of the individual (e.g. "the task tracking sheet was updated, the diagnosis was reviewed and updated, the team reviewed the focus, objectives and interventions with individual to monitor progress." 2. In some charts (e.g. CG and VAB), the present status section included information on the risk factors that was contradicted by statements in the interventions and response part of the same section (CG and VAB). 3. In general, the present status sections did not include sufficient review and analysis of the following: a. Use of restrictive interventions; and b. Clinical progress towards individualized discharge criteria. 4. In general, there was inadequate linkage within the 6-P components of the case formulation and between the material in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions.

<table>
<tr>
<td></td>
<td></td>
<td>Current recommendations:
1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.
2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>C.2.d.ii</td>
<td>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</td>
<td>
<table>
<tr><td>4.a</td><td>Pertinent history</td><td>48%</td></tr>
<tr><td>4.b</td><td>Predisposing factors</td><td>40%</td></tr>
<tr><td>4.c</td><td>Precipitating factors</td><td>33%</td></tr>
<tr><td>4.d</td><td>Perpetuating factors</td><td>30%</td></tr>
<tr><td>4.e</td><td>Previous treatment</td><td>42%</td></tr>
<tr><td>4.f</td><td>Present status</td><td>46%</td></tr>
</table>

The mean compliance rate for this requirement has decreased from 22% in the last review period to 13% in the current review period.

The compliance rates for the sub-items have shown mixed changes from January to July 2008, as follows:

1. Item 4.a: 62% to 43%;
2. Item 4.b: 46% to 48%;
3. Item 4.c: 62% to 36%;
4. Item 4.d: 56% to 39%;
5. Item 4.e: 56% to 54%; and
6. Item 4.f: 45% to 56%.

The data showed that the quality of information in the predisposing
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<table>
<tr><td></td><td></td><td>and present status sections have improved during the period, but that the quality of the other 6-Ps have decreased.</td></tr>
<tr><td>C.2.d.iii</td><td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td><td>
<table>
<tr><td>5.a</td><td>There is a completed DMH WRP Case Formulation Worksheet, and</td><td>46%</td></tr>
<tr><td>5.b</td><td>The information is included in the case formulation</td><td>51%</td></tr>
</table>

The mean compliance rate for this requirement increased from 39% in the last review period to 46% in the current review period. However, the compliance rates for the sub-items have decreased from January to July 2008 as follows:

1. Item 5.a: 65% to 56%; and
2. Item 5.b: 67% to 58%.

The facility found that the WRPTs were inconsistent in the use of the Case Formulation Worksheet.
</td></tr>
<tr><td>C.2.d.iv</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</td><td>
<table>
<tr><td>6.a</td><td>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</td><td>83%</td></tr>
<tr><td>6.b</td><td>(The formulation) addresses how they affect treatment and rehabilitation outcomes</td><td>78%</td></tr>
</table>

The mean compliance rate for this requirement has improved from 46% in the last review period to 79% in the current review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 6.a: 87% to 93%; and
2. Item 3.b: 79% to 89%.
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>The facility recognized the need to improve consistency among WRPTs in addressing the implications for the case formulation in the development of foci, objectives and interventions.</td></tr>
<tr><td>C.2.d.v</td><td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</td><td>
<table>
<tr><td>7.a</td><td>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</td><td>80%</td></tr>
<tr><td>7.b</td><td>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</td><td>74%</td></tr>
</table>

The mean compliance rate for this requirement has improved from 39% in the last review period to 79% in the current review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 7.a: 55% to 93%; and
2. Item 7.b: 54% to 88%.

The facility found that the WRPTs were inconsistent in completing the DSM IV-TR Checklist prior to the 7-day WRP or when the psychiatric diagnosis has changed.
</td></tr>
<tr><td>C.2.d.vi</td><td>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 changes that will be necessary to achieve discharge.</td><td>
<table>
<tr><td>8.a</td><td>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</td><td>66%</td></tr>
<tr><td>8.b</td><td>The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes</td><td>84%</td></tr>
<tr><td>8.c</td><td>The case formulation documents a pathway to the discharge setting</td><td>88%</td></tr>
<tr><td>8.d</td><td>There is evidence of proper analysis of the following</td><td>78%</td></tr>
</table>
</td></tr>
</table>

			information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.	
		8.e	*There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section*	85%
		8.f	*There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.*	88%
		8.g	*The case formulation identifies 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.*	66%

The mean compliance rate for this requirement has improved from 27% in the last review period to 51% in the current review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 8.a: 23% to 79%;
2. Item 8.b: 62% to 89%;
3. Item 8.c: 74% to 89%;
4. Item 8.d: 69% to 86%;
5. Item 8.e: 76% to 82%;
6. Item 8.f: 74% to 93%; and
7. Item 8.g: 64% to 71%.

C.2.e	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);	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Findings:** Same as in C.2.c, C.2.f, C.2.g and C.2.o. **Other findings:** MSH used the DMH Clinical Chart Auditing Form to assess compliance with this requirement (May to July 2008). The average sample was 19% of the quarterly and annual WRPs due each month. The following is a summary of the compliance data: 4. *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).* 4.a *There is a focus of hospitalization for each axis I, II, and III diagnosis* 41% 4.b *There is a focus for each discharge criteria* 31% 4.c *Each focus has an objective and an intervention* 65% 4.d *Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.* 16% 4.e *Each objective includes a staff intervention in the therapeutic milieu.* 12% The mean compliance rate for this requirement has increased from 0% in the last review period to 3% in the current review period. The facility did not present comparative data for the sub-items (January to July 2008).

		The findings in C.2.c, C.2.f, C.2.g and C.2.o are relevant to the analysis of data regarding this requirement. This monitor also reviewed the records of 31 individuals receiving Rehabilitation Therapy Services, including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational and physical therapy treatment (AAA, ARB, BF, CDJ, CRO, DLG, FG, GB, GB-2, IR, JAS, JOR, JR, KB, LM, LMC, LMH, MAF, MEB, MJM, NM, PHS, PS, RAP, SG, SL, SM, SMN, TAN, TP and YFH) to assess compliance with C.2.e. Twelve records were in partial compliance (ARB, FG, JOR, LM, LMH, MEB, PS, RAP, SG, TAN, TP and YFH) and 19 records were not in compliance (AAA, BF, CDJ, CRO, DLG, GB, GB-2, IR, JAS, JR, KB, LMC, MAF, MJM, NM, PHS, SL, SM and SMN). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP. This monitor also reviewed records of 43 individuals who had IA-RTS assessments and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy, Vocational Rehabilitation) during the review period (AAA, AMM, AP, AS, BAM, BE, BSK, CDJ, DMS, EN, GB, HVT, IGM, JC, JC-2, JLS, JR, JS, JS-2, JTW, KD, KTB, LMC, MAB, MCL, MD, MEB, MH, MR, NH, PC, RAP, RGM, RT, SB, SF, SW, TLM, TP, TR, VP, WP and YH). Seven records were in compliance with C.2.e (BAM, CDJ, JC, JLS, JS, PC and WP); 17 records were in partial compliance (AMM, AS, EN, GB, IGM, JC-2, JTW, KD, MD, NH,

		RAP, SB, SF, TLM, TP, VP and YH); and 19 records were not in compliance (AAA, AP, BE, BSK, DMS, HVT, JR, JS-2, KTB, LMC, MAB, MCL, MEB, MH, MR, RGM, RT, SW and TR). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Foci and interventions are not consistently written as indicated by facility requirements and integrated into the WRP. Finally, this monitor reviewed the records of 40 individuals (ARD, BSK, BU, CH, DF, DM, FM, GLT, GR, JAC, JCB, JDE, JG, JM, KB, KCY, KLF, KSC, LK, MAF, MAO, MDW, MG, MGF, NA, PD, PS, RAV, RLH, RML, RMT, RS-2, SF, SFY, SKF, SM, SR, TDW, TJ and TK) to assess compliance with WRP integration and quality of Nutrition foci, objectives and interventions. Eighteen records were in substantial compliance (BSK, BU, DF, FM, GLT, GR, JAC, JCB, KLF, MAF, MAO, MGF, NA, PD, RAV, RLH, SF and SR); 16 records were in partial compliance (CH, JG, JM, KCY, KSC, LK, MG, PS, RML, RMT, RS-2, SFY, SKF, SM, TJ and TK); and six records were not in compliance (ARD, DM, JDE, KB, MDW and TDW) with having an adequate focus, objective and intervention integrated into the WRP. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not consistently aligned.

		Compliance: Partial. **Current recommendations**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.
C.2.f	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:	Please see sub-cells for compliance findings.
C.2.f.i	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;	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Monitor this requirement based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Implement corrective actions to improve compliance. **Findings:** MSH used the DMH Chart Auditing Form to assess compliance (February to July 2008) with the requirements of C.2.f.i through C.2.f.v. The average sample was 19% of the quarterly and annual WRPs due each month. The following is a summary of the data for this requirement. The data for C.2.f.ii to C.2.f.v are presented in each corresponding cell below, with the sub-indicators identified as necessary. The facility's plan of correction is the same as in C.2.a.

5.	*The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.*	
5.a	*All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change*	43%
5.b	*The individual's strengths are used in the interventions.*	24%
5.c	*There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.*	8%

The mean compliance rate for this requirement was 1% in the last review period compared to 15% in the current review period. The facility did not present comparative data regarding sub-items (January to July 2008).

MSH reported that the WRPTs were inconsistent in documenting the individual's strengths in each intervention, and in including a rationale for a focus area that was not accompanied by an objective and/or intervention.

MSH also used the DMH WRP Observation Monitoring Form (February to July 2008) to assess compliance. The average sample was 14% of the WRPCs each month. The following is a summary of the data:

7.	*The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.*	

7.a	*Strengths are identified and incorporated into the interventions offered.*	58%
7.b	*The strengths are related to each treatment, rehabilitation or enrichment objective.*	57%

The mean compliance rate for this requirement was 60% in the last review period compared to 57% in the current review period.

The mean compliance rates for the sub-items have increased from January to July 2008 as follows:

1. Item 7.a: 58% to 87%; and
2. Item 7.b: 58% to 83%.

Other findings:
This monitor reviewed the charts of six individuals (AM, CRT, DAC, LK, RS and SDE) to assess compliance with the requirements of C.2.f.i to C.2.d.vi, C.2.f.viii to C.2.g.i, C.2.g.iii to C.2.g.iv. and C.2.o

Regarding this requirement, the review found partial compliance in four charts (AM, CRT, RS and SDE) and noncompliance in two (DAC and LK). The main deficiency involved the proper integration of identified strengths in the development of interventions.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

<table>
<tr>
<td>C.2.f.ii</td>
<td>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);</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Same as above.

Findings:
The facility presented the following monitoring data:

<table>
<tr><td>6.</td><td>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.)</td><td></td></tr>
<tr><td>6.a</td><td>There are specific groups or individual therapy linked to specific objectives that focus on treatment (e.g., treatment of a specific medical or psychiatric condition) and are provided in the PSR Mall.</td><td>12%</td></tr>
<tr><td>6.a</td><td>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</td><td>31%</td></tr>
<tr><td>6.b</td><td>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</td><td>48%</td></tr>
</table>

The mean compliance rate for this requirement has increased from 6% in the last review period to 22% in the current review period.

MSH did not present comparative data for the sub-items (January to July 2008).

The facility found that the interventions did not consistently include skills training groups, as clinically indicated.

</td>
</tr>
</table>

		Other findings: Chart reviews by this monitor found compliance in all cases (AM, CRT, DAC, LK, RS and SDE) regarding the inclusion of an enrichment focus, with corresponding leisure and recreation groups. **Compliance:** Partial. **Current recommendation**: Same as above.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 23% for this requirement compared with 1% during the last review. The rate has increased from 0% in January to 33% in July 2008. **Other findings:** Chart reviews by this monitor found that no chart met the threshold for substantial compliance. There was partial compliance in four charts (CRT, LK, RS and SDE) and noncompliance in two (AM and DAC). **Compliance:** Partial. **Current recommendation**: Same as above.

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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 45% for this requirement compared with 7% during the last review. The compliance rate has increased from 7% in January to 67% in July 2008. **Other findings:** Reviews by this monitor found noncompliance in three charts (AM, CRT and LK), compliance in two (DAC and SDE) and partial compliance in one (RS). **Compliance:** Partial. **Current recommendation**: Same as above.
C.2.f.v	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 15% for this requirement compared with 1% during the last review. The rate has increased from 2% in January to 14% in July 2008. **Other findings:** Reviews by this monitor found partial compliance in four charts (AM,

<table>
<tr><td></td><td></td><td>CRT, LK and SDE) and compliance in two (DAC and RS).

Compliance:
Partial.

Current recommendation:
Same as above.</td></tr>
<tr><td>C.2.f.vi</td><td>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 provided as part of the 20 hours of active treatment per week;</td><td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Monitor hours of active treatment (scheduled and attended).

Findings:
MSH data (February to July 2008) are summarized as follows :

<table>
<tr><td></td><td>Scheduled hours (number of individuals by category)</td><td>Attended hours (number of individuals by category)</td></tr>
<tr><td>N</td><td>715</td><td>675</td></tr>
<tr><td>Hours:</td><td></td><td></td></tr>
<tr><td>0-5</td><td>14</td><td>39</td></tr>
<tr><td>6-10</td><td>5</td><td>25</td></tr>
<tr><td>11-15</td><td>8</td><td>97</td></tr>
<tr><td>16-20</td><td>688</td><td>514</td></tr>
</table>

Recommendation 2, March 2008:
Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, disconnection between WRP and MAPP data and inadequate participation by individuals.

Findings:
MSH reported that it has identified factors causing inadequate</td></tr>
</table>

scheduling and that beginning in February 2008, the program managers have received a monthly report of individuals' schedules and attendance for each unit and have taken corrective action by contacting WRPTs when individuals were scheduled for less than 20 hours per week. The WRPT mentors have reportedly received training to assist the teams in ensuring alignment between the WRP and the Mall schedule.

See this monitor's findings below regarding the accuracy of the facility's data regarding individuals' hours scheduled and attended.

Other findings:
Chart reviews by this monitor focused on the documentation of active treatment hours listed on the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. Based on MSH's MAPP data, it appears that the facility has increased the number of hours scheduled since the last reporting period. However, this monitor's review of the process of counting active treatment hours found several examples of misinterpretation by Mall providers of the correct procedure in completing group participation rosters. The examples included one individual (AH) who was documented as having attended more than one group at the same time. Another example was that of one facilitator who was documented as running six groups at the same time. The monitor reviewed documents showing that the facility was aware of the problems completing rosters and has given instructions to providers regarding corrective measures.

Individual	WRP scheduled	MAPP scheduled	MAPP attended
AM	4	19	8.40
CRT	6	20	6
DAC	10	19	11
LK	5	18	15
RS	7	22	17

		SDE | 5 | 20 | 15 **Compliance:** Partial. **Current recommendations**: 1. Monitor hours of active treatment (scheduled and attended). 2. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP and MAPP, disconnection between WRP and MAPP data and inadequate participation by individuals
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	**Current findings on previous recommendations:** **Recommendations 1-3 March 2008:** • Monitor this requirement using at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Ensure that plans of correction are focused on the actual delivery of programs in the community. **Findings:** MSH used the DMH Chart Auditing Form to assess compliance (February to July 2008). The average sample was 19% of the quarterly and annual WRPs due each month. The mean compliance rate was 13% compared to 5% during the last review period. The rate has increased from 0% in January 2008 to 10% in July 2008. The facility found that the WRPTs were inconsistently documenting off-facility activities. The facility presented other data regarding this requirement. The data focused on the number of individuals who actually received community learning vs. the number of individuals who were candidates

		for this intervention. The facility reported a 51% mean compliance rate. However, the data presented by the facility could not be relied on because of apparent errors. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under civil commitments (AA, ALC, KEG, PC, SE and SH). The review found noncompliance in all cases. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Improve data presentation regarding actual delivery of programs in the community.
C.2.f.viii	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement using the Mall Alignment Monitoring Form. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH Mall Alignment Monitoring Form to assess compliance (March to July 2008). Based on a target population of 20 individuals, the average sample was 63%. The facility reported a mean

		compliance rate of 20% compared to a rate of 38% during the last review period. Comparative data also showed the rate has dropped from 25% in January 2008 to 11% in July 2008. The facility found minimal alignment between the course outlines and the individual's WRP and that course outlines have not been updated and often did not align well with the current group offerings. In addition to the corrective action plan in C.2.a, the facility reported plans to review and update the course outlines. **Recommendation 3, March 2008:** Improve compliance with the completion of Mall progress notes and the integration of information into the WRPs. **Findings:** The current format of the Mall Facilitator Progress Note does not provide the information needed to adequately develop and revise the WRP. The DMH has revised this format, which provided needed correction. The revised format has yet to be implemented. The facility has reportedly refined its current system of tracking the completion of the Mall Facilitator Progress Notes and the integration of information derived from these notes into the WRPs. **Other findings:** Chart reviews by this monitor found partial compliance in five (AM, DAC, LK, RS and SDE) and compliance in one (CRT). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Mall Alignment Monitoring Form.

		2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.
C.2.g	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:	Please see sub-cells for compliance findings.
C.2.g.i	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;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH Observation Monitoring Form (February to July 2008), MSH reviewed an average sample of 22% of the WRPCs due each month and assessed compliance with the requirements in C.2.g.i to C.2.g.iv. The plan of improvement is the same as in C.2.a. The following is a summary of the compliance data regarding this requirement. The facility's data related to the requirements of C.2.g.ii to C.2.g.iv are presented in each corresponding cell below.

8.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	
8.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	66%
8.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	52%

The mean compliance rate for this requirement was 62% in the last review period compared to 57% in the current review period. The compliance rates for the sub-indicators have increased from January to July 2008 as follows:

1. Item 8.a from 72% to 81%; and
2. Item 8.b from 47% to 74%.

The facility also used the DMH Clinical Chart Auditing Form to assess compliance (February to July 2008). The average sample was 12% of the quarterly and annual WRPs due each month. The following is a summary of the compliance data regarding this requirement:

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	
9.a	*When an objective has been achieved the team*	43%

	develops a new objective and associated intervention(s) for that focus of hospitalization.	
9.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	30%

The mean compliance rate for this requirement has increased from 24% in the last review period to 31% in the current review period. The compliance rates for the sub-indicators have increased from January to July 2008 as follows:

1. Item 8.a from 34% to 61%; and
2. Item 8.b from 34% to 38%.

Recommendation 3, March 2008:
Implement corrective actions to ensure consistent implementation of the Mall progress notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.

Findings:
Same as those for Recommendation 3 in C.2.f.vii.

Other findings:
This monitor found noncompliance in four charts (AM, CRT, DAC and RS) and compliance in two (LK and SDE).

Additionally, this monitor reviewed the records of 11 individuals (ARB, CDJ, GB, LMC, MEB, MJM, PS, SL, SMN, TP and YFH) receiving direct Occupational and Physical Therapy services and found that 10 records were in compliance (ARB, CDJ, GB, MEB, MJM, PS, SL, SMN, TP and YFH) and one record (LMC) was not in compliance with C.2.g.i.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g.ii	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);	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The following is a summary of the compliance data gathered using the process observation tool regarding this requirement: 9. *The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.* 9.a *When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.* 70% 9.b *When an individual has not shown progress on an* 54%

			objective for two months the team revises or develops a new objective or a new intervention.	

The mean compliance rate for this requirement has increased from 62% in the last review period to 69% in the current review period. The compliance rates for the sub-indicators have decreased from January to July 2008 as follows:

1. Item 9.a: from 69% to 59%; and
2. Item 9.b: from 50% to 44%.

MSH also used the DMH Chart Auditing Form (February to July 2008) but the sample size was too small to permit meaningful interpretation.

Other findings:
This monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraints during this review period (AMM, CAS, CG, VAB and WO). The review focused on the documentation in the present status section of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found partial compliance in four charts (CAS, CG, VAB and WO).and noncompliance in one (AMM).

The main deficiencies involved lack of adequate documentation in the following areas:

1. Treatment provided to avert the use of restrictive intervention (in specific terms);
2. Modification of the treatment to decrease future risk; and
3. Risk factors in the present status section, particularly regarding dangerousness to others.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g.iii	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria. **Findings:** MSH reported that the Chief of Social Service has presented facility-wide training as part of the eight-hour WRP training sessions as well as discipline-specific training for social workers (in May and July 2008). The following is a summary of the facility's compliance data based on process observation: 10. *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.* 10.a *The team reviews all Foci that are barriers to discharge.* 82% 10.b *The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to* 63%

		discharge.

The mean compliance rate for this requirement has increased from 43% in the last review period to 59% in the current review period. The compliance rates for the sub-indicators increased from January to July 2008 as follows:

1. Item 9a: 82% to 87%; and
2. Item 9b: 31% to 52%.

The facility's plan of improvement in C.2.f.viii is also relevant to this requirement.

Other findings:
This monitor assessed the documentation of individualized discharge criteria and the discussion of the individual's progress towards discharge (as documented in the present status section of the case formulation). The review found partial compliance in four charts (DAC, LK, RS and SDE), compliance in one (CRT) and noncompliance in one (AM). The main deficiencies were as follows:

1. The discharge criteria were limited to the legal criteria in most cases.
2. The documentation of progress towards discharge was generic in most cases.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low

		compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, March 2008:** Same as in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** Reviews by this monitor found partial compliance in five charts (AM, CRT, DAC, LK and SDE) and noncompliance in one (RS). The main deficiencies were as follows: 1. The Mall notes were not completed and filed in a timely manner. 2. The current format of the Mall notes did not provide information needed to guide the revisions of the WRP. 3. The teams' reviews of the notes and utilization of this review to inform revisions of the WRP were inadequate in most cases (this review was adequate in the chart of SDE). As mentioned earlier, the DMH has recently revised the format of the Mall notes. If properly implemented, the new format provides sufficient information to guide the WRP reviews/revisions.

		Compliance: Partial. **Current recommendations**: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all PBS plans are trained to certification across environments before implementation. **Findings:** This monitor's interview of the Chief of Psychology, Senior Psychologists, and the Coordinator of the Psychological Specialty Services Committee, and documentation review (integrity checks for DY, JG, KR, ML, PW and TP and staff certification logs) found that MSH has consistently conducted staff training to certify persons responsible for implementing the intervention plans prior to the implementation of the plans. MSH also conducted regular integrity checks once the plans were implemented. Many of the plans were developed and implemented during the previous review period but were still in effect, and MSH continued to revise and implement the plans. MSH had two PBS plans (CB and CG) that were developed and implemented during this review period and staff responsible for implementing the plans had been trained to certification. **Compliance:** Substantial. **Current recommendation**: Ensure that all PBS plans are trained to certification across

		environments before implementation.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
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 recommendations:** **Recommendation 1, March 2008:** The WRPT should select all available group and individual therapies that meet the needs of the individual and then allow the individual to choose from these interventions. **Findings:** Using item #2 (*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life function*) from the DMH WRP Mall Alignment Monitoring Form, MSH analyzed its compliance based on an average sample of 63% of WRPs due for the month (February to July 2008), reporting a mean compliance rate of 7% (the mean compliance rate for the previous review period was 48%). The compliance rate for the last month of the previous review was 55% and the compliance rate for the last month of the current review period is 0%. This monitor reviewed ten charts (CG, DSH, JC, JD, JT, MC, PD, RP, SCC and SHC). The individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in three of the WRPs in the charts (JD, RP and SCC) and a number of deficiencies were noted in the remaining seven WRPs in the charts (CG, DSH, JC, JT, MC, PD and SHC), including the lack of appropriate foci and objectives and interventions for all discharge criteria, absence of foci and interventions for the individual's life goals, absence of therapeutic milieu interventions, poor alignment between the objectives and

		interventions, and a lack of correspondence between the objectives and recommended PSR Mall services. **Recommendation 2, March 2008:** Ensure that group leaders are consistent and enduring for specific groups. **Findings:** This monitor's interview with the Mall Director revealed that MSH is designing discipline-specific curriculums. The staff is to be trained on the new curriculums at the next Mall break. According to the Mall Director, MSH conducted accountability reports for April and May 2008. The accountability report was used to account for Mall facilitator participation. However, the accountability report was not available for review by this monitor. This monitor observed a number of Mall groups (Reality Orientation, Mind Over Mood, Legal Issues-Court Preparation, Social Skills, Substance Recovery, ESL, Healthy Lifestyle, Motivational Group, Sports and Fitness, DBT Skills Introduction, and Recovery Games). Most of the PM second-hour Mall groups were facilitated by substitute staff. This monitor learned, through a number of the substitute staff and individuals attending these groups that it was not unusual for the PM second-hour Mall groups to be facilitated by substitute staff. The AM Mall groups observed by this monitor were conducted by their regular facilitators. **Recommendation 3, March 2008:** Provide Motivational Interviewing, Narrative Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.

Findings:
This monitor's documentation review (Mall schedule and individuals' attendance in their scheduled Mall groups) and interview of the Mall Director, the Clinical Administrator, and the Treatment Enhancement Coordinator revealed that MSH tracks non-adherence to Mall groups through the Key Indicator Report and the trigger system. However, according to the Treatment Enhancement Coordinator, the data were found to be invalid due to glitches in the database, resulting in over-reporting. According to the Treatment Enhancement Coordinator, the error has been identified and corrected.

The table below showing the average daily census for the month (N) and the number of individuals non-adherent (less than 20% participation in the assigned treatments for seven consecutive days) for the month (n) is a summary of the facility's data.

	Feb	Mar	Apr	May	Jun	Jul	Mean
N	635	636	629	642	665	651	643
n	634	118	389	489	381	325	383

The table above indicates that on average, 59% of the individuals at MSH showed non-adherence to their WRPs for more than 20% of interventions in seven consecutive days during the review period. However, as indicated above, this data may not be reliable.

The Treatment Enhancement Coordinator had conducted training sessions (April 1-3, 2008) on matters related to non-adherence and the strategies that can be used to deal with non-adherence to group attendance.

This monitor observed the "Motivation Enhancement" group. MSH uses this group for treatment engagement with individuals refusing to

		attend their assigned groups. The group met in a large room. There were a handful of individuals seated in front of the facilitator, but many more were scattered around the room. The facilitator did not have anything to offer the individuals besides taking their attendance and recording their reasons for not attending their assigned groups. The facilitator did not have the necessary training and or the experience to provide any therapy such as motivational interviewing, narrative restructuring therapy and other cognitive interventions. Motivational enhancement for treatment engagement cannot be achieved without trained facilitators who themselves are motivated and have the tools to problem-solve and motive the individuals to engage in their Mall groups. This monitor learned both from the facilitators and the individuals that a number of individuals attended groups besides the ones they were assigned to. This suggests to this monitor that, at least in some cases, it is not that the individual is unwilling to attend groups but rather might not find the assigned groups meaningful or interesting. **Other findings:** This monitor reviewed the records of 20 individuals (AAA, ARB, BF, CDJ, DLG, FG, GB, GB-2, JAS, JR, LMC, MEB, MJM, NM, PHS, PS, SG, SM, TP and YFH) receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with C.2.i.i. Eighteen records were in compliance (AAA, ARB, BF, CDJ, DLG, FG, GB, JAS, JR, LMC, MEB, MJM, NM, PS, SG, SM, TP and YFH) and two records were not in compliance (GB-2 and PSH). **Current recommendations**: 1. The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions.

		2. Ensure that group leaders are consistent and enduring for specific groups. 3. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** Using item #7 (*The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do*) from the DMH WRP Chart Auditing Form, MSH analyzed its compliance based on an average sample of 19% of Quarterly and Annual WRPs due for the month (February to July 2008), reporting a mean compliance rate of 23% (the mean compliance rate for the previous review period was 1%). The compliance rate for the last month of the previous review period was 0% and the compliance rate for the last month of the current review period is 33%. According to the Clinical Administrator and the Mall Director, MSH has identified senior nursing clinicians from each unit to train unit nursing staff to address this recommendation. MSH intends to continue the training until all staff involved in the WRPTs are trained. This monitor reviewed 11 charts (CG, DSH, JC, JD, JT, KLF, MC, PD, RP, SCC and SHC). The objectives in seven of the WRPs in the charts (CG, DSH, JD, JT, RP, SCC and SHC) were directly linked to a relevant focus of hospitalization. This was not the case in the remaining four WRPs (JC, KLF, MC and PD).

		Current recommendation: Ensure that each objective is directly linked to a relevant focus of hospitalization.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** MSH did not submit data for this recommendation. According to the Clinical Administrator and the Treatment Enhancement Coordinator, MSH continues to train mentors on educating/training WRPT members on writing objectives in behavioral, observable and/or measurable terms. This monitor reviewed 12 charts (CG, DSH, JC, JD, JEM, JT, MC, PD, RP, SCC, SHC and VA). The objectives in four of the WPRs in the charts (JC, JT, PD and SHC) were written in behavioral, observable and/or measurable terms. One or more of the objectives in the remaining eight WRPs (CG, DSH, JD, JEM, MC, RP, SCC and VA) were not written in behavioral, or in an observable and/or measurable terms. **Recommendation 2, March 2008:** Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. **Findings:** According to the Treatment Enhancement Coordinator and the Mall Director, MSH is collaborating with ASH's Psychology Assessment section leader to develop a set of variables derived from the

		Integrated Assessments: Psychology Section, create a database, and provide them to the PSR services, in their words "to help tailor therapy and rehabilitation services." In addition, MSH has dissolved its Program Curriculum Committees and replaced it with one hospital-wide Curriculum Committee in order to standardize the curriculums. According to the Chair of this new committee, Ashvind Singh, the committee comprises experts from the fields of Education, Educational Assessment and Data Management, Curricula Development, School Psychology and Cognitive Disabilities. To date, the committee has developed nine curriculums. This monitor reviewed three of the nine curriculums (Substance Abuse, Nursing, and the ACT). These were well-developed curriculums which when implemented properly should lead to the expected outcomes. Using item #4 (*Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan*) from the DMH WRP Mall Alignment Form, MSH analyzed its compliance based on an average sample of 13 charts each month (February to July 2008), reporting a mean compliance rate of 59% (the mean compliance rate for the previous review period was 35%). The compliance rate for the last month of the previous review period was 39% and the compliance rate for the last month of this review period is 63%. This monitor reviewed 10 charts (CG, DSH, JD, JEM, JT, MC, PD, RP, SCC and VA). The therapies and rehabilitation services provided in the Malls and the individual's assessed needs were aligned in five of the WRPs in the charts (CG, DSH, JD, PD and SCC). The services provided in the remaining five WRPs (JEM, JT, MC, RP and VA) were not aligned with the individual's needs. In a number of cases, the individual's life goals did not have a focus and interventions and/or the services were not provided at the individual's cognitive level.

		Current recommendations: 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these. **Findings:** Using item #5 (*Utilizes the individual's strengths, preferences, and interests*) from the DMH WRP Mall Alignment Form, MSH analyzed its compliance based on an average sample of 13 charts each month (February to July 2008), reporting a mean compliance rate of 29% (the mean compliance rate for the previous review period was 33%). The compliance rate for the last month of the previous review period was 44% and the compliance rate for the last month of the current review period is 42%. This monitor reviewed 18 charts (CG, CRT, DSH, GMH, JC, JD, JEM, JND, JT, KLF, MC, PD, RP, SCC, SHC, TLF, VA and VLG). Appropriate strengths were stated in seven of the WRPs in the charts (CG, DSH, GMH, JEM, RP, TLF and VA), while one or more of the interventions in the remaining 11 WRPs (CRT, JC, JD, JND, JT, KLF, MC, PD, SCC, SHC and VLG) either did not include any strengths or the stated strengths were not appropriate. For example, the commonly stated "desire for discharge" or "desire to leave the hospital" are not motivating factors that facilitators can use to structure lesson plans or modify

		presentation methods to maximize individuals' learning. This monitor noted a trend in several WRPs where strengths were stated as complements to the associated activity. For example, when recommending a garden group the strength is stated as the individual's "strength in gardening" or when recommending a walking group the strength is stated as "strength of motivated [sic] to use walking for leisure." This monitor could not identify any source for the stated strengths after reviewing several documents (IAP Psychology, IAP Social Work, Strengths Survey, and the Present Status sections in the individuals' WRPs). **Current recommendation**: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. **Findings:** This monitor's interview of the Clinical Administrator and the WRP trainer found that MSH has conducted WRP training (April, May, and July 2008) on matters relating to case formulation with the WRPT members. However, MSH did not have any data for review on this recommendation. The Court Monitor's evaluation team observed nine WRPCs during this tour (BM, DC, ES, FO, JRB, RG, SW, TP and YB). In all cases, the monitors found that the core team members presented their findings

		relative to their areas of practice. However, in a number of cases the findings were not thoroughly discussed. Furthermore, documentation in these WRPs generally did not reflect the interdisciplinary functioning of the WRPTs. **Recommendations 2 and 3, March 2008:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. **Findings:** This monitor's interview of the WRP trainer revealed that MSH had included in its WRP training (April, May, and July, 2008) information on writing the individual's vulnerabilities in the case formulation of the individual's WRP. This monitor reviewed nine charts (CRT, GMH, JEM, JND, KLF, PD, TLF, VA and VLG). The individual's vulnerabilities were documented in the case formulation section in five of the WRPs in the charts (GMH, JND, TLF, VA and VLG) and where appropriate the vulnerabilities were updated in the subsequent WRPs. Such was not the case for the remaining four WRPs (CRT, JEM, KLF and PD). **Recommendations 4 and 5, March 2008:** • Use the staged model of substance abuse training for group facilitators. • Use the staged model of substance abuse manual for delivering rehabilitation services to individuals with substance abuse issues. **Findings:** This monitor's interview of the Mall Director and the Treatment Enhancement Coordinator, and review of the training documentation,

indicated that facilitators are trained using the staged model of substance abuse from the training manual.

Recommendation 6, March 2008:
Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

Findings:
This monitor's review of the Mall Course Catalog and interview of the Mall Director found that the number of WRAP groups offered this Mall term increased from the number of WRAP groups offered from the previous Mall terms. The table below showing the Mall terms and the number of WRAP groups per Mall term is a summary of the facility's data:

Number of WRAP Groups Offered for Each Mall Term			
Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Jul- Sep 2008
13	11	38	40

As seen in the table above, MSH has continued to increase the number of WRAP groups. According to the Mall Director, MSH intends to continue to increase the number of WRAP groups until all individuals have the opportunity to participate in the group.

Current recommendations:
1. Continue to undertake the clinical case formulation as a team rather than by assigning the task to a team member or to non-team members, and ensure that the documentation in the Present Status 6section reflects the practice.
2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
3. Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities.

		4. Continue to train the substance abuse facilitators using the stage model from the training manual. 5. Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. • Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** Using item #7 (*Is provided in a manner consistent with each individual's cognitive strengths and limitations)* from the DMH WRP Mall Alignment Form, MSH analyzed its compliance based on an average sample of 13 charts for the month (February to July 2008), reporting a mean compliance rate of 26% compared to 37% in the previous review period. The compliance rate for the last month of the previous review period was 40% and the compliance rate for the last month of the current review period is 30%. This monitor's interview of the Mall Director, the Chief of Psychology, and review of Integrated Assessments: Psychology Section found that MSH continues to assess individuals' cognitive levels at multiple junctures including testing conducted during the Integrated Assessments, focused assessments, and DCAT assessments. According to the Mall Director, an Excel Spreadsheet containing cognitive levels of all individuals was distributed to all Mall Coordinators and Program Directors. Furthermore, MSH is developing curricula for different

		cognitive levels, and the DCAT team is using the CAPTAIN's Log computer-based cognitive remediation program with low-functioning individuals. This monitor observed 10 Mall groups (Reality Orientation, Mind Over Mood, Legal Issues-Court Preparation, Social Skills, Substance Recovery, ESL, Healthy Lifestyle, Motivational Group, DBT Skills Introduction, and Recovery Games). Participants in most of the groups were heterogeneous in their cognitive levels. Many groups had "stand in" staff and they were not providing any meaningful facilitation, and this monitor was unable to assess if the individuals' cognitive levels were addressed. In the few groups with active facilitation, the facilitators modified their language suitable to the individual they addressed. The language in the handouts was suitable for individuals with average cognitive levels. **Current recommendations**: 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner.

- Use the data from monthly Mall Progress Notes in the WRP review process.

Findings:
This monitor's review of charts and interview of the Mall Director and the Treatment Enhancement Coordinator found that MSH has refined its Monthly Mall Progress Note tracking for compliance. The table below showing the required number of progress notes for 20% of the individuals in each program (N), the number of progress notes received by the WRPTs in each program (n), and the percentage of compliance (%C), reporting mean compliance of 39% is a summary of the facility's data:

	P1	P2	P3	P5	P6	Mean
N	320	287	392	395	226	
n	30	163	118	249	80	
%C	9	57	30	63	35	39

According to the Mall Director, failure by the last Mall hour staff to complete the notes f was one of the reasons for the low compliance. MSH has entrusted its Program Managers to bring the writing of the Mall Progress Notes into compliance.

According to the Treatment Enhancement Coordinator, the Mall Progress Note system is yet to be fully automated. The completion of MAPPI, due in April 2009, is expected to enable full automation of the Mall Progress Note system.

This monitor reviewed eight charts (CG, DSH, JD, JT, MC, RP, SCC and SHC). Two of the charts (CG and MC) did not have any progress notes or had very few notes. The remaining six charts (DSH, JD, JT, RP, SCC and SHC) had most of the required progress notes, of which only three showed evidence that the progress notes had been reviewed during the

		WRP review process. **Other findings:** This monitor reviewed the records of 31 individuals (AAA, ARB, BF, CDJ, CRO, DLG, FG, GB, GB-2, IR, JAS, JOR, JR, KB, LM, LMC, LMH, MAF, MEB, MJM, NM, PHS, PS, RAP, SG, SL, SM, SMN, TAN, TP and YFH) receiving Rehabilitation Therapy Services (including Rehabilitation Therapist facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with C.2.i.vii. Three records were in compliance (ARB, CDJ and TP) and 28 records were not in compliance (AAA, BF, CRO, DLG, FG, GB, GB-2, IR, JAS, JOR, JR, KB, LM, LMC, LMH, MAF, MEB, MJM, NM, PHS, PS, RAP, SG, SL, SM, SMN, TAN and YFH). **Current recommendations**: 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
C.2.i.viii	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Provide PSR Mall groups as required by the EP, 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.

		Findings: This monitor's documentation review (charts, Mall Progress Notes, and Mall schedules) observation of Mall groups and interview of the Mall Director found that beginning in April 2008, MSH offers Mall sessions as outlined in the EP. MSH's Mall operation hours include 9.30AM to 10.20AM and 10.40AM-11.30AM; and 3.25PM-4.15PM and 4.25PM-5.15PM during the weekdays (M-F). This monitor's interview of Mall staff and observation of Mall groups revealed that the last hour Mall groups usually were not conducted by the regular facilitators because clinical staff left the facility early, leaving nursing and other disciplines to carry the load. Such was the case with a number of groups observed by this monitor where the groups were cared for by "stand-in" staff. **Recommendations 2 and 3, March 2008:** • Provide groups as needed by the individuals and written in the individuals' WRPs. • Add new groups as the needs are identified in new/revised WRPs. **Findings:** This monitor's documentation review (new group request data) and interview of the Mall Director found that MSH had four requests for new groups during this review and the requests were addressed through new Mall groups/individual therapy. This monitor's interview of members of the Curriculum Committee, the Mall Director, and the Treatment Enhancement Coordinator found that MSH has established a committee of experts from various disciplines to write Mall curricula. The curricula written by this committee were more specific and aligned with the individual's cognitive level and stage of change. To date, the Curriculum Committee has completed nine curriculums utilizing the CASAS assessment instrument. The CASAS provides information on functional and life skills the U.S. Department of Labor and Education identified as essential for individuals to be

		employable and independent. The Social Work department might benefit from reviewing the CASAS data to identify the skills and supports individuals possessed, lacked, or needed for transition to the Community. **Current recommendations**: 1. Continue the current practice of providing Mall services for 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; 2. Provide groups as needed by the individuals and written in the individuals' WRPs. 3. Add new groups as the needs are identified in new/revised WRPs.
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's documentation review (charts, progress notes, activity calendars), visit to the SNF units, and interview of the unit staff found that MSH continues to provide Mall services to bed-bound individuals, though the schedules and routines were unstructured and did not meet the required hours of service. The table below giving the initials of the bed-bound individuals in each program, the number of hours scheduled and participated by each individual per month, and the mean hours of compliance participated by each individual for this review period is a summary of the facility's data:

<table>
<tr>
<td></td>
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<td>
<table>
<tr><th colspan="8">Monthly Hours of Active Treatment Scheduled/Delivered</th></tr>
<tr><th>Individual (Program)</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Mean</th></tr>
<tr><td>DC (P6)</td><td>86/41</td><td>83/38</td><td>73/28</td><td>89/34</td><td>80/34</td><td>68/35</td><td>80/35</td></tr>
<tr><td>DE (P6)</td><td>83/55</td><td>80/59</td><td>77/47</td><td>76/55</td><td>68/45</td><td>66/36</td><td>75/49</td></tr>
<tr><td>EL (P6)</td><td>89/43</td><td>85/44</td><td>75/44</td><td>83/40</td><td>83/40</td><td>77/24</td><td>82/39</td></tr>
<tr><td>JP (P6)</td><td></td><td></td><td></td><td>Ex'pd</td><td></td><td></td><td></td></tr>
<tr><td>LB (P6)</td><td>86/39</td><td>82/41</td><td>77/41</td><td>86/35</td><td>86/35</td><td>76/31</td><td>82/37</td></tr>
</table>

The table above shows that the total hours of Mall services delivered to bed-bound individuals was low. The failure to follow a schedule could be the reason for the low delivery of services.

This monitor observed four bed-bound individuals (BP, DE, HS and JP). One individual (DE) was awake and alert to speak with this monitor. According to DE, he received attention and services including range of motion exercises, priest visits, and videos. DE was happy with the services. A roster of activities and staff responsible for delivering the activities was posted on the wall by the individual's bed. This unit staff informed this monitor that when possible, individuals were transported to groups during Mall hours.

Current recommendation:
Continue current practice.
</td>
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<tr>
<td>C.2.i.x</td>
<td>routinely takes place as scheduled;</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, March 2008:
• Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
• Ensure that Mall groups and individual therapies are cancelled
</td>
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</table>

		rarely, if ever. **Findings:** This monitor's interview of the Mall Director and the Treatment Enhancement Coordinator revealed that MSH's Mall group scheduled versus cancelled data showed a 2% cancellation rate for this review period. However, MSH's audit revealed that the data is not accurate. The mean percentage of group cancellation is expected to be much higher than 2%. MSH has identified a number of factors contributing towards the inaccuracy (inconsistent reporting of cancellations, lack of uniformity in the definition of cancellation, and inaccurate coding on Mall rosters). MSH is working to clarify the situation with the providers and to correct the errors. This monitor's observation of Mall groups (Reality Orientation, Mind Over Mood, Legal Issues-Court Preparation, Social Skills, Substance Recovery, ESL, Healthy Lifestyle, Motivational Group, Sports and Fitness, DBT Skills Introduction, and Recovery Games) found some of the same errors identified by MSH. Groups were combined, facilitators and co-facilitators were absent, and groups were not conducted for the scheduled 50 minutes. Many of the groups were large. The participants in a number of the groups were heterogeneous, indicating that the groups were not provided in line with the individuals' cognitive and functional status. **Recommendation 3, March 2008:** Ensure that all disciplines facilitate a specified minimum number of hours of mall groups. **Findings:** This monitor's interview of the Mall Director and review of MSH's progress report found that most disciplines were not providing the expected hours of Mall services. However, there has been an increase

in the hours of services delivered for most of the disciplines in this review period in comparison with the previous review period. Most disciplines' hours of service for the last month of this review period also increased compared to the last month of the previous period.

The table below showing the disciplines and the hours per week they are expected to deliver, the actual hours of services per week delivered for the month, and the mean hours of service delivered by each discipline is a summary of the facility's data.

Weekly Provided Hours by Discipline							
	Feb	Mar	Apr	May	Jun	Jul	Mean
Psychiatry ACUTE (4)	0.7	1.1	2.6	3.8	4.6	2.1	2.5
Psychiatry L-T (8)	2.6	2.8	3.6	4.3	4.0	3.7	3.5
Psychology ACUTE (5)	6.2	6.0	4.5	5.1	4.4	4.1	5.1
Psychology L-T (10)	7.2	7.4	7.7	9.6	8.8	8.4	8.2
Social Work ACUTE (5)	3.5	5.9	5.2	5.1	5.8	4.3	5.0
Social Work L-T (10)	6.1	7.3	7.2	8.8	8.1	7.9	7.6
Rehab Therapy ACUTE (7)	10.0	9.0	5.4	6.6	6.3	6.4	7.3
Rehab Therapy L-T (15)	10.9	11.3	10.4	11.6	10.1	11.9	11.0
Nursing (10)	1.2	1.5	1.2	1.6	1.6	1.5	1.4

L-T = Long-Term

As the table above shows, three disciplines serving the acute care sections (Psychology, Social Work, and Rehabilitation Therapy) met their expected mean hours of service.

Recommendation 4, March 2008:
Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:
This monitor's review of MSH's progress report and interview with the Mall Director and the Treatment Enhancement Coordinator found that

		MSH's support and administrative staffing increased from 165 from the previous period to 183 for this review period. The administrative and supportive staff provided an average of 1.9 hours of service per week, which exceeds the expected hours from these staff. However, their mean hours of service for this review period decreased from the mean of 2.2 hours of service provided in the previous review period. **Current recommendations**: 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. **Findings:** This monitor's interview of the Mall Director revealed that MSH has trained additional data entry personnel and conducted a review of all weekend and evening group activities. Using the Enrichment Facilitator Consultation form, MSH evaluated if there was interruption to the

		activities offered, if the individuals were reinforced to participate regularly in these activities, and if there were competing activities as barriers for individual participation. The results of the evaluation showed a compliance rate of 82%, except for the question on interruption, which returned a mean compliance of 67%. Conducting more than one activity simultaneously and meal and shower times interfere with the scheduled activities. MSH should continue to address these barriers. This monitor reviewed MSH's supplementary/enrichment activity audit data. MSH had scheduled an average of 24 hours of activities (range 10-28.5 hours) per month, with a mean of 13 hours of activities provided per month (range 2.2 – 33.3 hours). The average hours of supplementary/enrichment activities scheduled for this review period remained the same as that scheduled during the previous review period; on the other hand the average hours of activities provided for this review period had increased by an average of four hours per month from that provided during the previous period. The data also showed that mean individual attendance at these activities was 56%. MSH should increase the hours of activities provided and find ways to increase individuals' participation (for example through encouragement, motivation, removing barriers, assisting them to choose meaningful activities to improve their quality of life). **Current recommendations**: 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** This monitor's interview of the Mall Director revealed that MSH continued with staff training (May 2008) to address this recommendation. This monitor reviewed 19 charts (CG, CRT, DSH, GMH, JA, JC, JD, JEM, JND, JT, KLF, MC, PD, RP, SCC, SHC, TLF, VA and VLG). Therapeutic milieu interventions were specified in eight of the WRPs in the charts (CG, CRT, GMH, JEM, JND, PD, TLF and VA). Milieu interventions were missing or were not appropriately matched with the objective in 11 of them (DSH, JA, JC, JD, JT, KLF, MC, RP, SCC, SHC and VLG). **Recommendation 2, March 2008:** Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings. **Findings:** Using item #12 (*Staff are observed discussing Mall activities with individuals*) from the Therapeutic Milieu Observation Monitoring Form, MSH analyzed its compliance based on 50 thirty- minute observations carried out across the 15 units in the facility between February and July 2008, reporting a mean compliance rate of 15%. The compliance rate for the last month of the previous review was 55% and the compliance rate for the last month of the current review period is 0%.

		The Mall Director attributes the low compliance rate to the possibility of the time and duration of the observation. MSH plans to have Master Trainers, mentors, and discipline chiefs to identify and remedy the low compliance, in addition to additional training. **Current recommendations**: 1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff know what the individuals are learning in the malls and individual therapies and reinforce their learning in all settings.
C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low. **Findings:** This monitor's interview of the Mall Director and the Training Enhancement Coordinator found that MSH has directed WRPTs to schedule all individuals with Focus 10 (exercise and recreational group interventions). This monitor reviewed 11 charts (CG, DSH, JA, JC, JP, JT, MC, PD, RP, SCC and SHC). All 11 WRPs in the charts had opened a focus 10 with associated objectives and interventions related to exercise and recreational activities. MSH's data as shown in the table below noting the BMI categories, the number of individuals in each BMI category, and the number of individuals assigned to exercise groups with their corresponding percent compliance is a summary of the facility's data:

BMI Level	# Individuals	# in Exercise Groups	%C
25 - 30	152	90	59.6
31 - 35	82	48	58.7
36 - 40	34	21	62.7
>40	22	14	63.7

As the table below shows, MSH offered sufficient numbers of exercise groups for participation by individuals with high BMIs or health risks due to their weight (the table below shows that the number of groups offered exceeded the number of groups needed). However, as seen in the table above, nearly 40% of individuals with high BMIs were not enrolled in any exercise group. MSH should ensure that all individuals with high BMIs and attendant co-morbid conditions be enrolled in exercise groups.

	Jul
# of exercise groups needed per week	32
# groups offered @1x per week	120

According to the Mall Director, WRPT mentors have been trained so that they can ensure that WRPTs enroll all individuals in recreational and exercise groups.

Compliance:
Partial.

Current recommendations:
1. Track and review participation of individuals in scheduled group exercise and recreational activities.
2. Implement corrective action if participation is low.

C.2.k	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment. **Findings:** This monitor's interview of the Chief of Social Work and documentation review found that MSH conducted needs assessment only for Program II. MSH had continued to provide individuals with information and families with education and support through various activities including providing the "Family and Friends Education and Support Group" on a monthly basis for families and on a weekly basis within the facility. In addition, MSH has created and posted on the intranet a "County Resource Guide" that captures about 85% of the population in the facility. **Compliance:** Partial. **Current recommendation**: Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment.
C.2.l	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH has implemented a nursing mentoring program in May 2008 to

	monitor such symptoms, consistent with generally accepted professional standards of care.	increase compliance with this requirement. MSH has included this area in the WRP training for new hires and existing staff. MSH used the DMH Integration of Medical Conditions into WRP audit beginning in February 2008 based on an average sample of 16% of individuals with at least one diagnosis listed on Axis III that have a WRP due each month (February-July 2008). The following table summarizes MSH's data: 1. *All medical conditions listed in Axis III are included on the Medical Conditions Form.* 55% 2. *The WRP includes each medical condition listed on the Medical Conditions Form 42.* 39% 3. *There is an appropriate focus statement for each medical condition or diagnosis.* 43% 4. *There is an appropriate objective for each medical condition or diagnosis.* 17% 5. *There are appropriate interventions for each objective.* 9% MSH's progress report indicated that the WRPTs have difficulty creating alignment between the medical condition problems, the objectives and the interventions. The above-mentioned mentoring and training was cited as the plan of correction addressing the low compliance with this requirement. A review of the WRPs of 40 individuals (AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH) found that there has been basically no improvement in this area during the last two reviews. Problematic areas include Axis III diagnoses not addressed in the WRPs and inadequate and inappropriate nursing interventions. As

		mentioned in the previous report, information contained in the nursing assessments was usually not included in the WRPs. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	Not applicable. MSH does not serve children or adolescents.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in C.2.o. **Findings:** Same as in C.2.o. **Compliance:** Partial.

		Current recommendations: Same as in C.2.o.
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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Implement process and clinical outcome measures regarding substance recovery services, including pre- and post-testing of individuals. **Findings:** MSH has begun implementation of the process outcome measures that were listed in the previous monitor's report (see next recommendation). The facility has yet to implement the clinical outcome measures that were proposed in the previous report. **Recommendation 2, March 2008:** Provide outcome data regarding substance recovery services. **Findings:** MSH began to gather process outcome data. The facility presented the following outcomes for this review period: 1. The mean number of individuals screened for substance abuse per month was 50 compared to 40 during the last review. 2. Approximately 70% of individuals who have been screened for substance abuse received a substance abuse assessment (no comparative data was available). 3. All individuals with substance abuse diagnosis who have an open focus regarding substance abuse have at least one objective and one intervention and the stage of change identified. This measure was based on a 31% sample. 4. Since the last review, 55 substance recovery providers received training in the substance recovery curriculum with an average

		competency rate of 88%. 5. MSH has provided 30 substance recovery groups during the Mall summer semester 2008 compared to 22 groups during the winter semester. MSH has yet to provide clinical outcome data. **Recommendation 3, March 2008:** Provide results of competency-based training of SR providers. **Findings:** MSH has assessed that a minimum of 60 trained and certified SR providers are needed across the facility to provide sufficient SR groups. Reportedly, the facility currently has 105 trained and certified providers. The facility has plans to develop approved curricula and lesson plans, then train and certify SR group providers. **Recommendations 4 and 5, March 2008:** • Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period). **Findings:** MSH used the DMH Substance Abuse Audit Form to assess compliance (January to May 2008). The average sample was 12% of all individuals with a current diagnosis of substance abuse as listed in WRP or Integrated Psychiatric Assessment or, if admitted before January 2007, the last monthly Psychiatric Progress Note. The following is a summary of the data:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	69%
2.	*There is an appropriate focus statement listed under Focus #5.*	95%
3.	*There is at least one objective related to the individual's stage of change.*	93%
4.	*There are interventions that are appropriately linked to the active objective(s).*	92%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule.*	93%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	36%

MSH reported that the WRPTs did not consistently individualize the discharge criteria, especially in terms of making them behavioral, observable and /or measurable. After analysis, MSH recognized that the data presented in this table were unusually positive. The facility is undertaking efforts to improve reliability as the current data were collected by one auditor.

Other findings:
In collaboration with PSH, MSH developed a Substance Abuse Treatment Program Plan of Improvement. This plan included the following areas:

1. Initial screening upon admission to the facility;
2. Second screening for individuals with positive history, including measures of stage of change;
3. Collateral skills assessment to identify areas of need other than psychiatric and psychological deficits to facilitate recovery;

		4. Assignment of individuals to substance abuse treatment tracks; 5. The application of the principles of Contingency Management to substance abuse treatment (i.e. systematic application of positive reinforcement to increased abstinence); 6. Tracking of process and clinical outcomes; 7. Staff training issues. This plan is well-aligned with current generally accepted standards. **Other findings:** This monitor reviewed the charts of six individuals who were diagnosed with substance use disorders. The review found compliance in two charts (DAC and SDE) and partial compliance in four (AM, CRT, LK and RS). The main deficiency involved the proper linkage of the stages of change to the objectives/interventions. **Compliance:** Partial. **Current recommendations**: 1. Implement the Substance Abuse Treatment Program Plan of Improvement in all four facilities. 2. Provide process and clinical outcome data regarding substance recovery services, including comparative data when these data are available. 3. Provide results of competency-based training of SR providers. 4. Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample. 5. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).

C.2.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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured. **Findings:** This monitor's interview of the Mall Director and documentation review found that MSH only assessed the competency of one discipline, Rehabilitation Therapy, using the Mall Facilitator Monitoring Audit Form. The table below showing the number of facilitators for the month (N), the number of facilitators observed for the month (n), and the percent compliance obtained (%C), reporting mean compliance of 86% is a summary of the facility's data.

	Feb	Mar	Apr	May	Jun	Jul	Mean
N	627	630	622	644	646	643	
n	5	12	9	8	10	19	
%S	1	2	1	1	2	3	
%C	86	90	78	92	75	90	86

The mean compliance rate for the previous review period was 84% and mean compliance for this review period is 86%.

According to the Mall Director, the small sample size of the facilitator audit was due the lack of monitors to conduct the audits. MSH plans to increase the sample size by having the senior staff from each discipline audit the facilitators' representing their discipline.

This monitor observed a number of Mall groups (Reality Orientation,

		Mind Over Mood, Legal Issues-Court Preparation, Social Skills, Substance Recovery, ESL, Healthy Lifestyle, Motivational Group, Sports and Fitness, DBT Skills Introduction, and Recovery Games). More than half these groups did not have their regular facilitators and the "stand-in" staff was not providing any facilitation (in some cases the television was turned on for the individuals to watch). The groups that had their regular facilitators were well-organized with active teaching and learning taking place (for example the Legal Issues-Court Preparation group, the Recovery Games group, and the Healthy Life-style groups). The facilitators in these groups had lesson plans, engaged the individuals, managed the group dynamics, and used a variety of methods to present the material. **Compliance:** Partial. **Current recommendation**: Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum. **Findings:** This monitor's interview of the Mall Director and documentation review (substance abuse training and MSH's progress report) found that MSH had 51 Substance Abuse Recovery group providers. Thirty-two of the 51 providers (63%) were trained and certified and the remaining 19

		(37%) were not. MSH intends to train the remaining Substance Abuse Recovery group providers to ensure that all Substance Abuse Recovery group providers have received the training. **Recommendation 2, March 2008:** Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. **Findings:** This monitor's documentation review and interview of the Mall Treatment Enhancement Coordinator found that MSH uses a score of 80 on the Substance Abuse Recovery Provider Training Post-Test as the cut-off score for competency. According to the Treatment Enhancement Coordinator, MSH is working with PSH to develop a new Substance Abuse Recovery Provider training, setting the competency criteria as the successful completion of the 40-hour training curriculum. **Recommendation 3, March 2008:** Ensure that training includes all of the five stages of change. **Findings:** This monitor's documentation review (training plan, attendance roster, and curriculum) and interview with the Treatment Enhancement Coordinator found that MSH provides Substance Recovery Training in all five stages of change. **Recommendation 4, March 2008:** Implement the review system and show data derived from the remedial training.

		Findings: This monitor's interview with the Mall Director and the Treatment Enhancement Coordinator revealed that MSH is working on a new review system. In the previous review, MSH planned on auditing a 20% sample per month. According to the Treatment Enhancement Coordinator, the new system will involve audit of 100% of the sample whose data is to be analyzed monthly for feedback and corrective action. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Implement the review system and show data derived from the remedial training.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Review reasons for cancellations and assess and correct factors contributing to such events. **Findings:** This monitor's interview of the Treatment Enhancement Coordinator revealed that MSH tracks missed appointments on a daily basis through the entry of missed appointments in a database that is posted on the MSH intranet. Using the database, WRPTs identify individuals who missed three or more scheduled appointments, address this with the

individual and document the discussion in the Present Status section, and where appropriate develop an intervention to assist the individual in keeping his/her scheduled appointment.

The table below showing the month, the number of scheduled appointments and cancelled medical appointments, and the reasons for cancellations is a summary of the facility's data:

Missed Appointments Monitoring – Medical Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
Feb	1388	209	15 staffing 0 transportation 194 other
Mar	1521	263	19 staffing 0 transportation 244 other
Apr	1731	403	20 staffing 0 transportation 383 other
May	1545	270	6 staffing 0 transportation 264 other
June	1659	347	5 staffing 0 transportation 342 other
July	1693	427	10 staffing 0 transportation 417 other

As shown in the table above, cancellations range between 15% and 24% per month. The identified reasons for the cancellations showed that transportation was not a barrier to keeping scheduled appointments.

		Staffing was one of the reasons for a small number of cancellations. However, refusals continue to remain high. MSH should review and reduce refusals and where indicated provide interventions to improve the individual's willingness to keep scheduled appointments. **Recommendation 2, March 2008:** Complete and implement the Medical Scheduler. **Findings:** This monitor's interview with the Treatment Enhancement Coordinator revealed that MSH's Medical Scheduler is yet to be completed. According to the Treatment Enhancement Coordinator, DMH is setting up a similar system across the DMH facilities. **Compliance:** Partial. **Current recommendations**: 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler.
C.2.s	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. **Findings:** This monitor's interview of the Treatment Enhancement Coordinator, the Curriculum Committee Chair, the Chief of Social Work, and the Chief of Psychology revealed that evaluations of an individual's cognitive levels, needs, and strengths are conducted during the

		Psychology and Social Work Integrated Assessments, DCAT assessments, and the Focused Neuropsychology and Psychology Assessments. Results of these assessments are made available to the WRPTs. The WRPTs use this information to match against the PSR Mall Course Catalog to assign individuals to their PSR Mall groups and therapy services. According to the Mall Director, MSH had increased the number of sessions for several core groups (Medication Education, Substance Recovery, WRAP, Social Skills, Anger Management, and Recovery Education) whose lesson plans were developed for various cognitive levels. This monitor reviewed eight charts (GMH, JEM, JND, KLF, PD, TLF, VA and VLG). Only four of the WRPs in the charts (GMH, JEM, TLF and VLG) had identified individual's strengths for use by the facilitator to achieve the discharge goals. In addition, a number of groups observed by this monitor had substitute staff who did not know the strengths of the individuals attending the group, and these substitute staff were not actively facilitating. Besides, a number of these groups had large numbers of individuals in attendance (in one case the large number of individuals was due to the combining of two groups), which would make it difficult for the facilitators to provide individual attention. **Recommendation 2, March 2008:** Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. **Findings:** This monitor's documentation review and interview of the Mall Director found that MSH conducted facilitator training (February, March, April, May, and July, 2008) attended by 246 providers and co-providers. The table below showing the number of staff trained per month (from February to July 2008) and the mean competency achieved (%C) is a

summary of the facility's data:

Basic Group Leadership Training for group facilitators							
	Feb	Mar	Apr	May	Jun	Jul	Mean
Number of staff trained	87	20	62	16	-	61	
% competency	90	89	94	86	-	83	88

MSH has a Curriculum Committee that is developing core curricula that address cognitive levels and individuals' stages of change. In addition, the Curriculum Committee is using the CASAS assessment. The results of the assessment should guide WRPTs to develop goals, strengths, and support and skill needs of the individual. The other facilities may want to review this assessment procedure for use in their own systems.

The primary facilitators in the groups observed by this monitor evidenced a good command of their course content, were well prepared, and were active in their facilitation. Such was not the case in a number of Mall groups led by substitute staff. No formal teaching and learning took place in many of the groups led by the substitute staff.

Recommendation 3, March 2008:
Develop and implement monitoring systems that address all of the required elements.

Findings:
Using item 10 from the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 12% of the WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

10.	*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.*	
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.*	85%
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	94%
10.c	*All interventions are offered at the cognitive functioning level of the individual*	88%

This monitor's review of the above data with the Mall Director and the Treatment Enhancement Coordinator revealed that the high compliance rate shown might not be valid. MSH plans to review and correct the auditing methodology to ensure that future audits provide valid data.

This monitor reviewed 10 charts (CG, DSH, JC, JD, JT, MC, PD, RP, SCC and SHC). Five of the WRPs in the charts (CG, DSH, JC, PD and SHC) had proper case formulations with interventions and Mall groups that were aligned with the individual's needs. The remaining five WRPs in the charts (JD, JT, MC, RP and SCC) had one or more elements that were unsatisfactory.

		Compliance: Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements.
C.2.t	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;	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** This monitor's interview of the Mall Director and the Treatment Enhancement Coordinator and documentation review (charts, progress notes, auditing tools and progress reports) found that MSH uses Mall Progress notes, WRPT findings and observations to address these recommendations. Using item 11 from the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 12% of the WRP's due for the month (February to July 2008). The table below

with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

11.	*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)*	
11.a	*Each objective is observable, measurable and behavioral.*	43%
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.*	85%
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.*	58%
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	28%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	47%

According to the Clinical Administrator, the plan of improvement includes further training, mentoring, and monitoring with feedback to address the elements in this recommendation.

This monitor reviewed 12 charts (CG, DSH, FM, JA, JC, JD, JT, MC, PD, RP, SCC and SHC). The groups and individual therapies in six of the WRPs in the charts (DSH, FM, JA, JC, JT and PD) were linked directly to the foci, objective, and the interventions specified in the WRP. Only

		five of the WRPs (DSH, FM, JD, PD and SHC) had most of the required Monthly Mall Progress Notes for each active treatment in the individual's WRP, and only three of the WRPs (CG, JD and SHC) had revised the objectives and interventions based on the individual's progress or lack thereof. **Compliance:** Partial. **Current recommendations**: 1. Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. 3. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.
C.2.u	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Increase the number of Mall groups that are provided to address this requirement, based on needs assessment. • Provide an analysis of low compliance and implement corrective action. **Findings:** MSH has implemented this recommendation based on a needs assessment (March 2008). The following table illustrates an increase in the number of these groups (April to September 2008 compared to October 2007 to March 2008):

Number of the Recovery Education groups (with hours) offered during the current and previous three Mall terms			
Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008
23	25 (26 hrs)	40 (64 hrs)	36 (58 hrs)

Recommendation 3, March 2008:

- Provide data to identify number of groups and discipline of providers.
- Continue to monitor implementation of this requirement and ensure at least a 20% sample size.

Findings:

MSH reported that it provides a total of 55 hours of this education at this time. The following is a breakdown of the hours provided by each discipline in all programs:

Discipline	Total hours
Nursing	20
Psychology	15
Social Work	10
Rehabilitation	6
Psychiatry	4
Administration	1

Compliance:

Partial.

Current recommendations:

1. Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment.
2. Provide data regarding providers of this education by discipline and

<table>
<tr><td></td><td></td><td>hours of education.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.v</td><td>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.</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, March 2008:
- Increase the number of Mall groups that are provided to address this requirement, based on needs assessment.
- Provide an analysis of low compliance and implement a plan of correction.

Findings:
MSH has implemented this recommendation. The facility has identified the number of groups needed and developed additional groups to meet this need. The following table illustrates an increase in the number of these groups (April to September, 2008 compared to October 2007 to March 2008):

<table>
<tr><td colspan="4">Number of Medication Management groups (with hours) offered during the current and previous three Mall terms</td></tr>
<tr><td>Oct-Dec 2007</td><td>Jan-Mar 2008</td><td>Apr-Jun 2008</td><td>Jul-Sep 2008</td></tr>
<tr><td>33</td><td>46 (64 hrs)</td><td>55 (91 hrs)</td><td>52 (87 hrs)</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Provide data regarding number of individuals in need for this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment.
2. Provide data regarding providers of this education by discipline and

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</table>

		hours of education. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Implement a system of trigger notifications and tracking of response by the WRPTs. **Findings:** The facility reports that this system has yet to be implemented due to problems with the database resulting in over-reporting of non-adherence occurrences. The facility has reportedly identified factors leading to inaccurate reporting and the database has been refined to begin providing accurate data starting in August 2008. The plan of implementation includes action to: 1. Retrain WRPT members concerning the need to develop alternative strategies when the trigger is met; 2. Ensure that trigger notifications are made to the WRPTs; 3. Track timely responses by the WRPTs to the notification; 4. Ensure system review of the process; and 5. Ensure that PSR Mall participation rosters are turned in on a timely basis **Recommendation 2, March 2008:** Continue training to the WRPTs to ensure implementation of: a) Appropriate individual therapy to individuals' non-adherence to WRP in the Key Indicator; and b) Clinical strategies to help individuals achieve readiness to engage in group activities.

		Findings: MSH presented information regarding this training. However, the information was insufficient to ensure proper implementation of this information (see Current Recommendation 3 below). **Compliance:** Partial. **Current recommendations**: 1. Implement a system of trigger notifications and tracking of response by the WRPTs. 2. Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. 3. Provide data regarding: a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.

D. Integrated Assessments		
D	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.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. MSH has made recent progress in the structure and quality of admission psychiatric assessments. 2. MSH has made some progress in the finalization of diagnoses that were initially listed as NOS and/or R/O, as clinically appropriate. 3. MSH has made some progress in the structure of the monthly psychiatric progress notes. **Summary of Progress on Psychological Assessments:** 1. MSH has achieved substantial compliance with most of the requirements in this section. 2. The timeliness and quality of the assessments have improved significantly. 3. MSH has completed the review of and re-assessment (where needed) of all individuals admitted before June 1, 2006. **Summary of Progress on Nursing Assessments:** 1. MSH has achieved substantial compliance regarding quality and timeliness of the initial Nursing Admission Assessment. 2. MSH's initiation of nursing mentors has positively impacted compliance rates. 3. MSH has integrated its auditing data into RNs' performance evaluations. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. Assessments and audit tools for the IA-RTS and focused assessments have been implemented. A D.4 Monitoring tool that aligns with Enhancement Plan requirements has been developed and implemented. 2. Mentoring for psychosocial Rehabilitation Therapists on an individualized basis based on audit results has been initiated and

		appears to meet generally accepted standards of practice. 3. Data analysis based on requisite audit samples for each area of D.4 has been initiated. However, this process needs to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. **Summary of Progress on Nutrition Assessments:** 1. A discrepancy was noted between the N provided in the facility audit data and the lists of individuals with assessments due for several D.5 assessment types. The facility reported that this was secondary to a data entry error. This appears to be a systemic error that should be corrected in order to ensure validity of the data. 2. Timeliness and quality of D.5 Nutrition assessments continue to improve. Identified areas in which the facility should work to improve compliance include: ensuring that Nutrition objectives are consistently specific, behavioral, observable and measurable; and ensuring that Nutrition recommendations are consistently aligned with goals and nutrition diagnoses. **Summary of Progress on Social History Assessments:** 1. MSH has shown overall improvement regarding most of the EP criteria. 2. MSH has improved the timeliness and the quality of the 5-Day Social History assessments. 3. MSH now consistently identifies and addresses the factual inconsistencies in the Social History assessments. **Summary of Progress on Court Assessments:** MSH has achieved substantial compliance on all EP requirements related to court assessments.

1. Psychiatric Assessments and Diagnoses		
	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,	**Methodology:** <u>Interviewed</u>: 1. Bala Gulasekaram, MD, Chief of Psychiatry 2. Michael Barsom, MD, Medical Director 3. Nady Hanna, MD, Medical Staff President <u>Reviewed</u>: 1. The charts of the following 45 individuals: ABR, AD, AR, CAS, CDF, CG, CPP, CRT, CT, DAC, DH, DLK, FM, FN, JAS, JCF, JM, JMI, JND, JR, JS, KCM, KDH, KS, LK, LL, MA, MAM, MDJB, MG, MRM, MVN, NSO, PS, PW, RG, RJA, RR, RS, RV, SDE, SM, SR, VAB and WH 2. MSH list of all individuals with their diagnoses and medication regimens 3. DMH template for the Admission Psychiatric Assessment 4. DMH Admission Assessment Instructions 5. DMH Admission Psychiatric Assessment Auditing Form 6. MSH Admission Psychiatric Assessment summary data (February to July 2008) 7. DMH Integrated Psychiatric Assessment Auditing Form 8. MSH Integrated Psychiatric Assessment Auditing summary data (February to July May 2008) 9. MSH Admission Medical Assessment Auditing Form 10. MSH Admission Medical Assessment Auditing summary data (February to July 2008) 11. DMH Monthly Physician Progress Note (PPN) Auditing Form 12. DMH Weekly PPN Auditing Form 13. MSH Weekly PPN Auditing summary data (May to July 2008) 14. MSH Monthly PPN Auditing summary data (February to July 2008) 15. DMH Physician Transfer Note Auditing Form 16. MSH Physician Transfer Note Auditing summary data (February to

		July 2008)
D.1.a	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, January 2008:** • Continue to monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance (February to July 2008). The average samples were 99% of admission assessments, 61% of integrated assessments and 16% of monthly notes on individuals who have been hospitalized for more than 90 days, respectively. The following is a summary of the data and the facility's analysis, as applicable. **Admission Assessment** 4.a — *Admission diagnoses Axis I-V are addressed* — 98% 4.b — *DSM-IV diagnosis consistent with history and presentation* — 93% The mean compliance rate for the main indicator has remained at 90% or higher since the last review period. **Integrated Assessment** 2.b — *Statements from the individual are included, if available.* — 93% 2.d — *Includes diagnosis and medications given at* — 47%

	previous facility are included	
7.	*Includes diagnostic formulation*	77%
8.	*Includes differential diagnosis*	56%
9.	*Includes current psychiatric diagnoses*	92%

The mean compliance rates for the above indicators have changed from the last review period to this review period as follows:

1. Item 2b: 75% to 93%;
2. Item 2d: 36% to 47%;
3. Item 7: 68% to 77%;
4. Item 8: 71% to 56%; and
5. Item 9: 90% to 92%.

The mean compliance rates have shown mixed changes (January 2008 vs. July 2008).

The facility reported that compliance regarding item 2.d has increased slightly but remained low because information from outside facilities was not always available at the time of admission to MSH. Since the last review, the facility has reportedly had a three-fold increase in the number of admissions from the jail, which has limited compliance in this area. In July 2008, Senior Psychiatrists/Monitors were instructed to score this area as NA if the MD indicated that information was not available upon admission. Corrective actions included efforts by the facility's Public Information Officer (PIO) to obtain complete information at the time of admission/transfer.

The facility attributed low compliance with items 7 and 8 to performance issues with select practitioners and reported corrective action plans through a Focused Physician Practice Evaluation process.

Item#	**Monthly PPN**	
3.b.1	*The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments*	96%
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	87%
3.b.3	*Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution*	85%

The mean compliance rate for the main indicator has increased from 79% for the prior review period to 94% for the current review period. MSH did not present comparative data regarding the sub-indicators (January vs. July 2008). The facility developed a system to remind the medical staff regarding the performance of a MMSE in a timely manner when indicated for individuals with cognitive impairments.

Other findings:
Chart reviews by this monitor found that the facility has made progress in correcting the deficiencies in the quality of information in the admission and integrated psychiatric assessments.

The DMH has finalized a new template for the admission psychiatric assessment that includes suicide and violence risk. The new template meets current generally accepted professional standards of care and proper implementation can significantly enhance compliance with EP requirements. MSH began implementation of this template in early July 2008. Random chart reviews by this monitor verified that implementation has been reasonably consistent.

		However, this monitor's findings regarding some deficiencies in the overall quality of the admission and integrated assessments and reassessments are listed in D.1.c.ii, D.1.c.iii and D.1.f. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. 2. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice and encourage all psychiatrists to obtain board certification. **Findings:** The facility has maintained current practice. All psychiatrists at the facility have successfully completed at least three years of psychiatry residency training in a program approved by the Accreditation Council for Graduate Medical Education.

		Since the last review, the facility has maintained the same number of psychiatrists and configuration of board-certified vs. board-eligible psychiatry staff. The turnover in psychiatry staff has been minimal. The facility reported that all psychiatrists are continually encouraged to obtain board certification. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
D.1.b.ii	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Utilize the data from the Physician Quality Profiles in the processes of reprivileging of all medical staff and initiate performance improvement, as needed, to address identified trends/patterns. **Findings:** MSH has made progress in the implementation of this recommendation. The facility reported that its administrative physicians (Senior Psychiatrist, Chief of Psychiatry, Medical Staff President and Medical Director) have reviewed performance data with each individual physician on an ongoing basis. Patterns and trends of performance were reportedly discussed individually with each psychiatrist. The facility has reportedly utilized the Physician Performance data in the process of reprivileging of the psychiatry staff. **Compliance:** Partial.

		Current recommendation: Provide documentation, without identification of individual practitioners, of performance improvement/corrective actions that were implemented to address trends/patterns in the physician quality profile data.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
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:	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH did not present data regarding the timeliness of the admission medical assessment. The data that were presented addressed the timeliness of the admission psychiatric assessment. MSH used the current MSH Medical Admission Assessment Monitoring audit form to assess compliance with the requirements of D.1.c.i.1 to D.1.c.i.5. The average sample was 97% of admissions for the reporting month. The mean compliance rates are presented in each corresponding cell below. The sub-indicators and comparative analysis are listed as appropriate.

		Recommendation 3, March 2008: Finalize the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. **Findings:** The DMH is in the process of finalizing this tool. **Other findings:** This monitor reviewed the charts of 11 individuals (ABR, AD, CRT, DAC, KS, LK, LL, MA, MG, RR and SDE) who were admitted during this reporting period. All of these assessments were based on the facility's template that was revised by the DMH in September 2008. The review found the following: 1. There was timely implementation of the admission medical assessment in all cases. 2. None of the charts included a plan of care to address the conditions that were identified and that required follow-up care (e.g. KS, LK and RR). 3. In some charts, there was no follow-up regarding the individual's refusal of parts of the physical examination, including examination of the abdomen (DAC) and the rectum (in male individuals e.g. ABR and AD). The monitor also reviewed the charts of three individuals (CPP, FM and MRM) who were admitted in September 2008 and received admission medical assessments using the DMH newly revised template. This review found that the template provided appropriate prompts to correct the above-mentioned deficiencies. **Compliance:** Partial.

		Current recommendations: 1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	100% (compared to 99% during the last review period).
D.1.c.i.2	medical history;	99% (the same as in the last review).
D.1.c.i.3	physical examination;	99% (the same as in the last review).
D.1.c.i.4	diagnostic impressions; and	90% (the facility presented no data during the last review; however, comparative data were presented for this item in section F.7.a, which appear to be in error).
D.1.c.i.5	management of acute medical conditions	86%, compared to 77% during the last review; however, the facility presented different comparative information regarding this item in section F.7.a.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Finalize and implement a risk assessment tool for use during the first 24 hours of admission that aligns with the instructions regarding risk factors in the integrated psychiatric assessment.

		Findings: The new DMH template for the Admission Psychiatric Assessment includes a risk assessment tool that aligns with the risk factors in the integrated psychiatric assessment. The facility implemented this template on July 1, 2008. **Recommendations 2 and 3, March 2008:** • Continue to monitor the Admission Psychiatric Assessment using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** MSH used the DMH Admission Psychiatric Assessment Auditing Form to assess compliance (February to July 2008). The average sample was 99% of the admissions each month. The mean compliance rate for this requirement was 100%, compared to 99% during the last review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The sub-indicators and data analysis are listed, as appropriate. The plan of improvement is the same as that reported in D.1.a. **Other findings:** This monitor reviewed the charts of the above-mentioned 11 individuals. The review found compliance in the charts of individuals whose assessments were completed using the new DMH template (AD, CRT, LK, LL, MA and SDE). This template was implemented July 1, 2008 and provided corrections of the deficiencies that were reported in the previous report and were still noted in the other charts using the older template. This template must be fully implemented in order to achieve substantial compliance with this section.

<table>
<tr><td></td><td></td><td>Compliance:
Partial.

Current recommendations:
1. Ensure full implementation of the new DMH template for the Admission Psychiatric Assessment.
2. Continue to monitor the Admission Psychiatric Assessment using the DMH standardized instrument.
3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).</td></tr>
<tr><td>D.1.c.ii.1</td><td>psychiatric history, including a review of presenting symptoms;</td><td>
<table>
<tr><td>2.</td><td>Psychiatric history, including a review of presenting symptoms.</td><td></td></tr>
<tr><td>2.a</td><td>Identifying data including legal status</td><td>93%</td></tr>
<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>93%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>93%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>95%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>91%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>96%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>97%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>98%</td></tr>
</table>

The mean compliance rate for the main indicator has improved from 65% during the last review period to 81% during this period. The facility's data for July 2008 showed improved consistency in compliance with the sub-indicators.</td></tr>
<tr><td>D.1.c.ii.2</td><td>complete mental status examination;</td><td>96% (essentially unchanged since the last review period).</td></tr>
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<table>
<tr><td>D.1.c.ii.3</td><td>admission diagnoses;</td><td>Same as in D.1.a (admission psychiatric assessment).</td></tr>
<tr><td>D.1.c.ii.4</td><td>completed AIMS;</td><td>100%, compared to 96% during the last review.</td></tr>
<tr><td>D.1.c.ii.5</td><td>laboratory tests ordered; and</td><td>99% (essentially unchanged since the last review period).</td></tr>
<tr><td>D.1.c.ii.6</td><td>consultations ordered.</td><td>98%, compared to 96% during the last review.</td></tr>
<tr><td></td><td>plan of care</td><td>
<table>
<tr><td>8.</td><td>Plan of care</td><td></td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>89%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>69%</td></tr>
<tr><td>8.c</td><td>Special precautions to address risk factors as indicated</td><td>94%</td></tr>
</table>
Comparative data were not available for the main indicator. However, the mean compliance rates for the sub-items (January vs. July 2008) have shown improvement for 8.a (61 to 89%) and 8.c (90 to 94%). The mean compliance rate remained low for item 8.b, which was assessed to be a result of inadequate review of PRN medications in the plan of care.
</td></tr>
<tr><td>D.1.c.iii</td><td>within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</td><td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Implement the operational instructions regarding the assessment of risk factors in the integrated assessments and standardize this process in all facilities.

Findings:
MSH has implemented this recommendation.</td></tr>
</table>

		Recommendations 2 and 3, March 2008: • Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** MSH used the DMH Integrated Assessment Psychiatry Section Auditing Form to assess compliance (February to July 2008). The average sample was 62% of the assessments due each month. The mean compliance rate for this item was 90%. This rate has increased from 54% for the previous review period. The mean compliance rates for the other requirements in D.1.c.iii are listed in each corresponding cell below. The sub-indicators and data analysis are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 12 individuals who were admitted during this review period (ABR, AD, AR, CRT, DAC, KS, LK, LL, MA, MG, RR and SDE). Chart reviews by this monitor found some general improvement in the timeliness and quality of the integrated assessments during this review period. However, this monitor found deficiencies that must be corrected to achieve substantial compliance. The following are examples: 1. Most assessment did not include a statement regarding presence or absence of current suicidal ideations, intent or plan in the mental status examination. 2. The formulation of the individual's strengths was generic, focusing on the desire to leave the facility (CRT, DAC, LK and MG) or some characteristics such as being physically healthy (MA), able to

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<td>express needs (KS) or the absence of assaultiveness (ABR).
3. The MMSE was not completed despite statements in the assessment regarding evidence of cognitive impairment (ABR).
4. The differential diagnosis was not completed despite provisional Axis I diagnoses listed as NOS (ABR and RR).
5. The assessment of risk factors regarding the use of restrictive interventions was inadequate (DAC) or not completed (MA).
6. The risk assessment regarding aggression, fire-setting and/or elopement was not completed (MA).
7. The medical history was not completed (SDE).
8. The assessment of insight and judgment was generic (AD, LK, LL, MG and RR).
9. The mental status examination did not address mood/affect or status of alertness (AD).
10. The plan of care did not address consent for medications (MA).
11. The overall quality of the assessment was substandard (AR).

Compliance:
Partial.

Current recommendations:
1. Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument.
2. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).</td>
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<tr>
<td>D.1.c.iii.1</td>
<td>psychiatric history, including a review of present and past history;</td>
<td>
<table>
<tr><td>2.</td><td>Psychiatric history, including a review of present and past history.</td><td></td></tr>
<tr><td>2.a</td><td>Identifying data including legal status.</td><td>79%</td></tr>
<tr><td>2.b</td><td>Statements from the individual are included, if available.</td><td>92%</td></tr>
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<tr><td>2.c</td><td>Chief complaint</td><td>97%</td></tr>
<tr><td>2.d</td><td>Diagnosis and medications given at previous facility are included.</td><td>47%</td></tr>
<tr><td>2.e</td><td>Effectiveness of medications from previous facility is included</td><td>55%</td></tr>
<tr><td>2.f</td><td>Past psychiatric history is documented including a review of pertinent physical exam status.</td><td>79%</td></tr>
</table>

Comparable data for the main indicator was not available because this item did not exist in the older tool. However, the mean compliance rates for the sub-items have shown mixed changes (January vs. July 2008) as follows:

1. Item 2.a: 89% to 83%;
2. Item 2.d: 51% to 39%;
3. Item 2.e: 49% to 50%; and
4. Item 2.f: 84% to 77%

Data analysis and corrective action regarding the low compliance in 2.d and 2.e were the same as that addressed in D.1.a regarding 2.d.
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<tr>
<td>D.1.c.iii.2</td>
<td>psychosocial history;</td>
<td>
<table>
<tr><td>3</td><td>Psychosocial history is documented.</td><td></td></tr>
<tr><td>3.a</td><td>Developmental history</td><td>81%</td></tr>
<tr><td>3.b</td><td>Family history</td><td>84%</td></tr>
<tr><td>3.c</td><td>Educational history</td><td>86%</td></tr>
<tr><td>3.d</td><td>Religious and cultural influences</td><td>66%</td></tr>
<tr><td>3.e</td><td>Occupational history</td><td>77%</td></tr>
<tr><td>3.f</td><td>Marital status</td><td>86%</td></tr>
<tr><td>3.g</td><td>Sexual history</td><td>66%</td></tr>
<tr><td>3.h</td><td>Legal history</td><td>64%</td></tr>
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<table>
<tr><td></td><td></td><td>The mean compliance rate for the main indicator was reported at 37%, which represented a significant decrease from the rate of 81% reported for the last review period. The facility assessed that this decrease was largely due to the introduction of new criteria in March 2008 and a change in monitoring methodology for this item. Corrective action is reportedly underway.</td></tr>
<tr><td>D.1.c.iii.3</td><td>mental status examination;</td><td>
<table>
<tr><td>4.</td><td>Complete mental status examination is documented</td><td></td></tr>
<tr><td>4.a</td><td>Attitude/cooperation</td><td>99%</td></tr>
<tr><td>4.ba</td><td>General appearance</td><td>96%</td></tr>
<tr><td>4.c</td><td>Motor Activity</td><td>97%</td></tr>
<tr><td>4.d</td><td>Speech</td><td>92%</td></tr>
<tr><td>4.e</td><td>Mood/affect</td><td>93%</td></tr>
<tr><td>4.f</td><td>Thought process/content</td><td>83%</td></tr>
<tr><td>4.g</td><td>Perceptual alterations</td><td>94%</td></tr>
<tr><td>4.h</td><td>Fund of general knowledge</td><td>83%</td></tr>
<tr><td>4.i</td><td>Abstraction ability</td><td>76%</td></tr>
<tr><td>4.j</td><td>Judgment</td><td>55%</td></tr>
<tr><td>4.k</td><td>Insight</td><td>74%</td></tr>
<tr><td>4.l</td><td>MMSE</td><td>72%</td></tr>
</table>

Comparative data regarding the mean compliance rate with the main indicator were not available. However, the rates for all the sub-items have increased (January vs. July 2008) as follows:
<table>
<tr><td>Item</td><td>Change in mean compliance rate</td></tr>
<tr><td>4.a</td><td>95% to 99%</td></tr>
<tr><td>4.b</td><td>90% to 96%</td></tr>
<tr><td>4.c</td><td>87% to 97%</td></tr>
<tr><td>4.d</td><td>80% to 92%</td></tr>
<tr><td>4.e</td><td>87% to 93%</td></tr>
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<tr><td></td><td></td><td>
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<tr><td>4.f</td><td>80% to 83%</td></tr>
<tr><td>4.g</td><td>89% to 94%</td></tr>
<tr><td>4.h</td><td>63% to 83%</td></tr>
<tr><td>4.i</td><td>60% to 76%</td></tr>
<tr><td>4.j</td><td>41% to 55%</td></tr>
<tr><td>4.k</td><td>49% to 74%</td></tr>
<tr><td>4.l</td><td>75% to 67%</td></tr>
</table>

To ensure compliance with item 4.j, MSH has required that the MMSE be completed in the Integrated Assessment for all individuals as of August 1, 2008.</td></tr>
<tr><td>D.1.c.iii.4</td><td>strengths;</td><td>91%, compared to 87% in the last review period.</td></tr>
<tr><td>D.1.c.iii.5</td><td>psychiatric risk factors;</td><td>
<table>
<tr><td>6.</td><td>Psychiatric risk factors are documented</td><td></td></tr>
<tr><td>6.a</td><td>Risk for suicide</td><td>75%</td></tr>
<tr><td>6.b</td><td>Risk for self-injurious behavior</td><td>65%</td></tr>
<tr><td>6.c</td><td>Risk factors for seclusion (medical and emotional)</td><td>79%</td></tr>
<tr><td>6.d</td><td>Risk factors for restraint (medical and emotional)</td><td>76%</td></tr>
<tr><td>6.e</td><td>Risk for aggression</td><td>80%</td></tr>
<tr><td>6.f</td><td>Risk for fire setting</td><td>76%</td></tr>
<tr><td>6.g</td><td>Risk for elopement</td><td>74%</td></tr>
<tr><td>6.h</td><td>Risk for victimization</td><td>51%</td></tr>
</table>

Comparative data for the main indicator were not available as there was not a comparable item in the last review. However, the mean compliance rates for the sub-indicators have increased for most of the items (for the review period) as follows:
<table>
<tr><td>Item</td><td>Change in mean compliance rate</td></tr>
<tr><td>6.a</td><td>76% to 75%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>6.b</td><td>77% to 65%</td></tr>
<tr><td>6.c</td><td>65% to 79%</td></tr>
<tr><td>6.d</td><td>65% to 76%</td></tr>
<tr><td>6.e</td><td>69% to 80%</td></tr>
<tr><td>6.f</td><td>69% to 76%</td></tr>
<tr><td>6.g</td><td>69% to 74%</td></tr>
</table>

No comparative data were available for 6.h. The facility did not present data for January vs. July 2008.

MSH has identified a trend of decreasing compliance with completing the Risk Assessments in the integrated assessments and assessed that compliance for 6.h was particularly low in the initial months of the review period because it was a new requirement. The facility will implement a system of continuous monitoring with immediate feedback to the physicians to improve the level of compliance.
</td></tr>
<tr><td>D.1.c.iii.6</td><td>diagnostic formulation;</td><td>77%, compared to 68% during the last review. The facility assessed that the lack of adequate information upon admission of individuals from jails has compromised compliance with this item.</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>56, compared to 68% during the last review. Contributing factors were the same as in D.1.c.iii.6 above.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>92%, compared to 68% during the last review.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td></td></tr>
<tr><td>10.a</td><td>Current target symptoms</td><td>45%</td></tr>
<tr><td>10.b</td><td>Specific medications to be used</td><td>95%</td></tr>
<tr><td>10.c</td><td>Dosage titration schedules, if indicated</td><td>70%</td></tr>
<tr><td>10.d</td><td>Adverse reactions to monitor for</td><td>24%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>10.e</td><td>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</td><td>51%</td></tr>
<tr><td>10.f</td><td>Response to medications since admission, if applicable including PRN and Stat medications.</td><td>70%</td></tr>
<tr><td>10.g</td><td>Medication consent issues were addressed.</td><td>88%</td></tr>
</table>

Comparative data for the main indicator were not available. However, available comparative data showed increases in compliance from the last review period as follows:

<table>
<tr><td>Item</td><td>Change in mean compliance rate</td></tr>
<tr><td>6.a</td><td>33% to 45%</td></tr>
<tr><td>6.b</td><td>46% to 95%</td></tr>
<tr><td>6.c</td><td>46% to 70%</td></tr>
<tr><td>6.d</td><td>39% to 51%</td></tr>
<tr><td>6.e</td><td>52% to 88%</td></tr>
</table>
</td></tr>
<tr><td>D.1.c.iii.10</td><td>management of identified risks.</td><td>61% (essentially unchanged from the last review).</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, March 2008:
Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders.

Findings:
During this review period, MSH facilitated one program, “Mild Cognitive Impairment.” The facility provided incomplete information regarding the instructor.</td></tr>
</table>

Other findings:
This monitor found that the number of individuals who have received diagnoses listed as NOS for three or more months has apparently decreased since the last review. However, the charts of several individuals who still have these diagnoses contained deficiencies in the documentation of efforts to finalize the diagnosis, as indicated; the assessment of the cognitive impairments, as indicated; and/or alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes. In addition, some of these individuals (e.g. JMI) are not identified in the facility's database. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the chart reviews:

Initials	Diagnosis
ABR	Impulse Control Disorder NOS
CDF	Cognitive Disorder, NOS
DH	Depressive Disorder NOS and Psychotic Disorder NOS
JCF	Psychotic Disorder NOS
JM	Dementia NOS
JMI	Cognitive Disorder, NOS and Mild Mental Retardation
JND	Dementia NOS and Psychotic Disorder NOS
RJA	Cognitive Disorder, NOS
SR	Psychotic Disorder NOS and Mood Disorder NOS

Compliance:
Partial.

Current recommendations:
1. Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. Provide information regarding affiliations of instructors and attendees.

		2. Provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as D.1.a. **Findings:** Same as D.1.a. **Compliance:** Partial. **Current recommendations**: Same as D.1.a.
D.1.d.iii	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as D.1.d.i. **Findings:** Same as D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as D.1.d.i.

D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** The facility did not provide any specifics regarding its current practice, i.e. the number of individuals who have received this diagnosis during the review period, review of the justification and results of this review. **Other findings:** Char reviews by this monitor did not find evidence of "no diagnosis" listed on Axis I. **Compliance:** Deferred due to lack of information from the facility. **Current recommendations**: 1. Continue current practice. 2. Provide information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review of justification and results of this review.
D.1.e	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue to monitor this requirement and provide separate data for weekly and monthly notes. • Implement corrective actions to improve compliance. **Findings:** MSH used the DMH Weekly Physician Progress Note (PPN) Auditing

Form to assess compliance (May to July 2008). The average sample was 29% of the individuals with length of stay less than 60 days. The following is a summary of the data:

1.	*The reassessments are completed weekly for the first 60 days on the admission units:*	
1.a	*There is a note present every 7 days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.*	78%
1.b	*The note must contain the subjective complaint, objective findings, assessment and plan of care*	98%

No comparative data were available as this monitoring began during this review period. However, the data showed decreased compliance with the required frequency of documentation (May to July 2008), which was assessed to be a result of a change in staffing on the admissions units.

MSH used the DMH Monthly PPN Auditing Form to assess compliance (February to July 2008). The average sample was 31% of the individuals who have been hospitalized for 90 days or more. The mean compliance rate for this requirement has increased from 58% during the last review to 66% for this review. No comparative data were provided for the sub-items (January vs. July 2008).

Other findings:
This monitor reviewed the charts of 11 individuals (ABR, AD, CRT, DAC, KS, LK, LL, MA, MG, RR and SDE) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes, the review found compliance in five charts (AD, LK, LL, MA and SDE) and partial compliance in six (ABR, CRT, DAC, KS, MG and RR). There was timely implementation of the monthly notes

		in the limited number of charts of all individuals who were hospitalized for 90 or more days. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement and provide separate data for weekly and monthly notes. 2. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH Monthly PPN Auditing Form to assess compliance (February to July 2008). The average sample was 16% of the individuals who have been hospitalized for 90 or more days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. The sub-indicators and data analysis are listed, as appropriate. Comparative data were incomplete because monitoring using standardized indicators and sub-indicators began during this review period and some of the items were not included in the older tools.

		Recommendation 3, March 2008: Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention. **Findings:** At this time, the psychiatrists at MSH do not include individual psychotherapy as part of the active treatment described in the WRP, except where DBT is part of the WRP. The facility reported that the psychiatrists provide supportive psychotherapy on an ongoing basis as part of the daily delivery of care while performing medication management, assessing risk factors and addressing adherence to treatment interventions. This care is not claimed as part of the active treatment hours, but rather is regarded as part of the routine delivery of psychiatric care. **Other findings:** Chart reviews by this monitor found general evidence of improved consistency in the implementation of the facility's template for the monthly notes and relative improvement in content in these notes compared to the last review. Examples were found in the charts of FN, JAS, JR, JS, KDH, RG and SM. However, the facility still falls short of substantial compliance regarding this requirement due to shortcomings in the content of documentation as follows: 1. In some charts, the documentation of interval events did not provide specific information regarding interval events (CT, MVN and NSO). 2. In a few charts, the documentation of current status, relevant laboratory findings, risk factors and risks/benefits ignored current significant changes in laboratory findings and associated risks for

		the individual (MDJB) or did not adequately address these changes (DLK). 3. In most charts, the documentation of risks and benefits of treatment was generic, citing theoretical side effects rather than actual developments in the individuals. This monitor also reviewed the charts of six individuals who have experienced the use of seclusion and/or restraints during this review period (CAS, CG, KCM, PW, VAB and WH) to assess the use of PRN/Stat medications prior to seclusion and/or restraints (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 review found that the following pattern of deficiencies still existed: 1. PRN medications were prescribed for generic indications. 2. There was inadequate documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications. 3. There was evidence of inadequate behavioral guidelines for individuals who were refractory to current medication trials. 4. The documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications was either missing or did not include a critical review and assessment to inform future management. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement based on a review of at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates

<table>
<tr><td></td><td></td><td>areas of relative improvement (during the reporting period and compared to the last period).
3. Ensure correction of the deficiencies cited by this monitor above.</td></tr>
<tr><td>D.1.f.i</td><td>significant developments in the individual's clinical status and of appropriate psychiatric follow up;</td><td>
<table>
<tr><td>2.a</td><td>Subjective complaints are documented.</td><td>98%</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented</td><td>98%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>95%</td></tr>
<tr><td>2.d</td><td>Progress towards objectives in the WRP.</td><td>94%</td></tr>
<tr><td>2.e</td><td>The mental status exam is documented</td><td>97%</td></tr>
<tr><td>2.f</td><td>The individual's legal status and any change in legal status, if applicable.</td><td>98%</td></tr>
<tr><td>2.g</td><td>Current status of medical problems and treatment are documented</td><td>93%</td></tr>
<tr><td>2.h.1</td><td>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow up provided as indicated</td><td>93%</td></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)</td><td>97%</td></tr>
</table>

Comparative data for the main indicator were not available as there was no comparable item in the last review. However, the mean compliance rates for the sub-indicators have increased for all of the sub-items (for the review period) as follows:
<table>
<tr><td>Item</td><td>Change in mean compliance rate</td></tr>
<tr><td>2.a</td><td>89% to 98%</td></tr>
<tr><td>2.b</td><td>86% to 98%</td></tr>
<tr><td>2.c</td><td>86% to 94%</td></tr>
<tr><td>2.d</td><td>76% to 93%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>2.e</td><td>86% to 97%</td></tr>
<tr><td>2.f</td><td>84% to 98%</td></tr>
<tr><td>2.g</td><td>78% to 93%</td></tr>
<tr><td>2.h</td><td>80% to 98%</td></tr>
</table>
</td></tr>
<tr><td>D.1.f.ii</td><td>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;</td><td>
<table>
<tr><td>3.a</td><td>The MMSE is completed and documented in the progress note.</td><td>74%</td></tr>
<tr><td>3.b</td><td>The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.</td><td>94%</td></tr>
</table>
The only available comparative data showed that the mean compliance rate for item 3.b has increased from 79% in the prior review period to 94% in the current review period.
</td></tr>
<tr><td>D.1.f.iii</td><td>Analyses of risks and benefits of chosen treatment interventions;</td><td>
<table>
<tr><td>4.a</td><td>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>89%</td></tr>
<tr><td>4.b</td><td>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>90%</td></tr>
<tr><td>4.c</td><td>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</td><td>92%</td></tr>
</table>
The mean compliance rate for the main indicator has increased from 62% during the last review period to 86% during this review period. Comparative data were not available for the sub-items.
</td></tr>
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<table>
<tr>
<td>D.1.f.iv</td>
<td>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;</td>
<td>
<table>
<tr><td>5.a</td><td>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.</td><td>89%</td></tr>
<tr><td>5.b</td><td>The monthly note identifies specific risk behaviors including triggers during the interval period.</td><td>86%</td></tr>
<tr><td>5.c</td><td>If applicable, treatment is modified to minimize risk.</td><td>82%</td></tr>
</table>

The mean compliance rate for the main indicator has increased from 80% during the last review period to 82% during this review period. Comparative data were not available for the sub-items.
</td>
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<tr>
<td>D.1.f.v</td>
<td>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;</td>
<td>
<table>
<tr><td>6.a</td><td>Rationale for current psychopharmacology plan including analysis of risks and benefits.</td><td>82%</td></tr>
<tr><td>6.b</td><td>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</td><td>91%</td></tr>
<tr><td>6.c</td><td>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</td><td>93%</td></tr>
<tr><td>6.d</td><td>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</td><td>95%</td></tr>
</table>

Comparative data for the main indicator were not available. However, the mean compliance rates for the sub-indicators have increased for all the sub-items (for the review period) as follows:

<table>
<tr><td>Item</td><td>Change in mean compliance rate</td></tr>
<tr><td>6.a</td><td>62% to 82%</td></tr>
<tr><td>6.b</td><td>78% to 91%</td></tr>
</table>
</td>
</tr>
</table>

		6.c 68% to 93% 6.d 76% to 95%
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	7.a *Describes the rationale/specific indications for all PRN orders.* 89% 7.b *Reviews the PRNs and Stats during the interval period.* 82% 7.c *Discusses use of PRN/STAT as indicated to reduce the risk of restrictive interventions.* 62% 7.d *Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.* 50% The mean compliance rate for the main indicator has increased from 71% during the last review period to 74% during this review period. Comparative data were not available for the sub-items.
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 psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	8.a *There is a description in the note of the response to non-pharmacologic treatment.* 91% 8.b *If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.* 76% 8.c *There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.* 91%

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<table>
<tr><td>8.d</td><td>There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.</td><td>90%</td></tr>
</table>

The only available comparative data showed that the mean compliance rate for item 8.a has increased from 68% for the prior review period to 90% for the current review period.
</td>
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<tr>
<td>D.1.g</td>
<td>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.</td>
<td>
Current findings on previous recommendations:

Recommendations 1-3 March 2008:
• Implement corrective action plan to improve compliance.
• Monitor this requirement based on a review of at least a 20% sample.
• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used the DMH Physician Inter-Unit Transfer Note Audit Form to assess compliance (February to July 2008). The average sample was 49% of the individuals who have experienced inter-unit transfer per month. The following is a summary of the compliance data:
<table>
<tr><td>1.</td><td>Psychiatric course of hospitalization,</td><td>22%</td></tr>
<tr><td>2.</td><td>Medical course of hospitalization,</td><td>39%</td></tr>
<tr><td>3.</td><td>Current target symptoms,</td><td>78%</td></tr>
<tr><td>4.</td><td>Psychiatric risk assessment,</td><td>35%</td></tr>
<tr><td>5.</td><td>Current barriers to discharge,</td><td>72%</td></tr>
<tr><td>6.</td><td>Anticipated benefits of transfer.</td><td>58%</td></tr>
</table>

Data analysis showed mixed changes in the mean compliance rates from the last review period to this period as follows:
</td>
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Item	Change in mean compliance rate
1.	60% to 22%
3.	61% to 78%
4.	58% to 35
5.	57% to 72%
6.	35% to 58%

No comparative data were available for item 2.

Comparative data (January vs. July 2008) increased compliance for most items as follows:

Item	Change in mean compliance rate
1.	55% to 43%
3.	60% to 93%
4.	60% to 72%
5.	55% to 96%
6.	35% to 64%

No comparative data were available for item 2.

Recommendation 4, March 2008:
Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

Findings:
MSH reported that all individuals who present severe management problems have behavioral guidelines that are implemented on a unit and program level. However, the facility did not present supporting information and reviews by this monitor in other sections indicate that the facility has yet to make further progress regarding the number and

quality of behavioral guidelines (see F.2).

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this reporting period. The review found compliance in two charts (MAM and PS), partial compliance in three (DH, RS and RV) and noncompliance in one (MDJB). The main deficiencies were as follows:

1. The transfer assessment was missing in one chart.
2. There was inconsistent and generally inadequate review of the anticipated benefits of transfer, course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers in most charts.

These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the reviews:

Initials	Date of transfer
DH	05/29/08
MAM	03/28/08
MDJB	04/04/08
PS	07/31/08
RS	01/23/08
RV	01/29/08

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement based on a review of at least a 20% sample.
2. Provide data analysis that evaluates low compliance and delineates

		areas of relative improvement (during the reporting period and compared to the last period).

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Ashvind Singh, PhD, Psychologist 2. Cynthia Lusch, Clinical Administrator 3. Doug Strosnider, Mall Director 4. Edwin Poon, PhD, Senior Psychologist 5. Erich Mullen, PT, PBS Team Member 6. Gretchen Hunt, BY CHOICE Coordinator 7. John Lusch, Program Director 8. Ken Layman, Treatment Enhancement Coordinator 9. Michael Cooper, PhD, Coordinator Specialty Services 10. Latasha Fields, PT, PBS Team Member 11. Lisa Rimland, WRP Trainer 12. Marilu Tiberi-Vipraio 13. Richard Hartley, PhD, Senior Psychologist 14. Sean Johnson, Assistant BY CHOICE Coordinator 15. Sheri Greve, PsyD, Consultant to PSR Mall Services 16. Swati Roy, PhD, Chief of Psychology <u>Reviewed</u>: 1. Charts of the following 56 individuals: AR, AT, BC, CA, CAS, CB, CF, CG, CR, CRT, CS, CT, CW, DC, GMH, HRM, IM, IS, JA, JAW, JB, JDM, JEM, JLH, JLM, JM, JM2, JND, JR, JS, JS-2, JSH, KD, KLF, LL, MB, MG, MR, NB, PD, RAJ, RAP, RB, RC, RJB, RM, RMV, RTB, SE, SM, THE, TLF, VA, VD, VLG and YH 2. BCC Attendance Summary 3. Behavioral Guidelines completed in the last six months 4. Completed PBS-BCC Checklists 5. Home Language Survey Data 6. List of completed DSM-IV-TR checklists 7. List of individuals with diagnostic uncertainties

		8. List of individuals undertaking psychological assessments. 9. List of individuals whose primary/preferred language is other than English 10. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 11. Neuropsychological assessments completed in the last six months 12. Psychological assessments completed in the last six months 13. Structural and functional assessments developed and implemented in the last six months 14. Structural assessments completed in the last six months <u>Observed</u>: 1. WRPT Conference for DC and YB 2. The following four bed-bound individuals: BP, DE, HS and JP 3. PSR Mall group: DBT Skills Introduction 4. PSR Mall group: Healthy Lifestyle 5. PSR Mall group: Legal Issues-Court Preparation 6. PSR Mall group: Mind Over Mood 7. PSR Mall group: Motivational Group 8. PSR Mall group: Reality Orientation 9. PSR Mall group: Recovery Games 10. PSR Mall group: Social Skills 11. PSR Mall group: Sports and Fitness 12. PSR Mall group: Substance Recovery
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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue the practice of orienting new staff to the manual. **Findings:** This monitor's interview of the Chief of Psychology and documentation review (protocols and curriculum vitae) found that MSH had hired four

	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.	new staff into its Psychology Department. The four psychologists had received training on assessment procedures, EP issues, and service-related information using the DMH WRP Manual and the DMH Psychology Manual. **Compliance:** Substantial. **Current recommendation**: Continue the practice of orienting new staff to the manual.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to ensure that academic and cognitive assessments of new admissions are completed on a timely basis. **Findings:** Using item 1 (*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*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample for each month (February to July 2008), reporting mean compliance of 94% (mean compliance for the previous review period was 79%). This monitor reviewed eight charts (AT, CG, JDM, JM, JM-2, JS, NB and SM) of individuals of 22 years and below, who by law should have received the cognitive and academic assessments within 30 days of admission unless comparable testing has been performed within one year of admission. The documentation showed that all eight individuals

		were assessed in a timely manner or they did not need an assessment due to prior testing within the last year. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's interview of the Chief of Psychology and her Senior team and documentation review (CVs of newly hired staff and credentialing/privileging requirements) found that all clinicians responsible for performing or reviewing psychological assessments and evaluations met MSH's credentialing and privileging requirements. In addition, the Chief of Psychology stated that these staff were competent in conducting psychological evaluations based on the review of their completed assessments and their written reports. The table below showing the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent is a summary of the facility's data. 1.a — *Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations* — 38 1.b — *Number of psychologists who meet the hospital's* — 38

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>credentialing and privileging requirements</td><td></td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking psychological assessments</td><td>2</td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>2</td></tr>
</table>

MSH plans to observe all psychologists responsible for conducting evaluations while they undertake the tasks to verify their competency in administering the assessments.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td></tr>
<tr><td>D.2.d</td><td>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</td><td>Compliance:
Substantial.</td></tr>
<tr><td>D.2.d.i</td><td>expressly state the clinical question(s) for the assessment;</td><td>Current findings on previous recommendation:

Recommendation, March 2008:
Continue current practice.

Findings:
Using item 3 (Expressly state the clinical question(s) for the assessment) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting a mean compliance rate of 100% (mean compliance for the previous review period was also 100%).</td></tr>
</table>

		MSH's mean sample of assessments audited for this recommendation was below 20%. In addition, this monitor learned from the Chief of Psychology that the assessments were not chosen randomly. MSH plans to correct the two factors in future audits. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). Nine of the focused assessments (HRM, JA, JS, JS-2, JSH, MB, NB, SM and THE) expressly state the clinical question(s) for the assessment. One of them included additional information that was considered to be more appropriate to other sections in the report. **Current recommendation**: Continue current practice.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations. **Findings:** Using item 4 (*Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 98%). MSH plans to increase its sample size and randomly choose the assessments for its audit.

		This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments included findings that addressed the clinical question(s), and also included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested intervention priorities useful to the individual's WRPT. **Current recommendation**: Continue current practice.
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy. **Findings:** Using item 5 (*Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 98%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments indicated whether individual or group therapy would benefit the individual. The recommendations were aligned with their findings. **Current recommendation**: Continue current practice.

D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using item 6 (*Be based on current, accurate, and complete data*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 100%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments were based on current, accurate, and complete data. The assessments included the individual's identification information, relevant sources of information, behavioral observations, and statements on the validity of the assessment. **Current recommendation**: Continue current practice.
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all psychological assessments of individuals with maladaptive behaviors determine whether behavioral supports or interventions are warranted or whether a full positive behavior support plan is required.

		Findings: Using item 7 (*Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 100%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments determined whether the behavioral supports or interventions were warranted or whether a full Positive Behavior Support plan was required. **Current recommendation**: Continue current practice.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation. **Findings:** Using item 8 (*Include the implications of the findings for interventions*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous

		review period was 98%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments included implications of the findings for interventions, and the recommended interventions were aligned with the findings **Current recommendation**: Continue current practice.
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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all focused psychological assessments meet this requirement. **Findings:** Using item 9 (*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*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 90%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All ten focused assessments indicated if there were unresolved issues, and what if any steps should be taken to address the unresolved issues.

		Current recommendation: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using item 10 (*Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 18% of the focused assessments completed for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 100%). MSH plans to increase its sample size and randomly choose the assessments for its audit. This monitor reviewed ten focused assessments (HRM, JA, JB, JS, JS-2, JSH, MB, NB, SM and THE). All 10 focused assessments used assessment tools and techniques appropriate for the individuals assessed. All the assessments reviewed included statements of confidentiality, the instruments used were appropriate for addressing the clinical questions, and the instruments were from the DMH Clinical Indicator List of approved instruments. **Current recommendation**: Continue current practice.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing	**Current findings on previous recommendation:**

	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 and IV.B.2], above.	**Recommendation, March 2008:** Continue the review process until all individuals in the facility who were admitted before June 1, 2006 have had their psychological assessments are reviewed and addressed accordingly. **Findings:** This monitor's interview of the Chief of Psychology and documentation review found that since the last review, only two individuals admitted before June 1, 2006 whose assessments were yet to be reviewed remained at MSH. According to the Chief of the Psychology one of the two individuals was discharged from the facility before the assessments were completed, and the remaining one individual (KD) had returned from court and MSH completed his assessments as a new admission on July 18, 2007. This monitor's review of KD's chart verified MSH's report. In addition, this monitor reviewed six other charts (CAS, CR, JLM, RAP< RJB and SM) of individuals admitted before June 1, 2006 and still in MSH. All six had their assessments reviewed and where necessary new IAPs completed. **Compliance:** Substantial. **Current recommendations**: None.
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	**Compliance:** Substantial.

	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:	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that integrated psychological assessments are conducted in a timely manner as required. **Findings:** Using item 12 (*Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of all Integrated Assessments: Psychology Section due for the month (February to July 2008), reporting mean compliance of 96% (mean compliance for the previous review period was 68%). According to the Chief of Psychology, the compliance rate was less than 100% because two jail individuals were discharged prior to the completion of the Integrated Assessments (one individual was discharged within 24 hours of admission). This monitor reviewed the Integrated Assessments: Psychology Section for ten individuals (AR, CF, CT, CW, DC, JS, LL, MB, RTB and YH). All ten assessments were completed in a timely manner. **Current recommendation**: Continue current practice.
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Current findings on previous recommendation:**

		Recommendation, March 2008: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. **Findings:** Using item 13 (*Address the nature of the individual's impairments to inform the psychiatric diagnosis*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of all Integrated Assessments: Psychology Section due for the month (February to July 2008), reporting mean compliance of 100% (mean compliance for the previous review period was 97%). This monitor reviewed ten charts (AR, CF, CT, CW, DC, JS, LL, MG, RTB and SE). All ten Integrated assessments in the charts discussed the individual's behaviors, and signs and symptoms corresponding to the individual's psychiatric diagnoses. **Current recommendation**: Continue current practice.
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs. **Findings:** Using item 14 (*Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehab service planning process*) from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of all Integrated Assessments: Psychology Section due for the month (February to July 2008), reporting mean compliance of 100% (mean

		compliance for the previous review period was 99%). This monitor reviewed ten charts (AR, CF, CT, CW, DC, JS, LL, MB, RTB and SE). All ten Integrated Assessments: Psychology Section in the charts provided accurate and sufficient information regarding the individual's psychological functioning useful for the WRPT rehabilitation service needs. **Current recommendation**: Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.
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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. **Findings:** This monitor's documentation review (training records) and interview of the Chief of Psychology revealed that Kirk Hartley, the previous PBS team leader, and Christopher Cooper, the Coordinator of the PSSC, had provided training to the PBS team members on matters related to PBS assessment procedures and data management techniques. Using item 5 from the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of all active PBS plans during this review period (February to July 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data:

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and*	100%
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	n/a

As the table above shows, MSH conducted structural and functional assessments prior to developing a PBS plan. However, this data is based on two PBS plans. According to the PSSC Coordinator, MSH will review and refine its policy and procedures to determine the criteria

		for Behavior Guidelines and the identification of those who should be referred directly for a PBS plan. This monitor's findings based on review of the two PBS plans developed during this review period (CB and CG) is in agreement with the facility's data. Both plans had structural and functional assessments completed as part of the assessment procedure for developing PBS plans. **Current recommendation:** Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.
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 questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. **Findings:** Using items 17 to 20 from the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance for diagnostic categories lacking sufficient information based on a 100% sample of the integrated assessments conducted during this review period (February to July 2008). The table below with its indicators and corresponding mean samples and compliance is a summary of the data:

		Sample	Mean Compliance
17.	*Rule-Out*	100%	100%
18.	*Deferred*	100%	100%

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<tr><td>19.</td><td>No Diagnosis</td><td>100%</td><td>100%</td></tr>
<tr><td>20.</td><td>NOS- Diagnosis</td><td>100%</td><td>100%</td></tr>
</table>

This monitor reviewed 15 charts (BC, CA, CF, CT, CW, JAW, JLH, LL, MB, MG, RB, RM, RTB, SE and VA) of individuals whose WRPs had one or more diagnostic categories without sufficient information or had unresolved clinical questions. All 15 Integrated Assessments: Psychology Section in the charts had follow-up assessments, including the completed DSM-IV TR checklists, to clarify the diagnostic categories.

Current recommendation:
Continue current practice.
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<td>D.2.g</td>
<td>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.</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2008:
Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English, and that psychological assessments are provided in the individual's preferred language using interpreters.

Findings:
Using items 21-23 from the DMH Psychology Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of the individuals admitted during this review period (February to July 2008) whose primary/preferred language is other than English. The table below with its indicators and sub-indicators and their corresponding values is a summary of the data:

<table>
<tr><td>21.a</td><td>Number of individuals who needed assessment during the evaluation period whose primary language was not English</td><td>22</td></tr>
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21.b	*Of those in 21.a, number of individuals who were assessed in their primary language*	17
22.a	*Of those in 21.a, number of individuals who could not be assessed*	5
22.b	*Of those in 22.a, number of individuals who had plans developed to meet their assessment needs*	5
23.	*Of those in 22.b, number of individuals whose plans for assessment were implemented*	5

As seen in the table above, MSH successfully conducted assessments for individuals whose primary/preferred language is something other than English. In some cases, the examiners were competent in the individual's primary/preferred language (for example, Spanish); in others, interpreters or the AT interpreter system was utilized.

This monitor reviewed charts of nine individuals (CS, IM, IS, JA, JR, MR, RAJ, RC and VD) whose primary/preferred language was something other than English. Spanish was the primary/preferred language for eight of these individuals, and Mein Lao and/or Thai was the preferred language for CS. The Spanish-speaking individuals were assessed in their preferred language by Spanish-speaking examiners or with the assistance of interpreters, and CS was tested using an AT interpreter.

MSH's Home Language Survey (a survey to determine the primary/preferred language or language of daily use) returned a large number of individuals whose "Home Language" is other than English. This might suggest that merely asking an individual their preferred language may not be sufficient. MSH might want to consider using a formal language assessment procedure to determine the functional language of an individual.

		Compliance: Substantial. **Current recommendation**: Continue current practice.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Albert Olmos, Standards Compliance 2. Alfred Johnson, RN 3. Aubri Griffis, Acting NC 4. Aurora Hendricks, Nurse Administrator 5. Gary Bruben, Nursing Education 6. Greg Mercado, RN 7. Jeannie Rvovarnik, Psychiatric Technician 8. Lisa Rimland, WRP Trainer 9. Mila Rose Gaffund, RN 10. Xanthia Strong, RN Reviewed: 1. MSH's progress report and data 2. Training rosters for Nursing Assessments 3. Minutes of Unit Supervisor/Nurse Coordinator Meetings for Apri, May and June 2008 4. Admission Assessments, Integrated Assessments and WRPs for the following 40 individuals: AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH Observed: WRPTs for Program III, Unit 415 and Program I, Unit 410
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:	**Compliance:** Partial.

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<td>D.3.a.i</td>
<td>a description of presenting conditions;</td>
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Current findings on previous recommendation:

Recommendation, March 2008:
Continue to monitor this requirement.

Findings:
MSH implemented the DMH Nursing Admission Assessment Monitoring form in February 2008.

MSH reported the following data using the DMH Nursing Admission Assessment Monitoring audit for items D.3.a.i-D.3.a.ix, based on an average sample of 96% of admissions for the month (February-July 2008):

<table>
<tr><td>1.</td><td>A description of presenting conditions</td><td>90%</td></tr>
<tr><td>2.</td><td>Current prescribed medications.</td><td>92%</td></tr>
<tr><td>3.</td><td>Vital signs are fully documented or there is documentation that the individual was non-adherent.</td><td>98%</td></tr>
<tr><td>4.</td><td>Allergies</td><td>96%</td></tr>
<tr><td>5.</td><td>Pain - All applicable sections of the Pain Assessment are completed.</td><td>93%</td></tr>
<tr><td>6.</td><td>Use of assistive devices.</td><td>91%</td></tr>
<tr><td>7.</td><td>Activities of daily living.</td><td>90%</td></tr>
<tr><td>8.</td><td>Immediate alerts</td><td>90%</td></tr>
<tr><td>9.</td><td>For conditions needing immediate nursing interventions there are immediate nursing interventions documented.</td><td>79%</td></tr>
</table>

MSH's data analysis demonstrated increases in compliance from February 2008 to July 2008 as follows:

1. Item 1: from 70% to 100%;
2. Item 2: from 78% to 98%;

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		3. Item 3: remained at 100%; 4. Item 4: from 97% to 98%; 5. Item 5: from 86% to 98%; 6. Item 6: from 89% to 96%; 7. Item 7: from 73% to 100%; 8. Item 8: from 86% to 96%; and 9. Item 9: from 77% to 89%. MSH indicated that the training provided to the RNs in April 2008, in addition to the Unit Supervisors discussing audit results with the RNs conducting the admission assessments, has increased compliance in these areas. A review of 40 admission assessments (AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH) found significant improvement in the content and quality of the initial admission assessments in each of the required areas that comports with MSH's data. **Current recommendation**: Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	See D.3.a.i.
D.3.a.iii	vital signs;	See D.3.a.i.
D.3.a.iv	allergies;	See D.3.a.i.
D.3.a.v	pain;	See D.3.a.i.
D.3.a.vi	use of assistive devices;	See D.3.a.i.

D.3.a.vii	activities of daily living;	See D.3.a.i.
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	See D.3.a.i.
D.3.a.ix	conditions needing immediate nursing interventions.	See D.3.a.i.
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH's Nursing Department continues to use the Wellness and Recovery Model for evaluation and assessments. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.c	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 Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Include data regarding PTs and LVNs in licensing data. **Findings:** This recommendation has been deleted in agreement with the Court Monitor since it was not specifically required by the cell.

	practice in the state of California.	**Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** MSH's licensing data verified that all RNs (213) have an active California license. At the time of this review, MSH's training rosters indicated that 105 out of 113 (93% of) RNs who are required to complete Nursing Assessments and undergo competency evaluations were deemed competent. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's used the DMH Nursing Admission Assessment Monitoring based on an average sample of 96% of admissions for the month (February-July 2008) to assess compliance:

		12. *Initial nursing assessments are completed within 24 hours of the individual's admission.* — 99% A review of 40 individuals' nursing admission assessments (AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH) found that 39 were timely completed. **Current recommendation**: Continue current practice.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH used the DMH Integrated Nursing Admission Assessment Monitoring based on an average sample of 65% of Integrated Assessments due for the month (February-July 2008) to assess compliance with this requirement: 13. *Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within 7 days of admission.* — 76% MSH's data analysis showed an increase in compliance from 68% in February 2008 to 79% in July 2008. The Nurse Coordinators are monitoring the admissions to ensure that the Integrated Assessments are timely completed. Also, MSH has implemented an accountability system that addresses timely documentation in regards to performance issues.

		A review of 40 integrated assessment (AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH) found that 18 were timely completed, four included documentation that indicated attempts were made but were unsuccessful to complete the assessments and 18 were not timely completed. **Other findings:** This monitor's review found the overall quality of the Integrated Assessments to be poor, containing superficial and vague documentation. **Current recommendation**: Continue to monitor this requirement.
D.3.d.iii	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH used the DMH WRPC CET Team Attendance and Nursing Participation Monitoring form based on an average sample of 17% of 14-Day WRPs due in the month (February-July 2008). 1. *Nursing assessments are reviewed at every scheduled WRP meeting of the individual (RN communicates clinically relevant findings).* 98% In observations of two WRPTs (Program III, Unit 415 and Program I, Unit 410), this monitor found that although the nurse was prepared for the WRPTs, the review of the nursing assessments did not relate to the

		individuals' WRP objectives. In addition, there was very little analysis of clinical information provided by the nurse during the WRPs. These observations did not support MSH's data for this requirement. **Current recommendations**: 1. Ensure reliability of auditing data. 2. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Andrea Cirota, Acting Supervising Rehabilitation Therapist 2. Asha Vij, Occupational Therapist 3. Jack McClary, Supervisor for Vocational Services 4. Julia Hastings, Physical Therapist 5. Kelly Baker, Acting Supervising Rehabilitation Therapist 6. Mari Cobb, Rehabilitation Therapy Chief 7. Marion Paclibar, Physical Therapist 8. Rebecca McClary, Rehabilitation Therapy Program Assistant Reviewed: 1. DMH Rehabilitation Therapy Service Manual final draft 2. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission and focused assessments) 3. DMH Rehabilitation Therapy IA-RTS audit data for February-July 2008 4. Focused assessment (Physical Therapy, Speech Therapy and Comprehensive Integrated Physical Rehabilitation Therapy Assessment) audit data for April-July 2008 5. DMH Vocational Rehabilitation Assessment Tool and Instructions (implemented 3/08) 6. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions (implemented 3/08) 7. Draft of Vocational Rehabilitation Screening Tool 8. DMH Occupational Therapy Focused Assessment and Instructions (implemented 3/08) 9. DMH Occupational Therapy Focused Assessment Monitoring Tool and Instructions drafts (implemented 3/08) 10. DMH Physical Therapy Focused Assessment and Instructions

		(implemented 3/08) 11. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions (implemented 3/08) 12. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions (implemented 3/08) 13. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions (implemented 3/08) 14. List of individuals who had IA-RTS assessments from February-July 2008 15. Records of the following 20 individuals who had IA-RTS assessments from February-July 2008: AMM, AS, BE, EN, IGM, JC, JR, JTW, KD, KTB, MAB, MR, NH, RGM, SB, SF, TLM, TM, VP and YH 16. Records for the following 10 individuals who had Vocational Rehabilitation Assessments from March-July 2008: AP, BAM, DMS, MCL, PC, RAP, RT, SW, TR and WP 17. List of individuals with Physical Therapy assessment in March-July 2008 18. Records for the following eight individuals with Physical Therapy assessment in March-July 2008: AAA, CDJ, GB, JC, JS, MD, MEB and RAW 19. List of individuals with Occupational Therapy assessment in March-July 2008 20. Records for the following seven individuals with Occupational Therapy assessment in March-July 2008: BSK, HVT, JLS, JS, LMC, MH and TP 21. List of individuals with Comprehensive Integrated Rehabilitation Assessment in March-July 2008 22. Record for the following individual who had a Comprehensive Integrated Rehabilitation Assessments in March-July 2008: GB 23. List of individuals who had type D.4.d assessments from January-May 2008 24. Records of the following nine individuals who had type D.4.d

		assessments from January- April 2008: ALL, EA, ELN, FG, GB, MAF, NEJ, PC and RR 25. Training rosters and post-tests for Rehabilitation Therapy focused assessment trainings 26. CIPRTA training outline for WRPT members and corresponding training rosters and post-tests 27. Training materials for Vocational Services training Rehabilitation Therapists and Clinical Social Workers and corresponding training rosters and post-tests 28. Integrated Assessment Rehabilitation Therapy Section training rosters and corresponding post-tests 29. Functional Status, Skills and Supports, Writing Interventions training materials and training rosters 30. Mentoring Call Logs and Mentoring Acknowledgement Forms for the month of July
D.4.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures, and system development. **Findings:** The draft of the statewide Rehabilitation Therapy Manual has been subsequently updated as procedures and processes have evolved. The current draft (final draft) addresses the role of the Rehabilitation Therapist in the WRP, as well as the role of the RIAT team, POST team, Occupational Therapist, Physical Therapist, Speech Therapist, and Vocational Rehabilitation Counselors and Instructors. The manual includes the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services, as well as information related to 24-hour support plans and

		discipline-specific progress notes. The final draft is pending statewide implementation. The Manual should continue to be updated as procedures and systems develop. **Recommendation 2, March 2008:** Finalize and implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation, and Comprehensive Physical Rehabilitation Therapy assessments, and ensure process/format is consistent with those of the other three state hospitals. **Findings:** The following assessment tools and instructions have been revised, approved, and were implemented on 3/1/08: MH-C 9078 DMH Vocational Rehabilitation Assessment and Instructions; MH-C 9079 DMH Speech-Language Therapy Focused Assessment and Instructions; MH-C 9080 DMH Physical Therapy Focused Assessment and Instructions; MH-C 9081 DMH Occupational Therapy Focused Assessment and Instructions; and MH-C 9082 DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions. This is verified upon review of corresponding procedures and record review of individuals who received focused assessments between March-July 2008. It is noted upon review of Vocational Rehabilitation assessments and audit data that no standardized assessments have been used to contribute to assessment objective findings. It is recommended that as the CASAS system is implemented facility-wide, the section pertinent to Vocational Rehabilitation is incorporated into the current Vocational Rehabilitation focused assessment as part of standardized assessment findings.

		Recommendation 3, March 2008: Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at MSH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT. **Findings:** A Vocational Rehabilitation Screen revised draft has been developed and is pending statewide collaboration and implementation. Training was provided for Vocational services referrals to 30 out of 31 Rehabilitation Therapy staff on 6/4/08 and to 23 out of 39 Clinical Social Workers on 8/13/08. This was verified by review of training sign-in sheets. Training on the referral process for PT, OT, ST, and CIPRTA was provided to 22/31 Rehabilitation Therapy staff, 20/39 Clinical Social Workers, 34/37 Psychology staff, 43/90 Physicians, 13/19 Unit Supervisors, and 5/5 Nursing Coordinators on the following training dates: 4/18/08, 4/30/07, and 5/7/07. This was verified by review of training sign-in sheets. Currently, referral sources for CIPRTA assessments can include: the physician, the WRPT, and for individuals newly admitted or transferred to the Skilled Nursing unit, an informal screening by Occupational and/or Physical Therapy. However, this informal screening only appears to cover functional mobility, and does not seem to screen for other activities of daily living or functional communication. **Other findings:** Currently, all IA-RTS assessments are completed by one assessment team. This does not give other admissions Rehabilitation Therapists

		opportunities to provide admission assessments. It is strongly recommended that more than one team of therapists provide assessments in order to prevent incidental factors such as burn-out and possible rote completion of admission assessments. **Compliance:** Partial. **Current recommendations**: 1. Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals continue to be consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and EP requirements. 2. Revise and implement the proposed Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals. 3. Ensure that admission IA-RTS assessments are completed by more than one assessment team (to be selected from the pool of current admissions therapists), and that unit Rehabilitation Therapists perform type D.4.d assessments. 4. Utilize standardized assessments (e.g., CASAS) when available as part of the Vocational Rehabilitation focused assessments as clinically indicated.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Assessment assessments due each month in the review period of February–July 2008 (total of 301). The following table outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within five calendar days of the individual's admission, and*	37%
1.b	*Filed in the medical record.*	54%

Compliance during the last month of the previous review period (January 2008) compared to July of this period is reported follows: Item 1 from 68% to 30%; sub-criteria (1.a and 1.b) were not used in January 2008, so no comparable data were available from the last review period.

The facility analyzed the audit data for the review period and reported that low compliance was due to the group assessments proving to be time-consuming (4+ hours per assessment). There was a change in the assessment process from unit-based completion to the RIAT team completion in May. There was also an increase in the admission rate during this review period. The increase in admissions for that month appears to be a contributing factor to the decline in timeliness.

The facility plan for corrective action is to increase RT participation in the assessment process (beginning in August 2008), thus increasing timeliness of the assessments.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 84% of Vocational Rehabilitation focused assessments due each month for March-July 2008 (61 out of 80). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within five calendar days of the individual's admission, and*	51%
1.b	*Filed in the medical record*	92%

No comparable data were available from the last review period as the assessment was implemented in March 2008.

The facility reports that low compliance for Item 1.a is due to staffing shortages in Vocational Services during this reporting period, as well as the lack of a Vocational Rehabilitation Assessment completion tracking process. The facility plan of correction is to implement an assessment log to improve the tracking and assigning of these assessments, beginning in August 2008.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for March-July 2008 (total of 8). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within five calendar days of the individual's admission, and*	100%
1.b	*Filed in the medical record*	100%

No comparable data were available from the last review period as the assessment was implemented in March 2008.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for March-July 2008 (total of 32). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	100%
1.b	*Filed in the medical record*	100%

No comparable data were available from the last review period as the assessment was implemented in March 2008.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on review of one Comprehensive Integrated Physical Rehabilitation assessments due for each month for March-July 2008 (total of two). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional*	

	standards of care:	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	100%
1.b	*Filed in the medical record*	100%

No comparable data were available from the last review period as the assessment was implemented in March 2008.

Other findings:
A review of the records for twenty individuals (AMM, AS, BE, EN, IGM, JC, JR, JTW, KD, KTB, MAB, MR, NH, RGM, SB, SF, TLM, TM, VP and YH) to assess compliance with timeliness of D.4 IA-RTS assessments found nine records in compliance (JTW, KD, MAB, MR, SB, SF, TM, VP and YH), and eleven records not in compliance (AMM, AS, BE, EN, IGM, JC, JR, KTB, NH, RGM and TLM).

A review of the records for ten individuals (AP, BAM, DMS, MCL, PC, RAP, RT, SW, TR and WP) to assess compliance with timeliness of type D.4 Vocational Rehabilitation focused assessments found all ten records to be in compliance.

A review of the records for seven individuals (BSK, HVT, JLS, JS, LMC, MH and TP) to assess compliance with timeliness of type D.4 Occupational Therapy focused assessments found five records in compliance (BSK, HVT, JLS, JS and MH) and two records (LMC and TP) not in compliance. It was noted during the review that assessments were not consistently filed in the medical record.

A review of the records for eight individuals (AAA, CDJ, GB, JC, JS, MD, MEB and RAW) to assess compliance with timeliness of type D.4 Physical Therapy focused assessments found all eight records to be in compliance.

		In the presentation of facility data, the facility reported that two CIPRTA assessments were completed in the review period. However, upon record review, the facility reported that only one Comprehensive Integrated Physical Rehabilitation Therapy Assessment was due and completed (GB). A review of this record found it to be in compliance with timeliness of assessment completion. **Compliance:** Partial. **Current recommendation:** Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Develop and implement D.4 monitoring tool(s) which report data on Enhancement Plan cells pertaining to all Rehabilitation Therapy assessments (Integrated and Focused) according to DMH format/standards, including timeliness. • Finalize and implement focused assessment audit tools. **Findings:** The following audit tools were developed and were implemented for April 2008: MH-C 9044b DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Form Instructions; MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form Instructions; MH-C 9044d DMH Physical Therapy Assessment Monitoring Form Instructions; MH-C 9044e DMH Speech-Language Pathology Assessment Monitoring Form Instructions; and the MH-C

9044f DMH Vocational Rehabilitation Assessment Monitoring Form Instructions. Data was provided for April-July 2008 for all monitoring tools except MH-C 9044e DMH Speech Therapy Assessment Monitoring Form, as there were no Speech Therapy assessments due in these months.

Recommendation 3, March 2008:
Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Integrated Assessment assessments due for each month in the review period of January –May 2008 (total of 301). The following table outlines the indicators with corresponding mean compliance rates for February-July 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	83%
2.b	*Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented*	51%
2.c	*Structured assessment activities and pertinent information related to setting/time are listed*	43%
2.d	*Leisure and enrichment profile items are completed*	81%

2.e	*Functional observation items are completed for [all pertinent sections]*	24%

The compliance during the last month of the previous review period (January 2008) compared July of this period is as follows: Item 2 from 22% to 52%. No comparable data were collected on sub-items in the last review period.

The facility analyzed the data and reported that Functional Observations are present in 2.e; however, compliance with including the Rehabilitation Therapy perspective is low. No facility data analysis was provided for low compliance with items 2.a, 2.b, 2.c, or 2.d.

The facility's plan of correction is to provide further training and mentoring to the Rehabilitation Therapy staff in the areas of structured assessment activities and functional observations.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due for each month in the review period of February-July 2008 (61 out of 80). The following table outlines the indicators with corresponding mean compliance rates for February-July 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	92%
2.b	*Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24-hour admission assessment), interview of individual, chart review, observation of structured activities used in the assessment process, and*	28%

	consultations are reviewed and documented.	
2.c	*Educational background items are completed.*	93%
2.d	*Employment history items are completed.*	93%
2.e	*Personal grooming and appearance items are completed.*	98%
2.f	*All physical functioning items are completed and specific functional measurements are documented if appropriate.*	51%
2.g	*All standardized assessments, as indicated.*	n/a

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility analyzed the data and reported that low mean compliance for Item 2 was due to both Industrial Therapists being off of work due to illness in the month of June, and compliance with Item 2,f was inconsistent due to this area not being addressed regularly. No facility data analysis was provided for low compliance with item 2.b.

The facility's plan for corrective action is to provide training and mentoring to Vocational Services staff on physical functioning.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Occupational Therapy Focused Assessments due for each month in the review period of March-July (total of eight). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	100%
2.b	*Onset date completed*	100%

2.c	*Previous pertinent clinical assessments, WRPs and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	73%
2.d	*Prior level of functioning completed including equipment owned*	55%
2.e	*Pertinent medical history completed, including precautions.*	100%
2.f	*Current functional abilities are addressed including:*	100%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility analyzed the data and reported that the low compliance with 2.c was due to the trend that reviewed medical documents were not being addressed in the assessment. No data analysis was provided for low compliance with 2.d.

The facility's plan of correction is to provide training to Occupational Therapy staff on the need for reviewing and documenting the medical records in the assessment.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period of March-July 2008 (total of 32). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	7%

2.b	*Diagnosis*	81%
2.c	*Functional PT diagnosis*	97%
2.d	*Onset date*	94%
2.e	*Age*	100%
2.f	*Chief complaint/mechanism of injury*	19%
2.g	*Past Medical History*	91%
2.h	*Prior level of function*	97%
2.i	*Special precautions*	97%
2.j	*Orientation*	91%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility analyzed the data and reported that the low compliance with item 2.f was due to the chief complaint/mechanism of injury not being addressed in the assessment. No analysis was provided for low compliance with items 2.a and 2.b.

The facility's plan of correction is to provide training to Physical Therapy staff on addressing the chief complaint/mechanism of injury.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of CIPRTA focused assessments due each month for March-July (total of 2). The following table outlines the indicators with corresponding mean compliance rates for March-July:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	50%
2.b	*Previous POST evaluations, Vocational evaluations, WRPs plans and other salient medical records,*	100%

	interview of individual, chart review, observation, and consultations are reviewed and documented.	
2.c	*Pertinent medical history completed, including precautions*	100%
2.d	*Prior level of functioning in all areas is addressed, including adaptive equipment*	50%
2.e	*Current functional abilities are addressed, as indicated*	100%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

Other findings:
A review of the records of twenty individuals (AMM, AS, BE, EN, IGM, JC, JR, JTW, KD, KTB, MAB, MR, NH, RGM, SB, SF, TLM, TM, VP and YH) to assess compliance with D.4.b.i for D.4 IA-RTS assessments found 15 records in substantial compliance (AMM, AS, BE, EN, IGM, JC, JTW, MAB, MR, NH, RGM, SB, TLM, VP and YH); four records in partial compliance (KD, KTB, SF and TM); and one record not in compliance (JR). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Assessments are not consistently comprehensive and accurate.
2. Assessments do not consistently adequately address and specify functional abilities.

A review of the records of ten individuals (DMS, WP, SW, RT, AP, MCL, TR, BAM, PC, RAP) to assess compliance with D.4.b.i in type D.4 Vocational Rehabilitation focused assessments found all 10 records in substantial compliance.

A review of the records of seven individuals (BSK, HVT, JLS, JS, LMC, MH and TP) to assess compliance with D.4.b.i in type D.4 Occupational

		Therapy focused assessments found all seven records in substantial compliance. A review of the records of eight individuals (AAA, CDJ, GB, JC, JS, MD, MEB and RAW) to assess compliance with D.4.b.i in type D.4 Physical Therapy focused assessments found all eight records in substantial compliance. Only one Comprehensive Integrated Physical Rehabilitation Therapy Assessment was completed (GB). This record was reviewed and found to be in substantial compliance with D.4.b.i. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Integrated Assessment assessments due each month in the review period of February-July 2008 (total of 301). The following table outlines the indicators with corresponding mean

compliance rates for February-July 2008:

3.	*Identifies the individual's current functional status, and*	
3.a	*The functional status is described for Physical Functioning*	58%
3.b	*The functional status is described for Social Functioning*	43%
3.c	*The functional status is described for Life Skills*	43%
4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	
4.a	*A description of the skills and supports necessary to live in the setting in which she/he will be placed, and*	35%
4.b	*A discussion of possible progression/steps towards this level of independence.*	40%

The mean compliance rate for item 3 during the previous review period was 76% and the current mean compliance rate is 36%. Compliance with Item 3 was 70% in January 2008 and 38% in July 2008. Compliance with item 4 was 73% in January 2008 and 90% in July 2008. No comparable data were collected on sub-items in the last review period.

The facility attributed the poor compliance with items 3 and 4 to the change in the assessment process, which required more than one team to complete IA-RTS assessments.

The facility plan of correction is to provide training and mentoring to the Rehabilitation Therapy staff in all areas relating to functional status and skills and supports needed to transfer to the next level of care.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 84% of Vocational Rehabilitation focused assessments due each month for March-July 2008 (61 total of 80). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

3.	*Identifies the individual's current functional status, and*	49%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	34%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility analyzed the data and reported that current functional status and skills and supports needed to transfer to the next level of care were not being included in the assessments.

The facility plan of correction is to provide training and mentoring will to the Vocational Services staff in these areas.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Occupational Therapy focused assessments due each month for March-July 2008 (total of 8). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Physical Therapy focused assessments due each month for March-July 2008 (total of 32). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

3.	*Identifies the individual's current functional status, and*	70%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	67%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility reviewed the data and reported that the low compliance with items 3 and 4 was because the content in these assessment areas was written from a Physical Rehabilitation perspective rather than a Psychiatric Rehabilitation perspective.

The facility's plan of correction is to provide training and mentoring to Physical Therapy staff not in compliance with these areas to ensure proper attention to the psychiatric rehabilitation needs of the individuals.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Integrated Physical Rehabilitation Therapy focused

assessments due each month for March-July (total of 2). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

Other findings:
A review of the records of 20 individuals (AMM, AS, BE, EN, IGM, JC, JR, JTW, KD, KTB, MAB, MR, NH, RGM, SB, SF, TLM, TM, VP and YH) to assess compliance with D.4.b.ii in D.4 IA-RTS assessments found 14 records in substantial compliance (AS, BE, EN, JC, JTW, KD, MR, NH, RGM, SB, TLM, TM, VP and YH); five records in partial compliance (AMM, IGM, KTB, MAB and SF); and one record (JR) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Assessments do not consistently provide thorough analysis of functional status.
2. Assessments do not consistently discuss skills and supports needed to facilitate transfer to the next level of care that are in line with the individual's needs.

A review of the records of 10 individuals (AP, BAM, DMS, MCL, PC, RAP, RT, SW, TR and WP) to assess compliance with D.4.b.ii in type D.4 Vocational Rehabilitation focused assessments found all 10 records in substantial compliance.

		A review of the records of seven individuals (BSK, HVT, JLS, JS, LMC, MH and TP) to assess compliance with D.4.b.ii in type D.4 Occupational Therapy focused assessments found two records in substantial compliance (BSK and JLS) and five records in partial compliance (HVT, JS, LMC, MH and TP). An identified pattern of deficiency that the facility should focus on in order to improve compliance is that the assessments do not consistently analyze potential skills and supports needed to facilitate transfer to the next level of care. A review of the records of eight individuals (AAA, CDJ, GB, JC, JS, MD, MEB and RAW) to assess compliance with D.4.b.ii in type D.4 Physical Therapy focused assessments found six records in substantial compliance (AAA, JC, JS, MD, MEB and RAW) and two records in partial compliance (CDJ and GB). An identified area of deficiency that the facility should focus on in order to improve compliance is that the assessments do not consistently analyze both functional status and potential skills and supports needed to facilitate transfer to the next level of care. Only one Comprehensive Integrated Physical Rehabilitation Therapy Assessment was completed (GB). A review of this record found it to be not in compliance with D.4.bii. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.ii criteria.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness	**Current findings on previous recommendation:**

activities.

Recommendation, March 2008:
Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Integrated Assessment assessments due each month for the review period of February-July 2008 (total of 301). The following table outlines the indicators with corresponding mean compliance rates for February-July 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	84%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	79%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	76%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	61%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response*	43%

	to the following [required] questions	
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	50%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	49%

Compliance during the last month of the previous review period (January 2008) compared July of this period as follows: Item 5 from 65% January to 83% in July; Item 6 from 57% in January to 86% in July; Item 7 from 16% in January to 79% in July. No comparable data were collected on sub-items in the last review period.

The facility analyzed the data and reported that the low compliance with item 7 was due to the trend that the motivation section was not addressing the sub-criteria of motivation in wellness activities. The facility reported that the data reflected improvement trends in some sub-items of items 5, 6, and 7 during the months of June and July. Substantial compliance (90% or higher) was reflected in June for items 5.a, 6.a, 7.a, and 7.b and in July for 5.a and 7.c.

The facility plan of correction is to provide training and mentoring to the Rehabilitation Therapy staff in the areas of strengths that include direct quotes from the individual, the clinical assessment of the individual's strengths, and assessment of motivation for engaging in wellness activities, which includes both direct quotes from the individual and the therapist's clinical assessment of the individual's motivation.

Using the DMH Vocational Rehabilitation Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each

month for the review period of March-July 2008 (61 out of 80). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	79%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	77%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	90%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	51%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	41%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	28%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	39%

No comparable data were available from the last review period, as the

assessment was implemented in March 2008.

The facility attributed low compliance to the newness of the vocational rehabilitation assessment tool as well as new hires within the Vocational Services department. The facility reported that compliance was low in all areas except for the identification of strengths for engaging in wellness activities. The facility plan of correction is to provide training and mentoring to Vocational Services staff in all areas and review the assessments prior to finalization.

Using the DMH Occupational Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period of March-July 2008 (total of 8). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	100%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	100%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	91%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	60%
7.b	*The individual's current level of motivation has*	40%

	been identified by considering the individual's stage of change, and;	
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	40%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility attributed low compliance with items 7.a, 7.b, and 7.c to a discrepancy between physical and psychiatric perspectives. The facility plan of correction is to provide training to Physical Therapy staff regarding these areas.

Using the DMH Physical Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period of March-July 2008 (total of 32). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	93%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	96%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	76%
7.	*Motivation for engaging in wellness activities*	

7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	71%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	36%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	52%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility attributed low compliance with items 6.b, 7.a, 7.b, and 7.c to a discrepancy between physical and psychiatric perspectives. The facility plan of correction is to provide training to Occupational Therapy staff regarding these areas.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of CIPRTA Focused Assessments due each month for the review period of March-July 2008 (total of 2). The following table outlines the indicators with corresponding mean compliance rates for March-July 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	50%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	100%

6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	50%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	100%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	50%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	50%

No comparable data were available from the last review period, as the assessment was implemented in March 2008.

The facility attributed low compliance with items 5.a, 6.b, 7.b, and 7.c to a discrepancy between physical and psychiatric perspectives. The facility plan of correction is to provide training to the POST team regarding these areas.

Other findings:
A review of the records of 20 individuals (AMM, AS, BE, EN, IGM, JC, JR, JTW, KD, KTB, MAB, MR, NH, RGM, SB, SF, TLM, TM, VP and YH) to assess compliance with D.4.b.iii in D.4 IA-RTS assessments found 13 records in substantial compliance (AMM, AS, BE, EN, IGM, JC, JTW, KD, KTB, MR, NH, RGM and YH) and seven records in partial compliance (JR, MAB, NH, SB, SF, TLM and TM). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Assessments do not consistently provide thorough analysis of

		individual strengths for engaging in wellness activities. 2. Assessments do not consistently provide thorough analysis of individual motivation for engaging in wellness activities. A review of the records of 10 individuals (AP, BAM, DMS, MCL, PC, RAP, RT, SW, TR and WP) to assess compliance with D.4.b.iii in type D.4 Vocational Rehabilitation focused assessments found one record in substantial compliance (PC) and nine records in partial compliance (AP, BAM, DMS, MCL, RAP, RT, SW, TR and WP). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Assessments do not consistently provide thorough analysis of individual strengths for engaging in wellness activities. 2. Assessments do not consistently provide thorough analysis of individual motivation for engaging in wellness activities. A review of the records of seven individuals (BSK, HVT, JLS, JS, LMC, MH and TP) to assess compliance with D.4.b.iii in type D.4 Occupational Therapy focused assessments found all eight records in substantial compliance. A review of the records of eight individuals (AAA, CDJ, GB, JC, JS, MD, MEB and RAW) to assess compliance with D.4.b.iii in type D.4 Physical Therapy focused assessments found six records in substantial compliance (CDJ, GB, JS, MD, MEB and RAW) and two records in partial compliance (AAA and JC). An identified area of deficiency that the facility should focus on in order to improve compliance is that the assessments do not consistently provide thorough analysis of individual strengths for engaging in wellness activities. Only one Comprehensive Integrated Physical Rehabilitation Therapy Assessment was completed (GB). A review of this record found it to be

		in partial compliance with D.4.b.iii. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that individuals who are performing assessments (admission and focused) have received competency-based training regarding these assessments, and have achieved competency per protocol. **Findings:** According to facility report, all 31 Wellness and Recovery Plan Team Rehabilitation Therapists received competency-based training on 3/3/08, 3/5/08, 4/17/08, 4/28/08, 5/14/08, and 6/18/08 for the Integrated Assessment: Rehabilitation Therapy Section. The facility reported that 30 out of 31 RT staff were trained to competency. The training was verified by review of raw data from training rosters and training post-tests. The four members of the current Rehabilitation Integrated Assessment team received hands-on training on 7/28/08 regarding Functional Status, Skills and Supports, and Writing Interventions (based on identified need for further training in these areas); this training was verified by review of training materials and rosters. All four Vocational Rehabilitation staff members who are performing Vocational Rehabilitation assessments received competency-based

		training on the Vocational Rehabilitation Assessment on 06/04/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post-tests. Both Physical Therapy staff members who are performing Physical Therapy assessments received competency-based training on the Physical Therapy focused assessment on 5/23/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post-tests. Both Occupational Therapy staff members who are performing Occupational Therapy assessments received competency-based training on the Occupational Therapy focused assessment on 5/20/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post-tests. All four POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments received competency-based training on the Comprehensive Integrated Physical Rehabilitation Therapy focused assessment on 05/13/08 and were trained to competency. This training was verified by review of raw data from training rosters and training post-tests. **Recommendation 2, March 2008:** Establish inter-rater agreement prior to the implementation of Rehabilitation Therapy focused assessment audit tools. **Findings:** Two raters currently complete IA-RTS audits, and the facility reports 100% inter-rater agreement. Facility PLATO data reveals an inter-rater agreement of 81% with a range of 78-84%. No inter-rater agreement data is available for focused assessment

		raters, as only one rater completes audits of focused assessments. **Recommendation 3, March 2008:** Develop and implement a system by which to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings. **Findings:** A mentoring system has been developed and implemented to provide feedback based on assessment data. A review of Mentoring Call Logs and Mentoring Acknowledgement Forms for the month of July found the current process to be excellent for providing feedback to Rehabilitation Therapists. The facility should focus on providing comparable mentoring with POST team and Vocational Rehabilitation staff based on focused assessment findings. See D.4.c, Recommendation 4 for findings regarding CEU courses. **Recommendation 4, March 2008:** Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff. **Findings:** This recommendation has not been met. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all clinicians responsible for performing or reviewing

		rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible. 2. Implement a system by which to provide feedback and mentoring to staff based on analysis of audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments). 3. Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.
D.4.d	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 § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all individuals admitted to MSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months. **Findings:** According to facility report, 54 out of 251 type D.4.d assessments were completed during the February-July review period. **Other findings:** A review of the records of nine individuals (ALL, EA, ELN, FG, GB, MAF, NEJ, PC and RR) who were reported to have received type D.4.d IA-RTS assessments. All records had evidence of completed assessments. Seven records (ALL, EA, ELN, FG, GB, NEJ, PC and RR) were in substantial compliance with D.4.d and one record (MAF) was in partial compliance with D.4.d in regards to assessment quality. **Compliance:** Partial.

		Current recommendation: Ensure that all individuals admitted to MSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.

5. Nutrition Assessments		
D.5	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:	**Methodology:** <u>Interviewed</u>: 1. Christina Marshall, Director of Nutrition Services 2. Ninfa Guzman, Hospital Administrative Resident 3. Portia Salvacion, Assistant Director of Nutrition Services <u>Reviewed</u>: 1. Nutrition Care Monitoring audit data for February-July 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from February-July 2008 for each assessment type 3. Records for the following five individuals with type D.5.a assessments from February-July 2008: CMG, GLT, GR, MGF and PD 4. Records for the following four individuals with type D.5.c assessments from February-July 2008: JAC, NA, RS and SF 5. Records for the following nine individuals with type D.5.d assessments from February-July 2008: CC, CH, DF, FM, JCB, LK, RML, RMT and SG 6. Records for the following six individuals with type D.5.e assessments from February-July 2008: BSK, KSC, PS, TDW, TJ and WH 7. Records for the following five individuals with type D.5.f assessments from February-July 2008: JDE, KCY, MJK, MRA and SRF 8. Records for the following nine individuals with type D.5.g assessments from February-July 2008: ARD, BE, GS, JDE, JM, MG, MR, SR and TL 9. Records for the following eight individuals with type D.5.i assessments from February-July 2008: CWL, DM, JM, KB, MAF, MAO, MDW, MG 10. Records for the following seven individuals with type D.5.j.i

		assessments from February-July 2008: AB, JG, KLF, SB, SFY, SM and TK 11. Records for the following nine individuals with type D.5.j.ii assessments from February-July 2008: BU, CRG, DT, JDR, MC, MCF, RAV, RDU and RLH 12. DMH Nutrition Status Type definitions (revised)
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a. Assessments due each month in the review period of February-July 2008 (total of 18). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	94%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%

9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	92%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Data analysis was provided for the facility for item 1, as they noted that despite a mean of 94% compliance for the six-month review period, compliance during the last month of the current review period (July 2008) was noted to be 75%. The facility reviewed the July 2008 log entries in the Nutrition Services High Risk Admission Log Book and found that high-risk telephone referrals received from Unit 104 (Admission Unit) were not communicated to the clinical staff in a timely manner per established Nutrition Services Procedure # 4101.002 (Procedure for Nutrition Screening Referral for High Risk), which in turn affected timeliness. The facility took the following actions:

- On 7/29/08, the Nutrition Services Assistant Director/Clinical met with the Food Services Supervisors involved and reviewed the need to comply with the established procedure.
- On 7/28 and 7/29/08, Nutrition clinical staff developed an interim revision of the procedure to prevent recurrence of the breach.
- On 7/30/08, a memo was disseminated to the clinical staff, Food Service Supervisors and the Office Technicians/Office Assistant,

		Hospital Administrative Resident, Director and Assistant Director/Nutrition Services regarding the interim procedure revision. **Other findings:** A review of the records of five individuals (CMG, GLT, GR, MGF and PD) to assess compliance with Nutrition type D.5.a assessment criteria found three records in compliance (DR, GLT and MGF) and two records in partial compliance(CMG and PD). Identified patterns of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.a assessments include the following: 1. Data regarding assessment classification by type is not consistent. Six records were reviewed that were reported to be type D.5.a assessments, and one of these records did not meet the criteria for classification as a type D.5.a assessment. The facility progress report stated that an N of 18 individuals required Nutrition type D5.a assessments but the facility list indicated an N of 15. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
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—MSH does not have a medical/surgical unit.
D.5.c	For new admissions directly into the skilled nursing	**Current findings on previous recommendation:**

	facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c Assessments due each month for the review period of February-July 2008 (total of 5). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	n/a
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%

		14. *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* — n/a 15. *Assessment utilizes approved abbreviations* — 100% 16. *Assessment is concise* — 100% 17. *Assessment is legible* — 100% 18. *Each page of the assessment is signed* — 80% No facility data analysis was provided for item 18, which was less than 90% compliance. The facility reports that the mean compliance rate for the last review period was 100% compared to the current review period of 100%. **Other findings:** A review of the records of four individuals (JAC, NA, RS and SF) to assess compliance with Nutrition type D.5.c assessment criteria found all four records in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.c assessments include the following: 1. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition recommendations are not consistently aligned with goals and nutrition diagnosis. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies,	**Current findings on previous recommendation:**

	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 be completed within 7 days of admission.	**Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d Assessments due each month for the review period of February –July 2008 (total of 96). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	99%
2.	*All required subjective concerns are addressed*	98%
3.	*All pertinent objective nutrition information is accurately addressed*	95%
4.	*Estimated daily needs for nutrients specified are appropriate*	99%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	98%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	96%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	99%
11.	*Recommendations are appropriate and complete*	98%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	99%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%

		14. *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* — 100% 15. *Assessment utilizes approved abbreviations* — 100% 16. *Assessment is concise* — 100% 17. *Assessment is legible* — 99% 18. *Each page of the assessment is signed* — 100% No facility data analysis was provided regarding type D.5.d Nutrition Assessments, as no areas were found to be below 90% compliance. **Other findings:** A review of the records of nine individuals (CC, CH, DF, FM, JCB, LK, RML, RMT and SG) to assess compliance with Nutrition type D.5.d assessment criteria found five records in substantial compliance (CH, JCB, RML, RMT and SG) and four records in partial compliance (CC, DF, FM and LK). An identified area of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.d assessments is that nutrition recommendations are not consistently aligned with goals and nutrition diagnosis. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its

compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due for each month for the review period of February-July 2008 (total of 41). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	97%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	92%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	98%

		18. *Each page of the assessment is signed* 100% No facility data analysis was provided regarding type D.5.e Nutrition Assessments, as no areas were found to be below 90% compliance. **Other findings:** A review of the records of six individuals (BSK, KSC, PS, TDW, TJ and WH) to assess compliance with Nutrition type D.5.e assessments found four records in substantial compliance (BSK, TDW, TJ and WH) and two records in partial compliance (KSC and PS). Identified areas of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.c assessments include the following: 1. Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. Nutrition recommendations are not consistently aligned with goals and nutrition diagnosis. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.f	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments due each month for the review period of February-July

2008 (total of five). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	80%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	80%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

		No facility data analysis was provided for items for items 2 and 10. **Other findings:** A review of the records of five individuals (JDE, KCY, MJK, MRA and SRF) to assess compliance with Nutrition type D.5.f assessment criteria found all five records in substantial compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g Assessments due each month for the review period of February-July 2008 (total of 138). The following outlines the indicators with corresponding mean compliance rates for February-July 2008: 1. *Assessment is completed on time per policy* 99% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 96% 4. *Estimated daily needs for nutrients specified are appropriate* 99% 5. *Assessment utilizes findings from subjective and objective data* 100%

6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	99%
7.	*Nutrition education is documented*	99%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	98%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	99%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	99%
18.	*Each page of the assessment is signed*	99%

No facility data analysis was provided regarding type D.5.g Nutrition Assessments, as no line items were found to be in less than 90% compliance.

Other findings:
A review of the records of nine individuals (ARD, BE, GS, JDE, JM, MG, MR, SR and TL) to assess compliance with Nutrition type D.5.g assessment criteria found seven records in substantial compliance (ARD, BE, GS, JM, MG, MR and TL) and two records (JDE and SR) in partial compliance. An identified pattern of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.g assessments is that nutrition objectives are not consistently

		specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.h	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 43% of Nutrition Assessments (all types) due each month for the review period of February –July 2008 (total of 647 out of 1526). Based on this data, the facility reports that 100% (weighted mean) of Nutrition admission assessments had evidence of a correctly assigned NST level. **Other findings:** A review of 63 records (AB, ARD, BE, BSK, BU, CC, CH, CMG, CRG, CWL, CWL-2, DF, DM, DT, FM, GLT, GR, GS, JAC, JCB, JDE, JDE-2, JDR, JG, JM, JM-2, KB, KCY, KLF, KSC, LK, MAF, MAO, MC, MCF, MDW, MG, MG-2, MGF, MJK, MR, MRA, NA, PD, PS, RAV, RDU, RLH, RML, RMT, RS, SB, SF, SFY, SG, SM, SR, SRF, TDW, TJ, TK, TL and WH) found that 62 records had evidence of a correctly assigned Nutritional Status Type Level, and were in compliance with D.5.h, and one record (KLF) was not in compliance with D.5.h. **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.5.i</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, March 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.i Assessments due each month for the review period of February –July 2008 (total of 217 out of 958). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>99%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>96%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>92%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>99%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>88%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>96%</td></tr>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>99%</td></tr>
<tr><td>10.</td><td>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</td><td>98%</td></tr>
</table></td></tr>
</table>

		11. *Recommendations are appropriate and complete* 100% 12. *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* 100% 13. *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* 97% 14. *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* 100% 15. *Assessment utilizes approved abbreviations* 100% 16. *Assessment is concise* 100% 17. *Assessment is legible* 100% 18. *Each page of the assessment is signed* 99% Facility data analysis was not provided for item 7. **Other findings:** A review of the records of eight individuals (CWL, DM, JM, KB, MAF, MAO, MDW, MG) to assess compliance with Nutrition type D.5.i assessment criteria found four records in substantial compliance (KB, MAF, MAO and MDW) and four records in partial compliance (CWL, DM, JM and MG). An identified pattern of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.i assessments is that nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendation:**

Recommendation, March 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i Assessments due each month for the review period of February-July 2008 (total of 23). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	96%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	96%
4.	*Estimated daily needs for nutrients specified are appropriate*	81%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	87%
11.	*Recommendations are appropriate and complete*	91%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	90%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%

14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	X
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

No facility data analysis was provided regarding items 4 and 10.

Other findings:
A review of the records of seven individuals (AB, JG, KLF, SB, SFY, SM and TK) to assess compliance with Nutrition type D.5.j.i assessment criteria found that one record was misclassified (SB) and one record was either misclassified or not in the record (AB). All five remaining records (JG, KLF, SFY, SM and TK) were found to be in partial compliance with Nutrition type D.5.j.i assessment criteria. Identified patterns of deficiencies that the facility should focus on in order to improve compliance with Nutrition type D.5.j.i assessments include the following:

1. Data regarding assessment classification is not consistent.
2. Nutrition objectives are not consistently specific, behavioral, observable and measurable.
3. Nutrition recommendations are not consistently aligned with goals and nutrition diagnosis.

Compliance:
Partial.

Current recommendations:
1. Develop and implement a formal system to log and track incoming referrals.
2. Continue current efforts to achieve compliance.

D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 37% of Nutrition Type D.5.j.ii Assessments due each month for the review period of February-July 2008 (80 out of 218). The following outlines the indicators with corresponding mean compliance rates for February-July 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	95%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	96%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	97%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when*	93%

	actual/potential aspiration/dysphagia is present	
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	95%
18.	*Each page of the assessment is signed*	99%

No facility data analysis was provided regarding type D.5.j.ii Nutrition Assessments as all sub-items were above 90% compliance.

Other findings:
A review of the records of nine individuals (BU, CRG, DT, JDR, MC, MCF, RAV, RDU and RLH) to assess compliance with Nutrition type D.5.j.ii assessment criteria found five records in substantial compliance (BU, CRG, DT, MCF and RDU) and four records in partial compliance (JDR, MC, RAV and RLH). An identified pattern of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii assessments is that nutrition objectives are not consistently specific, behavioral, observable and measurable.

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Four individuals: AAH, JU, RM and WS 2. Cynthia Lusch, Clinical Administrator 3. Ken Layman, Treatment Enhancement Coordinator 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Nakil Desai, CSW 6. Purvi Shah Patel, LCSW 7. Sharon Nevins, Executive Director 8. Shirin Karimi, LCSW, Chief of Social Work 9. Terry Garcia, LCSW, Supervising Social Worker Reviewed: 1. Charts of the following 22 individuals: AD, AS, CDF, CGS, CHW, CMG, DAC, DB, EK, JDC, JDG, JS, LAB, LGS, LK, MA, NSO, PAA, RR, SDE, SK and SM 2. MSH Family Therapy Needs Assessment 3. MSH Social History Auditing Tools 4. MSH Social History Auditing Instructions 5. MSH Progress Report Observed: 1. WRPT Conference for DC and YB 2. PSR Mall group: Reality Orientation 3. PSR Mall group: Mind Over Mood 4. PSR Mall group: Legal Issues-Court Preparation 5. PSR Mall group: Social Skills 6. PSR Mall group: Substance Recovery 7. PSR Mall group: ESL 8. PSR Mall group: Healthy Lifestyle 9. PSR Mall group: Motivational Group

		10. PSR Mall group: Sports and Fitness 11. PSR Mall group: DBT Skills Introduction 12. PSR Mall group: Recovery Games
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that the 5-Day Integrated Assessment and the 30-Day Social History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive. **Findings:** Using items 1-3 from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 79% of the Integrated Assessments: Social Work Section due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate*	94%
2.	*Current, and*	75%
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.*	93%
2.b	*Includes behavioral observations since the time of admission, and*	75%
2.c	*Provides adequate information regarding the individual's current psychosocial functioning.*	75%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the*	92%

		information is not available.
		The mean compliance rates for items 1, 2, and 3 for the previous review period were 97%, 94%, and 94% respectively. According to the Chief of Social Work, lower compliance during this review period was due to changes in Integrated Assessment Instructions introduced in March and May 2008. This monitor reviewed 13 charts (AD, CDF, CGS, CMG, DAC, DB, JDC, JS, LAB, NSO, PAA, RR and SK). Twelve of the Integrated Assessments: Social Work Section in the charts were current, accurate, and comprehensive. PAA's Integrated Assessment was not in the chart. This monitor reviewed nine charts (AD, CDF, CMG, JDC, JS, LAB, LGS, NSO and PAA). Five of the charts (AD, CDF, CMG, LGS and PAA) did not contain the 30-day Social History Assessments. The 30-day assessments in the remaining four charts (JDC, JS, LAB and NSO) were accurate, current, and comprehensive. **Compliance:** Partial. **Current recommendation:** Ensure that the 5-Day Integrated Assessment and the 30-Day Social History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments.

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Findings:
Using items 4-6 from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 55% of the 30-Day Psychosocial Assessments due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>99%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>98%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>98%</td></tr>
</table>

Mean compliance for all three items for the previous review period was 95%.

This monitor reviewed ten charts (AS, CHW, JDG, JS, LAB, LK, MA, NSO, SDE and SM). All 30-day Social History Assessments in the charts addressed the factual inconsistencies and where factual inconsistencies were identified, appropriate resolutions were offered (for example in NSO and SM).

Compliance:
Substantial.

Current recommendation:
Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments.

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<tr>
<td>D.6.c</td>
<td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td>
<td>

Current findings on previous recommendation:

Recommendation 1, March 2008:
Ensure all SW Integrated Assessments are completed and available to

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</table>

the WRPT before the seven-day WRPC.

Findings:
Using item 7 from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a 79% sample of all Integrated Assessments: Social Work Section due for the month (February to July 2008), reporting a mean compliance rate of 90%. The compliance for the previous period was 96%.

This monitor reviewed 14 charts (AD, CDF, CMG, DAC, DB, JS, LAB, LGS, LK, MA, NSO, RR, SDE and SK). Thirteen of the Integrated Assessments in the charts (AD, CDF, DAC, DB, JS, LAB, LGS, LK, MA, NSO, RR, SDE and SK) were timely and were made available to the WRPTs before the seven-day conference. One of them (CMG) was untimely.

Recommendation 2, March 2008:
Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the thirtieth day of admission.

Findings:
Using item 8 from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 55% of the 30-Day Psychosocial Assessments due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

8.	*Fully documented by the 30th day of the individual's admission.*	72%
8.a	*Competed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission*	71%
8.b	*Filed in the medical record.*	95%

		The mean compliance rate for item 8 in the previous review period was 80%. According to the Chief of Social Work, lower compliance for this review period was a result of an increase in the number of admissions. This monitor reviewed ten charts (DAC, EK, JDC, JS, LAB, LK, MA, NSO, RR and SDE). Five of the 30-day Social History Assessments in the charts (EK, JS, LK, MA and RR) were timely and available to the WRPTs before the 30-day conference. The assessments were not timely for the remaining five (DAC, JS, LAB, NSO and SDE). **Compliance:** Partial. **Current recommendations**: 1. Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status. **Findings:** Using item #10 (*Educational status*) from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a 79% sample of all Integrated Assessments: Social Work Section due for the month (February to July 2008), reporting a mean compliance rate of 92%. The compliance rate for the previous period was 96%.

This monitor reviewed eight charts (CHW, DAC, EK, JDC, JS, LAB, NSO and RR). Seven of the Integrated Assessments: Social Work Section included the individual's educational status and one of them (LAB) did not.

Using item 10 from the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 55% of the 30-Day Psychosocial Assessments due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

10.	*Educational status*	43%
10.a	*Education includes recommendations for learning accommodations and testing, or states if none are needed, and*	46%
10.b	*Discusses the impact of the individual's education on his/her Wellness and Recovery.*	84%

The compliance for item 10 for the pervious review period was 96%.

According to the Chief of Social Work lower compliance for this review period is due to changes in instructions and inclusion of additional sub-indicators (10.a and 10.b) to the main indicator (10). According to the Chief of Social Work, auditors for this item have raised questions regarding the discipline best suited to address the individual's educational status. The Chief of Social Work is scheduling a joint discussion/training session for the Psychology and Social Work staff to clarify the question.

This monitor reviewed eight charts (CHW, DAC, EK, JDC, JS, LAB, NSO and RR). Six of the 30-day Social History Assessments in the charts (CHW, EK, JDC, JS, LAB and NSO) addressed the social factors and the educational status of the individuals, and two of them (DAC and

		RR) did not. **Compliance:** Partial. **Current recommendation**: Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

7. Court Assessments		
		Methodology: Interviewed: 1. David Niz, Chief, Forensic Psychiatry 2. Michael Barsom, MD, Medical Director Reviewed: 1. Charts of the following six individuals who were admitted under PC 1026: CW, FN, GS, JS, MB and SP 2. Charts of the following six individuals who were admitted under PC 1370: GC, JAS, JFK, MCL, PB and PS-2 3. DMH PC 1026 Report Auditing Form. 4. DMH PC 1026 Report Auditing Form Instructions. 5. MSH PC 1026 Report Auditing summary data (February to July 2008). 6. DMH PC 1370 Report Auditing Form. 7. DMH PC 1370 Report Auditing Form Instructions. 8. MSH PC 1370 Report Auditing summary data (February to July 2008). 9. Forensic Review Panel (FRP) meeting minutes (March 14, April 29, May 29, June 26 and July 29, 2008).
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:	**Compliance:** Substantial.

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);	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period). **Findings:** MSH used the DMH PC 1026 Court Report Monitoring Form to assess compliance (February to July 2008). The facility reviewed 100% of the court reports produced during this reporting period. The mean compliance rate for this period was 95%, which is the same rate reported during the last review. **Other findings:** The facility reported that FRP auditors continuously monitor all 1370 and 1026 court reports and that the FRP provides focused face-to-face training to individual report writers who demonstrate a pattern of non-compliance. This monitor reviewed the charts of six individuals who were admitted under PC 1026 (CW, FN, GS, JS, MB and SP) to assess compliance with the requirements of D.7.a.i to D.7.a.ix. This review was conducted with participation by the facility's Chief of Forensic Psychiatry. Overall, the review found sufficient progress to reach substantial compliance with this section. However, to ensure that compliance is maintained in the future, the facility needs to make sustained progress to ensure the following: 1. The assessment of the individual's understanding of potential for danger (D.7.a.iii) is not limited to the instant offense, but also addresses triggers for anger and other behaviors that may contribute to further escalation.

		2. The relapse prevention plans (D.7.a.v) include more specific clinical information. Regarding this requirement, the review found compliance in all charts. **Current recommendation**: Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period).
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 93%, compared to 91% during the last review. **Other findings:** This monitor found compliance in all six charts. **Current recommendation**: Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 95%, compared to 93% during the last review.

<table>
<tr>
<td></td>
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<td>Other findings:
This monitor found partial compliance in all six charts. Although all the reports included an assessment of precursors for criminal behavior, the assessment was focused on the instant offense and did not address triggers for anger and other behaviors that may contribute to dangerous/criminal behavior.

Current recommendation:
Same as above.</td>
</tr>
<tr>
<td>D.7.a.iv</td>
<td>acceptance of mental illness and understanding of the need
for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
<td>Current findings on previous recommendation:

Recommendation, March 2008:
Same as above.

Findings:
MSH reported the following mean compliance rates:

<table>
<tr><td>1.</td><td>Acceptance of mental illness</td><td>95%</td></tr>
<tr><td>2.</td><td>Understanding of the need for treatment</td><td>95%</td></tr>
<tr><td>3.</td><td>Understanding of the need to adhere to treatment</td><td>96%</td></tr>
</table>

Comparative data were not available for the sub-items but the mean rate for all three sub-items was reported at 98% during the last review.

Other findings:
This monitor found compliance in four charts (CW, GS, JS and MB) and partial compliance in two (FN and SP).

Current recommendations:
Same as above.</td>
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</table>

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<tr>
<td>D.7.a.v</td>
<td>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;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Same as above.

Findings:
MSH reported the following mean compliance rates:

<table>
<tr><td>1.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>98%</td></tr>
<tr><td>2.</td><td>Individual's recognition of precursors and warning signs and symptoms for dangerous acts</td><td>94%</td></tr>
</table>

During the last review, the mean compliance rate for these two sub-items was 98%.

Other findings:
This monitor found compliance in five charts (FN, GS, JS, MB and SP) and partial compliance in one (CW).

Current recommendations:
Same as above.

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<tr>
<td>D.7.a.vi</td>
<td>willingness to achieve understanding of substance abuse
issues and to develop an effective relapse prevention plan (as defined above);</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Same as above.

Findings:
MSH reported a mean compliance rate of 90%, compared to 78% during the last review.

</td>
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</table>

		Other findings: This monitor found compliance in five charts (CW, FN, JS, MB and SP) and partial compliance in one (GS). **Current recommendation**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 95%, compared to 86% during the last review. **Other findings:** This monitor found compliance in all charts to which this requirement was applicable (FN, JS and MB). **Current recommendation**: Same as above.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 94%, compared to 82% during the last review.

		Other findings: This monitor found compliance in four charts (CW, FN, JS and SP) and partial compliance in two (GS and MB). **Current recommendations**: Same as above.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 70%, compared to 54% during the last review. **Other findings:** This monitor found compliance in four charts (CW, FN, GS and MB) and partial compliance in two (GS and JS). **Current recommendation**: Same as above.
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	**Compliance:** Substantial. .

	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** MSH reported a mean compliance rate of 94%, compared to 99% during the last review. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1370 (GC, JAS, JFK, MCL, PB and PS-2) to assess compliance with the requirements of D.7.b.i to D.7.a.iv. This review was conducted with participation by the facility's Chief of Forensic Psychiatry. Overall, the review found sufficient progress to reach substantial compliance with this section. Regarding this requirement, this monitor found compliance in five charts (JAS, JFK, MCL, PB and PS-2) and partial compliance in one (GC). **Current recommendation**: Same as D.7.a.i (as applicable to PC 1370).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above.

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Findings:
MSH reported a mean compliance rate of 97%, compared to 93% during the last review.

Other findings:
This monitor found compliance in five charts (JAS, JFK, MCL, PB and PS-2) and partial compliance in one (GC).

Current recommendation:
Same as above.

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<tr>
<td>D.7.b.iii</td>
<td>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</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Same as above.

Findings:
MSH reported the following mean compliance rates:

<table>
<tr><td>1.</td><td>Description of any progress or lack of progress</td><td>99%</td></tr>
<tr><td>2.</td><td>Individual's response to treatment</td><td>97%</td></tr>
<tr><td>3.</td><td>Current relevant mental status</td><td>97%</td></tr>
<tr><td>4.</td><td>Reasoning to support the recommendations</td><td>96%</td></tr>
</table>

Comparative data showed that the facility has maintained mean compliance rates of greater than 90% for all sub-items.

Other findings:
This monitor found compliance in five charts (JAS, JFK, MCL, PB and PS-2) and noncompliance in one (GC).

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		Current recommendation: Same as above.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 84%, compared to 75% during the last review. Comparative data showed the mean compliance rate has increased from 81% in January 2008 to 98% in July 2008. **Other findings:** This monitor found compliance in all six charts. **Current recommendations**: Same as above.
D.7.c	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH has maintained a FRP that provides needed oversight. The FRP has continued to review 100% of PC court reports during its monthly meetings. The meetings address trends in the auditing data of the court reports and questions that may arise about the content of the reports or other forensic-related treatment issues. Members of the FRP who audit reports continue to provide the WRPTs with the completed audit forms via email with written feedback regarding any strengths and/or deficiencies in the reports. The Chief of Forensic

		Psychiatry reportedly provides focused face-to-face training for individual report writers who demonstrate a pattern of non-compliance. The specific discipline supervisors participate in these meetings. The facility reported that FRP members also receive ongoing training on an individual basis within the context of the FRP meetings. During this review period, the members received a series of mandatory didactic trainings provided by the Chief of Forensic Psychiatry that addressed all types of forensic reports. These trainings covered the following topics: 1. The constitutional basis of the PC commitments, including landmark cases (Gallindo, etc); 2. A review of the DMH manual and an item-by-item discussion of each enhancement plan requirement; 3. The hospital's role in the treatment of these individuals and how the recovery model applies; 4. The importance of appropriate documentation to support the opinions in the court reports; 5. The importance of PC 1026 extensions and PC 2972 renewals, including the differences in the specific language required for each statute and the double jeopardy clause; 6. The role and function of the Conditional Release Program and the importance of collaboration with the CONREP care providers; and 7. The dual roles of evaluators and treatment providers and how to resolve conflicts which may arise between them **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide information regarding any relevant training to FRP

		members, including the provider, frequency and the content of training.
D.7.c.i	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH has maintained FRP membership structure that includes three senior psychiatrists, five forensically trained psychiatrists, supervising psychologist (or her designee), designee of Nursing Services, supervising social workers and court report-writing team members. The membership has expanded to include the membership of the court report-writing team members to ensure their participation in the assessment of trends in compliance and attention to required changes in the content of the reports. The Chief of Forensic Psychiatry serves as chair of the FRP. The FRP meets on a monthly basis. The facility did not provide information to clarify if a designee of the facility director participates in the meetings. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide information on the membership of the FRP and attendance by members during the review period. 3. Clarify information to address the required participation by the Facility Director or designee in the FRP.

E. Discharge Planning and Community Integration		
		Summary of Progress: MSH has shown improvement in compliance with several of the requirements in this section: a. A greater number of WRPs reviewed stated the timeline for the next review of the objectives/interventions. b. A greater number of WRPs reviewed had documented the individual's functional status and the documentation was comprehensive following the DMH WRP Manual guidelines. c. A greater number of WRPs reviewed identified the names of staff/disciplines responsible for implementing the interventions.
E	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.	**Methodology:** <u>Interviewed</u>: 1. The following four individuals: AAH, JU, RM and WS 2. Cynthia Lusch, Clinical Administrator 3. Ken Laymen, Treatment Enhancement Coordinator 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Nakil Desai, CSW 6. Purvi Shah Patel, LCSW 7. Sharon Nevins, Executive Director 8. Shirin Karimi, LCSW, Chief of Social Work 9. Terry Garcia, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. Charts of the following 25 individuals: AW, CG, CLG, CRC, CRT, DSH, GMH, JC, JD, JEM, JND, JS, JT, KLF, KRS, MC, PD, RH, RP, SCC, SHC, TDR, TLF, VA, and VLG 2. List of individuals who met discharge criteria, but remain hospitalized 3. List of individuals who met discharge criteria in the last six months

		4. DMH WRP Discharge Planning and Community Integration Auditing Form 5. MSH's progress report 6. Discharge Planning and Community Integration Audit Tool 7. List of individuals referred for discharge but still in hospital 8. List of individuals needing family therapy/education 9. PSR Mall Hours of Service by Discipline <u>Observed</u>: 1. WRPCs for DC and YB 2. PSR Mall group: Reality Orientation 3. PSR Mall group: Mind Over Mood 4. PSR Mall group: Legal Issues-Court Preparation 5. PSR Mall group: Social Skills 6. PSR Mall group: Substance Recovery 7. PSR Mall group: ESL 8. PSR Mall group: Healthy Lifestyle 9. PSR Mall group: Motivational Group 10. PSR Mall group: Sports and Fitness 11. PSR Mall group: DBT Skills Introduction 12. PSR Mall group: Recovery Games
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:	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that discharge setting and relevant skills for that setting are developed at the first seven-day WRP. **Findings:** Using item 4 and sub-items from the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its

indicator and sub-indicators and their corresponding mean compliance rates is a summary of the data:

4.	*The skills and supports necessary to live in the setting in which the individual will be placed.*	52%
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement.*	56%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	82%

The mean compliance rate for the previous period for item 4 was 34%. MSH's plan of improvement includes further training and mentoring by the Chief of Social Work and three Supervising Social Work staff.

This monitor's documentation review (training documentation) and interview with the Chief of Social Work revealed that MSH conducted training on "Social Work: The WRP and Discharge Planning" in May and June 2008. The training sessions were attended by 20 Social Work staff. According to the Chief of Social Work, additional two-hour training was conducted using the MSH Computer Lab in May and July 2008. MSH has a standing monthly training session for new employees (other employees may attend these training sessions).

This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Five of the WRPs in the charts (AW, CLG, KLF, KRS and TDR) documented the individual's anticipated discharge setting and relevant skills for the anticipated setting; the remaining four WRPs (CRC, JC, JS and RH) did not.

Recommendation 2, March 2008:
Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as

		needed) to achieve that discharge criteria. **Findings:** This monitor reviewed ten charts (CG, DSH, JC, JD, JT, MC, PD, RP, SCC and SHC). Proper linkage was noted between the discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy in three of the WRPs (JD, RP and SCC). The linkage in the remaining seven WRPs (CG, DSH, JC, JT, MC, PD and SHC) did not show a good linkage between the discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy. **Recommendations 3 and 4, March 2008:** • Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. • Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC. **Findings:** This monitor reviewed eight charts (CRT, GMH, JEM, JND, KLF, PD, VA and VLG). The WRPTs discussed the individual's discharge status, and reviewed it with the individual in two of the WRPs in the charts (JND and VA). The WRPTs failed to discuss the discharge criteria and/or review it with the individual in the remaining six WRPs (CRT, GMH, JEM, KLF, PD and VLG). **Compliance:** Partial. **Current recommendations**: 1. Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. 2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual

		therapy (as needed) to achieve that discharge criteria. 3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. 4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions. **Findings:** This monitor's interview with the Chief of Social Work revealed that MSH has been providing training to its Supervising Senior Social Work staff and mentors on the training curriculum on "Social Work: The WRP and Discharge Planning." The curriculum was based primarily on the WRP Discharge Planning and Community Integration Audit Tool. According to the Chief of Social Work, MSH also developed and distributed a list of "strength" descriptors to be linked with the individual's interventions. Documentation review showed that 20 out of the 35 Social Work staff attended the training conducted in May and June 2008. MSH also conducts training on discharge matters during the New Employee Orientation program. Using item 1 and sub-items from the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicator and sub-indicators and their corresponding mean compliance

rates is a summary of the data:

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are states on the first page of the WRP; and*	68%
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective.*	60%

This monitor's interview of the Chief of Social Work indicated that Social Workers were inconsistent in documenting the factors that impacted discharge. MSH plans to conduct specific training on addressing these issues with follow-up supervision by supervising Social Work staff.

This monitor reviewed eight charts (GMH, JEM, JND, KLF, PD, TLF, VA and VLG). Four of the WRPs in the charts (GMH, JEM, TLF and VLG) had identified strengths of the individuals for use by the facilitator to achieve the discharge goals. The remaining four WRPs in the charts (JND, KLF, PD and VA) did not identify the strengths and/or the strengths were not appropriate for the interventions to be of use to the facilitator to achieve the discharge goals.

This monitor reviewed nine charts (CLG, CRC, CRT, JC, JS, KLF, KRS, RH and TDR). Four of the WRPs in the charts (CLG, CRT, KLF and KRS) had developed an objective using the individual's life goals, and the life goals did not have relevant objectives in the remaining five WRPs (CRC, JC, JS, RH and TDR).

		Compliance: Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP. **Findings:** Using item 2 (*The individual's level of psychosocial functioning*) from the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a 12% sample of all Quarterly and Annual WRPs due for the month (February to July 2008), reporting a mean compliance rate of 97% compared to 66% in the previous review period. Mean compliance for the last month of the previous review period was 78% and mean compliance for the last month of this review period is 97%. This monitor reviewed ten charts (AW, CLG, CRC, JC, JS, KLF, KRS, PD, RH and TDR). The functional status of nine individuals (AW, CLG, JC, JS, KLF, KRS, PD, RH and TDR) was properly addressed in the Present Status sections of their WRPs, and was not fully covered in one of them (CRC).

		Compliance: Substantial. **Current recommendation**: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. **Findings:** Using item 3 and sub-items from the DMH Discharge Planning and community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

3.	*Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.*	
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.*	46%

		3.b — *These barriers are listed in Focus 11, with appropriate objectives and interventions.* — 38% The mean compliance rates were 29% and 55% respectively for the previous review period. This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Six of the WRPs in the charts (AW, CLG, JC, KLF, KRS and RH) had discussed the individual's barriers to discharge and/or opened Focus 11 with an objective and interventions. The barriers to discharge were not discussed and/or a focus was not opened with relevant objective and interventions in the remaining three WRPs (CRC, JS and TDR). **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Assess skills and supports deficits the individual may have for the intended placement. • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP at the next scheduled conference.

Findings:
Using item 4 and sub-items from the DMH Discharge Planning and community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

4.	*The skills and supports necessary to live in the setting in which the individual will be placed.*	
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement*	56%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	82%

The mean compliance rate for 4.b was 30% for the previous review period and 82% for this review period. There were no comparable data in the previous report for 4.a.

This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Seven of the WRPs in the charts (AW, CLG, CRC, JC, KLF, KRS and RH) had identified the skills and support that are needed for the individual to successfully transition to the next placement. Two of them (JS and TDR) did not address all the elements in these recommendations.

Compliance:
Partial.

Current recommendations:
1. Assess skills and supports deficits the individual may have for the

<table>
<tr><td></td><td></td><td>intended placement.
2. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.
3. Include these skills and supports in the individual's WRP at the next scheduled conference.</td></tr>
<tr><td>E.2</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Ensure that the individual is an active participant in the discharge planning process.

Findings:
Using item 13 and sub-items from the DMH WRP Observation Monitoring Form, MSH analyzed its compliance based on a mean sample of 15% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:
<table>
<tr><td>13.</td><td>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.</td><td></td></tr>
<tr><td>13.a</td><td>The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge.</td><td>72%</td></tr>
<tr><td>13.b</td><td>The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to discharge criteria.</td><td>77%</td></tr>
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		Mean compliance for 13.a above was 58% for the previous review period. This monitor's interview of the Chief of Psychology revealed that the WPR trainers review PLATO report data on a monthly basis. Using this report, the WRP trainers identify the WRPTs with low compliance, and meet with the teams to discuss strategies to address this recommendation. This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Eight of the WRPs in the charts (AW, CLG, CRC, JS, KLF, KRS, RH and TDR) had documented evidence that the individual actively participated in the discussion of his/her discharge criteria. Where appropriate, there was documentation that individuals did not understand, were confused, or chose not to participate in the discussion. The individual's participation in the discussions on discharge criteria was not documented in JC's WRP. This monitor observed two WRPCs (DC and YB, both monthly conferences). The WRPTs reviewed the individual's progress and what the individual should do to meet the discharge goals. However, the procedure was not comprehensive for DC. **Recommendations 2 and 3, March 2008:** • Develop individualized and measurable discharge criteria. • Prioritize objectives and interventions related to the discharge processes. **Findings:** This monitor reviewed eight charts (CRT, GMH, JEM, JND, KLF, PD, TLF and VA). Three of the WRPs in the charts (JEM, KLF and VA) had objectives and interventions to address the individual's discharge criteria. The discharge criteria in the remaining five WRPs (CRT, GMH,

		JND, PD and TLF) were not objective or measurable, were not individualized, and/or did not prioritize objectives and interventions related to the discharge process. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 3. Prioritize objectives and interventions related to the discharge processes.
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:	**Current findings on previous recommendation:** **Recommendation, March 2008:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP. **Findings:** This monitor's interview with the Chief of Social Work found that MSH continues to train WRPT members on the DMH WRP discharge planning process following the WRP Manual. The data collected and analyzed (findings from both the facility's progress report and the monitor's review) and documented in the following cells showed that MSH's compliance improved for many of the requirements. However, compliance with many of the recommendations is still at the "partial" level. **Compliance:** Partial.

		Current recommendation: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Write all objectives, including those dealing with discharge criteria, in behavioral and measurable terms. **Findings:** Using item 6 and sub-items from the DMH Discharge Planning and Community Integration Auditing form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

	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:	
6.	*Measurable interventions regarding these discharge considerations*	59%
6.a	*The interventions are aligned with their respective objectives, and*	98%
6.b	*All objectives are written in a way that explains what the individual will do or learn, and how it will*	59%

		be measured. This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Four of the WRPs in the charts (JC, KRS, RH and TDR) had the objectives written in behavioral and measurable terms with their interventions aligned with their respective objectives. The remaining five WRPs (AW, CLG, CRC, JC and KLF) had one or more objectives that were not written in an objective or measurable manner, and/or their interventions were not aligned with their respective objectives. **Compliance:** Partial. **Current recommendation:** Write all objectives, including those dealing with discharge criteria, in behavioral and measurable terms.
E.3.b	the staff responsible for implement the interventions; and	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. • Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. • Ensure that there is a system for identifying when a staff member is no longer responsible for the individual's assigned group and that the WRPT is alerted. **Findings:** Using item #7 (*The staff responsible for implementing the intervention*) from the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a

		12% sample of all Quarterly and Annual WRPs due for the month (February to July 2008), reporting a mean compliance rate of 81% compared to 66% in the previous review period. Mean compliance for the last month of the previous review period was 53% and mean compliance for the last month of this review period is 87%. This monitor reviewed 11 charts (AW, CLG, CRC, GMH, JC, JS, KLF, KRS, RH, TDR and TLF). Eight of the WRPs in the charts (AW, CLG, CRC, GMH, JC, KRS, RH and TDR) had noted the staff member responsible for each intervention, and the names of the staff responsible for the remaining three WRPs (JS, KLF, and TLF) were not noted in their corresponding interventions. The staff identified in the intervention sections was also the same ones listed in the Mall schedules. However, a number of PM second-hour Mall groups this monitor observed had "stand-in" staff (for example, Mind Over Mood, Substance Abuse, and Social Skills). The "stand-in" staff indicated to this monitor that the regular staff often failed to show up. According to the Mall Director, change in staffing is identified through the Mall facilitator roster and confirmed through direct contact with the listed facilitator. The Mall Director then shares the information with the WRPTs. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.

E.3.c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, March 2008:** For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC. **Findings:** Using item 8 and sub-items from the DMH Discharge Planning and Community Integration Auditing form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

	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:	
8.	*The time frames for completion of interventions*	80%
8.a	*The frequency of the interventions are specified*	80%
8.b	*The duration of the interventions are specified.*	80%

Mean compliance for the previous period was 56% and mean compliance for this review period is 80%. Mean compliance for the last month of the previous period was 46% and mean compliance for the last month of this review period is 84%.

This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). All but one of the WRPs in the charts (JS) had

		identified appropriate time frames for the next scheduled review of the objectives and interventions. **Compliance:** Partial. **Current recommendation**: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.
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:** Partial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Reduce the overall number of individuals still hospitalized after referral for discharge has been made. **Findings:** This monitor's interview of the Chief of Social Work and documentation review (individuals who have met discharge criteria, and those who are still hospitalized) found that external factors continue to be the major barrier to individuals' timely discharge. The external barriers include non-availability of placement, nature of individual's medical status, and conservator's consent for placement. At the time of this tour, MSH had a total of 54 individuals who were referred for discharge but were still hospitalized. Thirty-six of the 54 individuals had been referred for discharge between February and July, 2008, and the remaining 18 had been referred before February 2008. One of them (JL) had been

		referred as early as January 2006, but is yet to be discharged due to his medical status (Huntington Disease) and the conservator's resistance to placement. According to the Chief of Social Work, MSH has continued to pursue placement for all eligible individuals through persistent review and negotiations with conservators, CONREP, and the courts. **Current recommendation**: Reduce the overall number of individuals still hospitalized after referral for discharge has been made.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure and document that individuals receive adequate assistance when they transition to the new setting. **Findings:** Using item 10 and sub-items from the DMH Discharge Planning and Community Integration Auditing form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:	
10.	*Individuals receive adequate assistance in transitioning to the new setting. (E4b)*	50%
10.a	*The Present Status section of the individual's*	66%

		WRP describes the assistance needed to transition to t he discharge setting; and
		10.b *Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.* 53%
		The mean compliance rate for the previous review period was 59% and mean compliance for this review period is 50%. Mean compliance for the last month of the previous review period was 64%, and mean compliance for the last month of this review period is 67%. This monitor reviewed nine charts (AW, CLG, CRC, JC, JS, KLF, KRS, RH and TDR). Four of the WRPs in the charts (AW, KLF, KRS and TDR) indicated the assistance needed by the individual and/or the assistance provided to the individual when transitioning to the discharge setting. The remaining five WRPs (CLG, CRC, JC, JS and RH) did not provide such documentation. **Current recommendation**: Ensure and document that individuals receive adequate assistance when they transition to the new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of cell E.5 and sub-cells are not presently applicable to MSH because the facility no longer serves children and adolescents. At the time of the last tour during which MSH served children and adolescents (March 2008), the facility was judged to be in substantial compliance with the requirements of E.5 and sub-cells.
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	
	Summary of Progress on Psychiatric Services: MSH has not made significant progress in medication management during this review period. **Summary of Progress on Psychological Services:** 1. MSH has established the Psychology Specialty Services Committee (PSSC). The PSSC meets regularly to review individuals who trigger/exhibit maladaptive behaviors and triage the cases for appropriate behavioral interventions, provide clinical advice to the treatment team, and offer multidisciplinary support on complex issues. 2. MSH has implemented a system-wide PBS plan. 3. MSH has established a Curriculum Committee to write curricula for Mall group services. The curricula will address the individuals' cognitive levels and stages of change. 4. With regard to PBS plans, structural and functional assessments are routinely conducted prior to the development and implementation of PBS plans; staff responsible for implementation of the PBS plans are trained and certified before implementation of the PBS plans; and PBS plans are revised frequently based on the individual's progress or lack thereof. **Summary of Progress on Nursing Services:** 1. Overall, compliance rates have increased regarding documentation of PRN and Stat medications. 2. The MSH Treatment Enhancement Coordinator began meeting with the Nursing Department and Nursing Education Department in May 2008 to address nursing needs regarding the WRPs. **Summary of Progress on Rehabilitation Therapy Services:** 1. Twelve-week lesson plans were developed and implemented for many

	Rehabilitation Therapy PSR Mall groups. However, not all PSR Mall groups facilitated by Rehabilitation Therapy staff currently have curricula and lesson plans developed and in use. 2. Rehabilitation Therapy PSR Mall groups are not consistently listed in WRPs with quality objectives and foci that are aligned, and progress in the groups is not consistently documented in the present status section of the WRPs. 3. A formal plan to ensure compliance with F.4.a.ii has not yet been developed and implemented. 4. An F.4 monitoring tool has been developed and implemented. **Summary of Progress on Nutrition Services:** 1. The Meal Accuracy report has been implemented and review of data shows substantial compliance with tray accuracy. 2. Nutrition PSR Mall groups are not consistently listed in WRPs with quality objectives and foci that are aligned, and progress in the groups is not consistently documented in the present status section of the WRPs. **Summary of Progress on Pharmacy Services:** MSH has increased the number of recommendations made by pharmacists upon the prescription of new medication orders, including changes in existing orders. **Summary of Progress on General Medical Services:** DMH has initiated the development of medical and nursing protocols and a new template for nursing documentation. If properly implemented, these tools can facilitate communications between medical and nursing staff in the assessment and management of medical conditions. **Summary of Progress on Infection Control:** 1. MSH's Infection Control Department has achieved substantial

	compliance with most of the requirements of the EP. 2. A number of strategies have been implemented to assist the unit staff with WRPs regarding Infections Control issues to increase compliance in this area. **Summary of Progress on Dental Services** 1. MSH's Dental Department has achieved substantial compliance with most of the requirements of the EP. 2. The Dental Departments at all facilities have received the long-awaited dental software packages for implementation.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Ana Sobolewska, RN, Nursing Performance Improvement 2. Aurora Hendricks, CNS, Nurse Administrator 3. Bala Gulasekaram, MD, Chief of Psychiatry 4. Bruce Abrahams, MD, Chairman, P&T Committee 5. Michael Barsom, MD, Medical Director 6. Nady Hanna, MD, Medical Staff President Reviewed: 1. The charts of the following 40 individuals: AM, CG, DLH, DLK, DM, DT, EW, GAG, GDS, GNS, HDF, HL, JC, JGH, JM, JS, JV, KDR, LB, LS, LW, MCF, MDJB, MEB, MJ, MM, MRC, NSM, OM, OS, RAM, RLN, RP, RT, SMN, SO, SS, SW, TL and TM 2. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines (January 2008) 3. MSH list of individuals with psychotropic medications, diagnoses and attending physicians 4. MSH database regarding intra-class and inter-class polypharmacy 5. DMH Admission Psychiatric Assessment Auditing Form 6. DMH Admission Psychiatric Assessment Auditing Form Instructions 7. MSH Admission Psychiatric Assessment Auditing summary data (February to July 2008) 8. DMH Integrated Assessment: Psychiatry Section Auditing Form 9. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 10. MSH Integrated Assessment: Psychiatry Section Auditing summary data (February to July 2008) 11. DMH Monthly Psychiatric Progress Notes Auditing Form 12. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions

		13. MSH Monthly Psychiatric Progress Notes summary data (February to July 2008) 14. MSH Psychiatric PRN Stat Medications Monitoring Form 15. MSH Nursing PRN Medications Monitoring Form 16. MSH Nursing Stat Medications Monitoring Form 17. MSH PRN Stat monitoring summary data (February to July 2008) 18. MSH Nursing Policy #528, PRN Orders and Policy #530, Stat Orders (revised June 2008) 19. MSH Benzodiazepine Monitoring summary data (February to July 2008) 20. MSH Anticholinergics Monitoring summary data (February to July 2008) 21. MSH Polypharmacy Monitoring summary data October and February to July 2008) 22. MSH summary monitoring data regarding use of new generation antipsychotic medications (February and March and May to July 2008) 23. DMH Tardive Dyskinesia (TD) Monitoring Form 24. DMH TD Monitoring Form Instructions 25. MSH TD Monitoring summary data (February to July 2008) 26. MSH AD 3315, Adverse Drug Reactions (ADRs), revised March 5, 2008 27. MSH data regarding ADRs from February to July 2008 28. Last ten completed ADR reporting forms 29. Intensive case analyses (#3) for ADRs during this review period 30. MSH AD 3316, Medication Variance Reporting and Monitoring, revised March 1, 2008 31. Last ten completed medication variance reporting forms. 32. MSH data regarding medication variances (January to June 2008) 33. Meeting minutes of the Pharmacy and Therapeutics (P&T) Committee (February to July 2008) 34. MSH data regarding continuing education status of psychiatry staff

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 standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. **Findings:** MSH has not made any revisions to the guidelines during this review period. **Recommendations 2 and 3, March 2008:** • Monitor these requirements using standardized indicators across state facilities. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the previously mentioned DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance. The compliance data, with corresponding indicators and sub-indicators, and data analysis are summarized in each cell below. The facility was inconsistent in presenting comparative data for the last month of this review period compared to the last month of the previous review for sub-items that had compliance rates of less than 90%, as requested by this monitor. However, there was a trend of improvement in most items when comparing the rates for this review period to the rates for the last period. **Other findings:** See this monitor's findings in D.1.c.ii, D.1.c.iii, D.1.d.i and D.1.f.

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Compliance:
Partial.

Current recommendations:
1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Specifically, ensure that the current guidelines are aligned with current standards regarding monitoring for pancreatic dysfunction in individuals receiving high-risk new generation antipsychotic medications.
2. Monitor these requirements using standardized indicators across state facilities.
3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

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<td>F.1.a.i</td>
<td>specifically matched to current, clinically justified diagnoses or clinical symptoms;</td>
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<table>
<tr><td colspan="3">Admission Psychiatric Assessment</td></tr>
<tr><td>8.</td><td>Plan of care includes:</td><td></td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications, with rationale.</td><td>89%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medication as applicable, with specific behavioral indications</td><td>69%</td></tr>
<tr><td>8.c</td><td>Special precautions to address risk factors, as indicated.</td><td>94%</td></tr>
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Comparative data were not available for item 8.b. However, the mean compliance rates for the other two sub-items in July 2008 were 94% and 97%, respectively (compared to 94% and 94% in February 2008).

<table>
<tr><td colspan="3">Integrated Psychiatric Assessment</td></tr>
<tr><td>7.</td><td>Diagnostic formulation is documented.</td><td>77%</td></tr>
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10.	*Psychopharmacology treatment plan includes:*	
10.a	*Current target symptoms;*	45%
10.b	*Specific medication to be used;*	95%
10.c	*Dosage titration schedules, if indicated;*	70%
10.d	*Adverse reactions to monitor for;*	24%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics;*	51%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications;*	70%
10.g	*Medication consent issues were addressed.*	88%

The facility did not present comparative data for the sub-items (July compared to February 2008). However, the mean compliance rate for all the above items combined has increased from 67% in February 2008 to 78% in July 2008.

Monthly PPN		
2.b	*The current target symptoms which are the focus of treatment are identified in the progress note.*	98%
6.a.1	*The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	84%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.*	90%

There was a trend of improvement in the sub-items when comparing the mean rates for the previous review period to this period as follows:

1. Item 2.b: from 86% to 98%;
2. Item 6.a.1: from 77% to 85%; and
3. Item 6.a.2: from 76% to 90%.

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<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>
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<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines).</td><td>96%</td></tr>
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The mean compliance rate has increased from 76% in the prior review period to 96% in the current review period.
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<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>98%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>93%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan (is documented).</td><td>93%</td></tr>
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Comparative data showed a trend of improvement for the current review period compared to the last period as follows:

1. Item 2.b: from 86% to 98%;
2. Item 2.c: from 86% to 94%; and
3. Item 2.d: from 76% to 92%.
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<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented).</td><td>76%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>65%</td></tr>
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Comparative data (February vs. July 2008) were not presented. There
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<tr><td></td><td></td><td>was a trend of improvement when comparing the rates for this review period to the last period as follows:

1. Item 2.b: from 78% to 89%; and
2. Item 2.c: from 68% to 94%.</td></tr>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.1</td><td>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>84%</td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>90%</td></tr>
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A trend of improvement was noted when comparing the rates in February 2008 to the rates in July 2008 as follows:

1. Item 6.a.1: from 76% to 92%;
2. Item 6.a.2: from 89% to 93%.

The mean compliance rates for the current review period have increased compared to the last review as follows:

1. Item 6.a.1: from 62% to 84%;
2. Item 6.a.2: from 76% to 90%.
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<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>93%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented).</td><td>89%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>94%</td></tr>
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<table>
<tr><td></td><td></td><td>Comparative data were the same as in F.1.a.iv and F.1.a.vi.</td></tr>
<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>The facility provided the following weighted means for all items above:

<table><tr><td>Admission Psychiatric Assessment</td><td>88%</td></tr><tr><td>Integrated Assessment (Psychiatry)</td><td>46%</td></tr><tr><td>Monthly PPN</td><td>93%</td></tr></table></td></tr>
<tr><td>F.1.b</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Standardize the monitoring tools regarding PRN and Stat medications for use across state facilities.

Findings:
The DMH has implemented this recommendation regarding nursing services. The DMH Monthly PPN Auditing Form is sufficient to monitor this requirement regarding physicians' prescriptions of PRN/Stat medications.

Recommendations 2-4 March 2008:
• Monitor this requirement based on at least a 20% sample.
• Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the previous period).
• Utilize current oversight system to improve compliance.

Findings:
MSH used the DMH standardized Monthly PPN tool to audit this requirement. The average sample size was 61% of individuals who have been hospitalized for 90 or more days (February to July 2008). The</td></tr>
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following table summarizes the data:

Monthly PPN		
7.	*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:*	74%
7.a	*Describes the rationale/specific indications for all PRN orders;*	89%
7.b	*Reviews the PRNs and Stats during the interval period;*	82%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions;*	62%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	50%

MSH did not present comparative data and acknowledged persistent low compliance in the implementation of the requirements of 7.b, 7.c and 7.d. The facility reported plans to implement a system of continuous monitoring and immediate feedback to the prescribing physicians.

MSH also reported data based on the DMH Nursing Services Monitoring Form. The average samples were 23% (PRN) and 27% (Stat) of the total number of such medications administered each month. The following tables and corresponding analysis summarize the facility's data (February to July 2008):

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	97%
2.	*Documentation of the circumstances requiring PRN medication.*	67%

3.	*Documentation of the individual's response to PRN medication.*	68%

Comparative data were not available for item 1. The mean compliance rates for sub-items 2 and 3 have shown mixed changes when comparing the rates in February to the rates in July 2008 as follows:

1. Item 2: from 85% to 80%; and
2. Item 3: from 67% to 68%.

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	96%
2.	*Documentation of the circumstances requiring Stat medication.*	67%
3.	*Documentation of the individual's response to Stat medication.*	66%

Comparative data were not available for item 1. The mean compliance rates for sub-items 2 and 3 have shown mixed changes when comparing the rates in February to the rates in July 2008 as follows:

1. Item 2: from 88% to 82%; and
2. Item 3: from 79% to 80%.

To improve compliance by nursing with the requirements of this cell, MSH has implemented the following corrective actions:

1. Nursing Policies NP #528 PRN Orders and NP# 530 Stat Orders were revised in June 2008. Changes included a requirement for the medication nurse responsible for documenting on the MTR and the nursing staff initiating least restrictive interventions to complete the IDN documentation.
2. Unit Supervisors conducted in-service training for revised NP

		#528 and NP #530 for unit nursing staff in July 2008. 3. Beginning in March 2008, the facility instituted monthly meetings with Unit Supervisors and Nurse Coordinators including discussion of trends based on audit results and graphs. 4. The facility instituted an accountability system to address performance issues with the staff completing the documentation. 5. Binders were created for all units consisting of the DMH-approved statewide audit tools and instructions to be used as a resource when staff is completing documentation. The facility presented data showing a decrease of 291 PRN and 112 Stat medication administrations during this review period compared to the last period. **Other findings:** See this monitor's findings in D.1.f. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Monthly PPN, DMH Nursing Services PRN and DMH Nursing Services Stat Auditing Forms, based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1-3, March 2008:** • Continue to monitor this requirement using the DMH instruments. • Provide data analysis that evaluates areas of low compliance and

delineates areas of relative improvement (during the reporting period and compared to the previous period).

- Utilize current oversight system to improve compliance.

Findings:

MSH used the DMH Benzodiazepine (February and June 2008), Anticholinergics (April and July 2008) and Polypharmacy (February to April 2008 and July 2008) Audit Forms to assess compliance. The following is a summary outline of the monitoring indicators and corresponding mean compliance rates:

Benzodiazepines (average sample has varied depending on the indicator, ranging from 38 to 41% of all individuals receiving regularly scheduled benzodiazepines)		
1.	*Indication for regularly scheduled use of benzodiazepine clearly documented in medical record*	72%
2.	*Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN*	30%
3.	*Benzodiazepine used for individuals with cognitive disorders justified in PPN*	No data
	Routine Benzodiazepine use for more than two months, PPN clearly documents the risks of:	
4.	*Drug dependence*	41%
5.	*Cognitive decline*	43%
6.	*Sedation*	45%
7.	*Gait unsteadiness / falls if indicated*	29%
8.	*Respiratory depression (for those with underlying respiratory problems e.g. COPD)*	29%
9.	*Toxicity if used in individuals with liver impairment (if using long acting agents)*	11%
10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.*	32%

Regarding item 3, the facility reported that the sample was drawn from the larger population (i.e. all individuals on regularly scheduled benzodiazepines) rather than the subpopulation (i.e. all individuals on benzodiazepines who have borderline intellectual functioning, mental retardation, cognitive disorder NOS, dementia of any type). The exact percentage sampled and compliance rate could not be calculated due to the sampling method. The method will reporting corrected for the next review period.

The mean compliance rates have shown mixed changes from February to July 2008 as follows:

Item	February 2008	July 2008
1.	64%	69%
2.	44%	18%
4.	38%	45%
5.	41%	45%
6.	NA	45%
7.	33%	17%
8.	33%	25%
9.	0%	20%
10.	43%	24%

MSH has acknowledged persistent low compliance regarding this requirement and also found that the monitoring methodology did not consistently adhere to the instructions for the DMH auditing form. Corrective actions will include the following:

1. MSH will provide the physicians with a template for documentation regarding the use of benzodiazepines.
2. MSH will implement a system of continuous monitoring with immediate feedback to the physician to improve compliance.

3. Senior Psychiatrists will provide in-service training regarding the appropriate use of benzodiazepines.

Anticholinergics (average S=18%, with N varying depending on the indicator)		
1.	*Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)*	72%
	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for #2-6)	No data
2.	*Cognitive impairment*	
3.	*Sedation*	
4.	*Gait unsteadiness/falls*	
5.	*Blurred vision, constipation, urinary retention*	
6.	*Worsening narrow angle glaucoma*	
	Regularly scheduled anticholinergics use for more than 2 months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #7-13)	
7.	*Cognitive impairment*	44%
8.	*Sedation as indicated*	42%
9.	*Gait unsteadiness / falls (as indicated)*	0%
10.	*Blurred vision, constipation, urinary retention*	50%
11.	*Worsening narrow angle glaucoma, if present*	0%
12.	*Substance abuse/dependence if listed on Axis I*	21%
13.	*Worsening TD if present*	NA
14.	*Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for #14.*	100%

15.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk. N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #15.*	40%

Regarding items 2-6, the facility reported that the sample was drawn from the larger population (i.e. all individuals on any one of the four anticholinergics) rather than the subpopulation (i.e. all individuals over age 60 and with cognitive impairment of any type). The exact percentage sampled and compliance rate could not be calculated due to the sampling method. The method will reportedly be corrected for the next review period.

Comparative data showed mixed changes from February to July 2008 as follows:

Item	February 2008	July 2008
1.	39%	75%
7.	18%	63%
8.	15%	60%
9.	13%	0%
10.	14%	67%
11.	NA	NA
12.	5%	27%
13.	25%	NA
14.	NA	100%
15.	30%	50%

The facility's plan of correction is the same as that described for benzodiazepine use above.

Polypharmacy (average S varied depending on indicator, ranging from 16% to 23% of individuals receiving inter or intra-class polypharmacy)		
1.	*Target symptoms were clearly identified.*	81%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy.*	58%
3.	*Documentation in PPN justifies the need for intra-class for polypharmacy.*	64%
4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions.*	47%

The mean compliance rates have increased for most of the items from February to July 2008 as follows:

Item	February 2008	July 2008
1.	64%	79
2.	NA	69%
3.	50%	NA
4.	30%	48%

Other findings:
This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:

1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;
2. Anticholinergic medications for individuals diagnosed with cognitive disorders;
3. Anticholinergic medications for elderly individuals; and
4. Various forms of polypharmacy.

This monitor also reviewed the charts of individuals receiving the above

types of medication uses. The reviews found that many individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented justification and/or assessment of the individuals for the risks associated with this practice.

The following tables outlines these reviews (diagnoses are listed only if they signified conditions that increase the risk of use):

Benzodiazepine use

Individual	*Medication(s)*	*Diagnosis*
DLH	Lorazepam	Alcohol Abuse and Cannabis Abuse
GDS	Clonazepam	Polysubstance Dependence
LW	Lorazepam	Polysubstance Dependence and Cognitive Disorder NOS
MM	Lorazepam	Cocaine Dependence
NSM	Clonazepam	Polysubstance Dependence
OM	Clonazepam	Polysubstance Dependence
RAM	Clonazepam	Polysubstance Dependence
TM	Lorazepam	Polysubstance Dependence

Anticholinergic use

Individual	*Medication(s)*	*Diagnosis*
CG	Benztropine	Mild Mental Retardation
DM	Hydroxyzine	Mild Mental Retardation
GAG	Benztropine	Borderline Intellectual Functioning
JV	Benztropine	Borderline Intellectual Functioning
SMN	Benztropine	R/O Mild Mental Retardation

Anticholinergic use for elderly individuals

Individual	*Medication(s)*	*Diagnosis*
JM	Hydroxyzine	Mild Mental Retardation
JS	Diphendyra-mine	
RLN	Benztropine	

Polypharmacy use

Individual	*Medication(s)*	*Diagnosis*
CG	Chlorpromazine, benztropine, haloperidol and divalproex	Mild Mental Retardation
DT	Ziprasidone, risperidone, quetiapine, clonazepam, divalproex, bupropion, and buspirone	Polysubstance Abuse
JC	Clozapine, haloperidol, olanzapine, benztropine, lorazepam and divalproex	Polysubstance Abuse
LS	Clozapine, chlorpromazine, lorazepam, sertraline, divalproex and oxcarbazepine	
MRC	Risperidone, ziprasidone, trazodone, buspirone, citalopram, gabapentin and hyroxyzine	
SO	Olanzapine, chlorpromazine, trazodone, clonazepam and divalproex	

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<table>
<tr><td>SW</td><td>Risperidone microspheres, quetiapine, olanzapine, topiramate, atomoxetine, duloxetine and hydroxyzine</td><td></td></tr>
<tr><td>TM</td><td>Clozapine, olanzapine, lorazepam, divalproex and hydroxyzine</td><td>Polysubstance Abuse</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement using the DMH instruments based on at least a 20% sample.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
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<tr>
<td>F.1.d</td>
<td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, March 2008:
Standardize the monitoring tool regarding the use of new generation antipsychotic medications.

Findings:
The DMH is in the process of developing a standardized tool. MSH has recently updated its monitoring instrument to include the new antipsychotic agent paliperidone.

Recommendation 2, March 2008:
Ensure that the monitoring indicator regarding serum amylase/lipase also includes quetiapine.
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Findings:
MSH has implemented this recommendation. The facility has updated its monitoring instrument to include quarterly monitoring of amylase and lipase for all new generation antipsychotic medications, including quetiapine.

Recommendations 3 and 4, March 2008:

- Continue to monitor this requirement based on at least a 20% sample and provide data both for all medications (aggregate) and for each specific medication.
- Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used its current monitoring tool to assess its compliance with this requirement. Monitoring of the new generation antipsychotic medications was done for the months of February, March and May through July 2008, on a rotating basis. The average sample was 28% of all individuals receiving new generation antipsychotic medications (aripiprazole, clozapine, olanzapine, quetiapine, risperidone and/or ziprasidone). The facility presented data for each specific medication and for all medications. The following table is a summary outline of the monitoring indicators and corresponding mean compliance rate sfor all new generation antipsychotic medications:

1.	*Family/personal risk factors addressed in PPN (if medication started within last 90 days)*	25%
2.	*Justification for use documented in PPN for individuals with diagnosis of (for olanz, risp, quet)*	
2.a	*Dyslipidemia*	28%
2.b	*Diabetes*	20%
2.c	*Obesity*	43%

3.	*Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia.*	18%
4.	*Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60 on quet*	NA
5.	*ECG within previous 12 months.*	44%
6.	*Appropriate baseline and regular monitoring of:*	
6.a	*Body mass index*	79%
6.b	*Waist circumference*	66%
6.c	*Fasting blood sugar (FBS) monthly (if started olanzapine or clozapine w/in last 6 months)*	79%
6.d	*FBS quarterly (including olanzapine and clozapine after first 6 months)*	97%
6.e	*Triglycerides*	92%
6.f	*Cholesterol*	92%
6.g	*HgbA1C if FBS high*	74%
6.h	*Prolactin level*	63%
6.i	*Breast exam*	79%
6.j	*AIMS exam*	78%
7.	*Serum amylase/lipase (if on clozapine, olanzapine, risperidone)*	58%
8.	*PPN documentation of potential and actual risk for each medication used.*	67%
9.	*Treatment modified in an appropriate and timely manner to address identified risks*	29%

MSH did not present comparative data.

Other findings:
This monitor reviewed the charts of 13 individuals who were receiving NGA medications and diagnosed with 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*
DLK	Risperidone and quetiapine	Obesity
GNS	Olanzapine	Obesity
HDF	Quetiapine	Diabetes mellitus, hyperlipidemia and hypertension
HL	Olanzapine and haloperidol	Obesity, hyperlipidemia and hypertension
LB	Quetiapine	Hyperlipidemia
MCF	Olanzapine	Obesity, hyperlipidemia and hypertension
MDJB	Risperidone	Obesity
MEB	Olanzapine	Diabetes mellitus
MJ	Clozapine	Obesity
MRC	Risperidone and ziprasidone	Diabetes mellitus, hyperlipidemia and hypertension
RP	Risperidone	Obesity and hypertension
RT	Clozapine	Obesity, hyperlipidemia and hypertension
TL	Risperidone	Obesity

The reviews found that, in general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. During this review period, the facility appeared to have improved the frequency of laboratory monitoring for serum lipids in individuals diagnosed with metabolic disorders and are receiving high risk medication regimens. However, several significant deficiencies still exist and must be corrected in order to achieve substantial compliance. The following is an outline:

		1. There was inadequate documentation of attempts to utilize/optimize safer antipsychotic treatment alternatives for individuals diagnosed with a variety of metabolic disorders and currently receiving high-risk treatments with olanzapine (HL and MCF) and risperidone (DLK, MDJB and MRC). 2. There was inadequate laboratory monitoring of serum lipase and amylase in several individuals currently receiving high-risk treatment with NGA medications. 3. The WRP did not address the problem of repeated refusals of blood tests in an individual diagnosed with obesity, hyperlipidemia and hypertension (HL) and another individual diagnosed with diabetes mellitus, hyperlipidemia and hypertension (MRC). These individuals were receiving high-risk treatment with olanzapine and risperidone, respectively. 4. There was inadequate frequency of laboratory monitoring of serum lipids in an individual diagnosed with obesity and receiving high-risk treatment with risperidone (DLK). 5. There was no documentation of any clinical monitoring or intervention to address significant worsening of hyperprolactinemia in a female individual receiving high-risk treatment with risperidone (DLK). 6. The WRPs and corresponding psychiatric progress notes did not recognize or address hyperprolactinemia in a female individual (MDJB) whose laboratory tests showed a prolactin level of 218 (normal range is 0-24). This individual was receiving high-risk treatment with risperidone and the progress note inaccurately indicated that the overall risk was low. 7. The psychiatric progress notes included a risk benefit assessment that included a theoretical outline of potential side effects, but did not address the actual presence of significant dyslipidemia that was not responsive to current interventions. The individual, who was diagnosed with obesity, hyperlipidemia and hypertension, was receiving high-risk treatment with clozapine (RT).

		Compliance: Partial. **Current recommendations**: 1. Standardize the monitoring tool regarding the use of new generation antipsychotic medications. 2. Continue to monitor this requirement based on at least a 20% sample and provide data both for all medications (aggregate) and for each specific medication. 3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
F.1.e	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue to monitor this requirement based on a 100%sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH TD Auditing Form to assess compliance (February to July 2008). The average sample was 100%. The facility's data were based on monitoring from February to July 2008 regarding indicator 1 and for two months (March and May 2008) regarding other indicators. The following is a summary of the compliance data: 1. *A baseline assessment shall be performed for each individual at admission.* — 100% 2. *Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic* — 100%

	medication	
3.	*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.*	93%
4.	*If an older generation antipsychotic is used there is evidence in monthly physician progress note of justification of using the older generation medication.*	100%
5.	*A neurology consultation / TD Clinic evaluation was completed as indicated.*	66%
6.	*Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.*	60%
7.	*Tardive Dyskinesia is included in Focus 6 of the WRP.*	66%
8.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	84%
9.	*The WRP reflect objectives and interventions for Tardive Dyskinesia*	84%

The facility presented incomplete comparative data, including a few errors in calculation, regarding sub-items with a mean compliance rate of less than 90%. In general, the facility data showed mixed changes since the last review regarding these items. The facility reported that its senior psychiatrists have completed TD consultations for all individuals with a diagnosis of TD, but did not specify what these consultations entailed.

Other findings:
This monitor reviewed the charts of six individuals (AM, EW, JGH, KDR, OS and SS) who were diagnosed with tardive dyskinesia per the WRPs and/or the psychiatric assessments. The facility submitted a database that identified 11 individuals with this diagnosis.

		This review found that MSH has made some progress as follows: 1. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed. 2. The objectives and interventions related to TD utilized appropriate learning outcomes in a few charts (e.g. EW and KDR). 3. The admission AIMS tests were completed in all the charts reviewed. 4. Most charts (AM, EW, OS and PDF) documented attempts to utilize and/or optimize safer antipsychotic treatment alternatives. 5. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications. However, the review also showed a pattern of deficiencies as follows: 1. The facility's database that was submitted to this monitor did not identify some individuals (e.g. KDR) who were diagnosed with TD. 2. The WRP did not include diagnosis, focus or interventions to address a diagnosis of TD as identified in the facility's database (PDF). 3. The WRPs did not include a diagnosis of TD for some individuals who were identified to have this disorder based on the monthly progress notes and the facility's database (AM). 4. The WRPs included some objectives that were inappropriate for the individuals (JGH and OS). 5. The WRPs included interventions that did not address the stated objectives regarding TD (AM and SS). 6. The AIMS tests were not completed quarterly as required (AM, EW, KDR and OS). **Compliance:** Partial.

		Current recommendations: 1. Monitor this requirement based on a 100% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue efforts to increase reporting of ADRs. **Findings:** MSH reported 43 ADRs during this reporting period, a decrease in reporting compared to the previous period (56 ADRs). This number is seriously inadequate. **Recommendation 2, March 2008:** Present data regarding ADRs including total number during the reporting period compared with the number during the last period, probability and severity classification of ADRs and any ICAs done. **Findings:** The classification by outcome and probability showed that three ADRs met the criteria for severe reactions and four ADRs were rated as definite reactions. MSH conducted intensive case analyses (ICAs) on all severe ADRs. The ICAs utilized appropriate methodology, but there were no recommendations for systemic corrective/educational actions as a result of these analyses.

		Compliance: Partial. **Current recommendations**: 1. Increase reporting of ADRs. 2. Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period; c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. 3. Provide analysis of patterns and trends, with corrective/ educational actions related to ADRs.
F.1.g	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. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Conduct DUEs that include review of use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. **Findings:** MSH presented data based on self-monitoring of the use of benzodiazepines, anticholinergic medications and polypharmacy as examples of DUEs. Although these data include some elements of a DUE, there were no conclusions regarding trends/patterns or recommendations for systemic corrections. As such, these "DUEs"

		were not aligned with requirements of the EP. **Compliance:** Partial. **Current recommendations**: 1. Conduct DUEs and provide summary data, including topic, findings, recommendations and actions taken. 2. Same as in F.1.a
F.1.h	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue efforts to report medication variances. • Present data regarding actual and potential variances during the reporting period compared with the last period, classification of categories of variance, outcome of variances and any intensive case analysis done. **Findings:** MSH did not present data for the reporting period (February to July 2008). However, the facility presented data for the period of January to June 2008. The data showed a decrease in reporting of variances, which was attributed by the facility to the introduction of the new data collection tool in March 2008. The facility's P&T Committee identified the decrease in reporting in its meeting on May 8, 2008. The facility found that staff who initiated MVRs often had an inadequate understanding of the process, particularly regarding the identification and reporting of potential variances, which has resulted in erroneous classification of the variance on all levels of review and analysis. Corrective actions included the following: 1. Unit Supervisors and Nursing Coordinators were instructed

		regarding the MVR process and policy and were instructed to re-educate unit nursing staff. 2. The Nursing Administrator has been visiting individual units and staff to address the issue of missing initials, which was the most common cause of variances. 3. All MVRs are currently reviewed for accuracy of classification and reporting staff will be notified directly of classification errors that need correction. Any specific staff member who frequently commits errors will be given individualized instruction and training to decrease or eliminate the occurrence of these errors. None of the variances that were reported during this review period resulted in a serious outcome to an individual or met the severity threshold for intensive case analysis. **Compliance:** Partial. **Current recommendations**: 1. Increase reporting of potential variances. 2. Present data to address to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction e. Outline of ICAs, including description of variance, recommendations and actions taken

		3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.i	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to utilize the current mechanism of Physician Quality Profile, including data relevant to this requirement, and identify trends and patterns, with corrective actions/educational activities as needed. **Findings:** MSH reported that it has continued to conduct Physician Performance Profile evaluations in which each practitioner's performance is reviewed individually and compared to hospital-wide patterns semi-annually. Corrective actions have been implemented accordingly. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.j	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial.

		Current recommendations: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication	**Compliance:** Partial.

	treatment, consistent with generally accepted professional standards of care, for:	
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, March 2008:** Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the Psychiatry Department. **Findings:** MSH did not address this recommendation. **Current recommendations**: 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the Psychiatry Department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** Same as above.

		Current recommendations: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as F.1.e. **Findings:** Same as F.1.e.

		Current recommendations: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in C.2.o, F.1.c and F.1.m.iii. **Findings:** Same as in C.2.o, F.1.c and F.1.m.iii. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o, F.1.c and F.1.m.iii.
F.1.o	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure full and consistent compliance with this requirement.

	through attendance at conferences elsewhere.	**Findings:** The facility has maintained compliance. **Compliance:** Substantial. **Current recommendations**: Continue current practice and present supporting documentation.

2. Psychological Services		
	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:	**Methodology:** <u>Interviewed</u>: 1. The following four individuals: AAH, JU, RM and WS 2. Abney Ziganay, PT 3. Admeish Singh, Shift Leader 10. Ashvind Singh, PhD, Psychologist 4. Augustine Trinidad, PTA 5. Cheryl Kempinsky, PhD, Psychologist 6. Christopher Cooper, PhD, PSSC Director 7. Chrystal Amey, PT, PBS Team Member 11. Cynthia Lusch, Clinical Administrator 8. Diane Black, RN, Supervising Nurse 9. Don Pieratt, PT, BY CHOICE Coordinator 10. Donald Magner, PT 12. Doug Strosnider, Mall Director 11. Elnora Abonico, PT 12. Eric Ruffins, PT 13. Eric McMullen, PT, DCAT Team Member 13. Fernando Medrano, RN 14. Foresteen Forbes, PhD, Psychologist 14. Gretchen Hunt, BY CHOICE Coordinator 15. Jocelyn Agtarap, RN, Nurse Supervisor 15. John Lusch, Program Director 16. Katherine Nguyen, RN, DCAT Team Member 17. Latasha Fields, PT, PBS Team Member 18. Lisa Rimland, WRP Trainer 16. Luciano Leon, ESL Teacher 17. Lydia Atayde, RN 18. Neven Antononius, RN 19. Nilda Vistro, RN 20. Robert Cosio, PTA

		21. Sean Johnson, Assistant BY CHOICE Coordinator 22. Sheri Greve, PsyD, Consultant to PSR Mall Services 23. Willie Cottens, PT 24. Willie Smith, RT <u>Reviewed</u>: 1. Charts of the following 45 individuals: AM, AMB, BP, CB, CBT, CG, CJ, CRT, CW, DAC, DE, DMS, DY, FR, GMH, HS, JG, JM, JP, JS, KLF, KO, KR, LL, MCL, MJ, ML, PD, PH, PS, PW, RAP, RL, RM, SDE, THE, TK, TLF,TP, TR, TR2, TS, VA, WRP, and YH 2. Behavior Consultation Committee Attendance Roster 3. Behavior Guidelines for the following five individuals: BW, DA, JS, RH and TM 4. BY CHOICE Training Log 5. DMH Psychology Services Monitoring Form. 6. Enrichment Activity Summary 7. Fidelity check data for DG, JG, MC and ML 8. Individual enrichment activity participation hours list 9. Individual Mall hours summary 10. List of individuals receiving DCAT services. 11. List of individuals that need neuropsychological services. 12. Interdisciplinary Consultation Progress Notes for the five PBS plans: DYM, KR, MC, ML and TP 13. MSH Neuropsychology Service Referral Tracking Database 14. MSH System-Wide PBS Model Plan 15. PBS Plans for CB, CG, DY, MC, ML, PW and TP 16. Program III Spring 2008 PSR Alignment Plan 17. Staff Certification Logs 18. Monthly Fidelity Checks/Behavioral Rehearsal of PBS plans 19. Psychology Progress Notes showing discussions with other disciplines 20. PBS Activity Logs 21. DCAT Activity Logs

		22. List of individuals with high triggers 23. Data/Graphs of PBS plans 24. PBS Training Log 25. Staff training/certification log 26. PBS Plan Intervention Integrity Checks 27. Specialty Teams Morning Meeting Minutes 28. DCAT/PBS Meeting Minutes 29. Psychology Specialty Service Meeting Minutes <u>Observed</u>: 1. WRPCs for DC and YB 2. The following four bed-bound individuals: BP, DE, HS and JP 3. BY CHOICE Incentive Store 4. PSR Mall group: DBT Skills Introduction 5. PSR Mall group: ESL 6. PSR Mall group: Healthy Lifestyle 7. PSR Mall group: Legal Issues-Court Preparation 8. PSR Mall group: Mind Over Mood 9. PSR Mall group: Motivational Group 10. PSR Mall group: Reality Orientation 11. PSR Mall group: Recovery Games 12. PSR Mall group: Social Skills 13. PSR Mall group: Sports and Fitness 14. PSR Mall group: Substance Recovery 15. Psychology Specialist Service Committee Meeting
F.2.a	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's documentation review (MSH progress report, list of PBS

	competence, consistent with generally accepted professional standards of care, in the following areas:	team members) and interview with Swati Roy, the Chief of Psychology, Christopher Cooper the PSSC Coordinator, and the Senior Psychologists confirmed that MSH has two PBS teams. Neither team is fully staffed; each is missing a psychologist and a nurse. PBS team #1 is also lacking a Data Analyst. Furthermore, the Registered Nurse from one of the PBS teams is on medical leave, and the Psychiatric Technician for one of the PBS teams is on temporary reassignment. According to the Chief of Psychology, MSH is in the process of hiring to fill the vacancies, and an applicant for the RN position has been selected and is to begin employment with the PBS team on September 15, 2008. **Compliance:** Partial. **Current recommendation**: Continue current practice.
F.2.a.i	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	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue with training of PBS team members in structural and functional assessments, utilization of evidence-based tools and development and implementation of PBS plans. **Findings:** This monitor's documentation review (training material and attendance roster) and interview of the Chief of Psychology, Senior Psychologists, the Coordinator of the Psychology Specialty Service, and the PBS team members found that MSH has offered PBS training to all its PBS team members. Training focused on Functional Assessments, Structural Assessments, PBS Model, assessment instruments, Strengths Based

		Interview, and Pica. This monitor attended one of the training/meeting sessions conducted by the Psychology Specialty Services Coordinator (after the exit conference on Friday, September12) with the PBS team members. The scope of discussion at this meeting included issues pertaining to motivating unit staff to implement plans and collect valid and reliable data, and data analysis and interpretation. **Recommendation 2, March 2008:** Conduct treatment implementation fidelity checks regularly in all settings where the PBS plans are implemented. **Findings:** This monitor's interview of the Chief of Psychology, Senior Psychologists, and the Coordinator of the Psychological Services Committee, and documentation review (integrity checks for DY, JG, TP, KR, PW, and ML, and staff certification Logs) found that MSH has consistently conducted staff training to certify persons responsible for implementing the intervention plans, prior to the implementation of the plans. MSH also conducted regular integrity checks once the plans were implemented. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.ii	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. • Continue to train WRPTs and individuals on the individuals' final

		choices in allocating points per cycle, ranging from 0 to 100 per cycle. **Findings:** This monitor's interview of the BY CHOICE Coordinator and documentation review found that MSH conducted staff training on BY CHOICE using the DMH competency tool at least four times a month and also delivers training during the monthly New Employee Orientation. **Recommendation 3, March 2008:** Report BY CHOICE point allocation statement in the Present Status section of the individual's case formulation and update at every scheduled WRPC. **Findings:** This monitor's interview of the BY CHOICE Coordinator found that MSH had reassigned cards to all individuals with re-ordered point allocation, which means that many individuals would be at the baseline point allocation. The Coordinator also reported that she was working to ensure that facilitators fill in the BY CHOICE point cards in real time. Filling in the BY CHOICE point cards early was observed in at least two Mall groups this monitor observed, where the time of participation column was completed before the end of the Mall group. Using item 16 and sub-items from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a mean sample of 20% of the Quarterly and Annual WRPs due for the month (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

16.	*The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.*	61%
16.a	*There is documentation that BY CHOICE point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan.*	78%
16.b	*There is documentation that the individual determines the point allocation.*	65%

The mean compliance rate for the previous review period was 29% compared to 61% in the current period. The mean compliance rate for the last month of the previous review period was 34% and mean compliance for the last month of this review period is 90%.

This monitor reviewed 13 charts (AMB, CBT, CW, DAC, DMS, JS, LL, PH, RAP, SDE, THE, WRP and YH). Eight of the WRPs in the charts (AMB, CW, DAC, LL, PH, RAP, THE and YH) had appropriate BY CHOICE point allocation statements in the Present Status section. The point allocation in the remaining five WRPs (CBT, DMS, JS, SDE and WRP) was not comprehensive.

Compliance:
Partial.

Current recommendations:
1. Continue with competency-based training of all staff in correctly implementing the BY CHOICE program.
2. Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.
3. Report BY CHOICE point allocation in the Present Status section of the individual's case formulation and update at every scheduled

		WRPC.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's interview of the Chief of Psychology revealed that the Chief continues to have clinical and administrative responsibility for the Positive Behavior Supports Teams and the BY CHOICE incentive program. However, the Chief of Psychology has assigned some of her duties to the Coordinator of the Psychology Specialty Services Committee, because the PBS assessment and service matters would be handled by the Coordinator. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Train PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** This monitor's documentation review (training roster) and interview of

the Senior Psychology Staff revealed that the Coordinator of Psychology Specialist Services and the former acting PBS team leader have been training the PBS staff on functional assessment procedures, data collection and analysis methods, graphing principles, plan implementation elements, and data interpretation techniques.

Using item 5 from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans developed and implemented during this review period (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	100%
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and*	100%

	following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior, as needed, and	
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	n/a

As shown in the table above, MSH is following the proper steps and assessment procedures when developing and implementing PBS plans. However, the data is based on a small sample of two PBS plans. According to the Psychology Specialty Services Coordinator, psychology interns acting as PBS team psychologists were not always available for PBS activities during this review period because they were assisting unit psychologists with behavioral assessments in developing behavior guidelines, as well as attending the WRPCs and morning reports to assist staff in managing individuals with maladaptive behaviors.

Recommendation 2, March 2008:
Ensure that Senior Psychologists monitor the appropriateness of Behavior Guidelines, Crisis Intervention Plans and the need for a referral to PBS teams.

Findings:
This monitor's interview of the PSSC Coordinator indicated that the Coordinator held training sessions (May 28, 2008) for the WRPT Psychologists and the Senior Psychologists. The training topics included the development of Behavior Guidelines following the PBS model, and the referral process based on the PBS-BCC checklist. The Coordinator and the Senior Psychologists reportedly have been reviewing Behavior Guidelines developed by the Unit Psychologists.

Current recommendation:
Continue current practice.

<table>
<tr>
<td>F.2.c.ii</td>
<td>hypotheses of the maladaptive behavior are based on structural and functional assessments;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

Findings:
Using item 6 from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample (n=2) of the PBS plans developed and implemented during this review period (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

<table>
<tr><td>6.</td><td>Hypotheses of the maladaptive behavior are based on structural and functional assessments</td><td>100%</td></tr>
<tr><td>6.a</td><td>There is at least one written hypothesis of the functions of the behavior, and</td><td>100%</td></tr>
<tr><td>6.b</td><td>The hypothesis is aligned with findings based on structural and/or functional assessments</td><td>100%</td></tr>
</table>

This monitor reviewed the two PBS plans (CB and CG) audited by MSH. Both PBS plans had developed their hypotheses from the structural and functional assessments, and the hypotheses were aligned with the data presented in the structural and functional assessments.

Current recommendation:
Continue current practice.

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<tr>
<td>F.2.c.iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
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Current findings on previous recommendation:

Recommendation, March 2008:
Continue current practice.

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Findings:
Using item 7 from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans developed and implemented during this review period (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

<table>
<tr><td>7.</td><td>There is documentation of previous behavioral interventions and their effects</td><td>50%</td></tr>
<tr><td>7.a</td><td>There is documentation of previous behavioral interventions, and</td><td>100%</td></tr>
<tr><td>7.b</td><td>The effects of these interventions.</td><td>50%</td></tr>
</table>

This monitor reviewed the two PBS plans (CB and CG) that were developed (but not implemented) during this review period. Both plans had documented and reviewed previous interventions, but one of them (CG) had failed to discuss the effects of the previous interventions. The facility's data is in agreement with the monitor's findings.

Current recommendation:
Continue current practice.

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<tr>
<td>F.2.c.iv</td>
<td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
Continue current practice.

Findings:
This monitor's documentation review (progress report, behavior guidelines, and PBS plans) and interview of the PSSC Coordinator revealed that MSH had developed and implemented one new PBS plan and 56 behavior guidelines during this review period (February to July

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</table>

		2008). All the intervention plans followed the positive behavior support model and did not include any aversive or punishment contingencies. This monitor's interview of the PSSC Coordinator and review of behavior guidelines found that most of the behavior guidelines were poorly written and the interventions lacked focus and specificity. According to the PSSC Coordinator, none of the behavior guidelines were developed with the assistance of the PBS team members. The PSSC Coordinator has planned to have each PBS team assist WRPT team psychologists in developing behavior guidelines. The unit psychologists will be responsible for training the unit staff. The PSSC Coordinator will continue to mentor WRPT psychologists in developing and implementing behavior guidelines. **Other findings:** This monitor's review of Behavior Guidelines turned up a few that used titles such as "Enhanced" Behavior Guidelines and "Simple" Behavior Guidelines". These creative terms are unnecessary and non-functional because the interventions in these guidelines were no different from the rest of them which were labeled "Behavior Guidelines." **Current recommendation:** Continue current practice.
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training. • Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.

		Findings: Using item 9 (*Behavioral interventions are consistently implemented across all settings, including school settings*) from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample (n=1) of all PBS plans developed and implemented during this review period (February to July 2008), reporting a mean compliance rate of 100%. This monitor's review of the one PBS plan is in agreement with the facility's data. Unit staff was familiar with the PBS plan and explained some of the treatment components to this monitor. Historically, behavioral guidelines were developed by unit psychologists for individuals with mild maladaptive behaviors and implemented exclusively in the units. However, PBS teams have taken the approach to address even moderately severe maladaptive behaviors through behavior guidelines. Thus, it is appropriate to implement all behavior intervention plans across settings where the maladaptive behaviors are exhibited. According to the PSSC Coordinator, the PSS Committee will work with the Clinical Administrator to ensure that behavior guidelines are implemented across settings, and to get the cooperation of the Program Directors and Assistant Program Directors to ensure reliable data collection by the staff. **Current recommendations**: 1. Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and	**Current findings on previous recommendations:**

	utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Recommendations 1 and 2, March 2008:** • Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PSB plans by evaluating and implementing appropriate behavioral interventions. • Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately evaluated for behavioral interventions. **Findings:** This monitor's interview of the Chief of Psychology and the PSSC Coordinator, and documentation review (PBS plans, behavior guidelines, progress report, and trigger data) revealed the following: According to the Chief of Psychology, MSH implemented the facility-wide PBS system in June 2008. Matters relating to triggers and behavioral interventions come under the Psychology Specialty Services Committee (PSSC), the PSSC was recently established, and the PSSC Coordinator was recently employed at MSH and appointed to his current position. According to the PSSC Coordinator, the PSSC is notified of all individuals who trigger a behavioral event. In addition, the Coordinator is informed about the triggers during the Morning Report. The trigger cases are reviewed by the PSSC at its weekly meetings, and decisions are made on how to best handle the high-risk behaviors. The Senior Psychologists also review the daily nursing report on individuals who triggered a behavioral event, and then contact WRPT psychologists to get an update on the individual's status. Using item 10 (*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*) from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of all individuals who met the trigger threshold during this review

		period (February to July 2008), reporting mean compliance of 32%. This monitor reviewed MSH's trigger data, PBS plans, and behavior guidelines. This monitor's findings are in agreement with the facility's data. A number of individuals with high-risk behaviors have not been acted upon to determine the potential appropriateness of behavioral interventions (which can only be determined after some level of assessment). For example, JA has had multiple aggressive behaviors towards others resulting in HPO inquiries and California Department of Mental Health investigation. According to the progress note dated December 3, 2007, JA had an altercation with another individual. The other individual wanted to press charges on JA. HPO was involved in the investigation. The date of incident recorded on page 7 of the SIR was 11/30/07. The finding (on page six of the SIR, dated December 6, 2007) was that both individuals did not sustain any injuries. As a result of these events, MSH had developed a Plan of Correction which involved WRP and nursing (unit 416) staff training, an attachment to the WRP to correctly reflect JA's discharge criteria, and random review of WRPs of individuals in Program II with maladaptive behaviors (dangerous behaviors towards self and others). This monitor's documentation review (WRP attachment, training documentation, and WRP review documentation) found that MSH has implemented/ completed the proposed plans of action, and in the case of WRP reviews the task is ongoing. The PBS team has not picked up JA's case for assessment to determine the appropriateness of behavioral intervention. A number of WRPs (CRT, GMH, KLF, PD, TLF, and VA) reviewed by this monitor showed internal inconsistency. In all these cases, there was documentation in the Present Status section of the individuals' WRPs indicating that the individual had exhibited maladaptive behaviors (recent or current). However, the WRPTs stated that the individuals did not have any maladaptive behavior under the "Behavioral

		Guidelines/PBS Plan" section of the Present Status section, and failed to refer the individual for much-needed PBS/behavior guideline assessments. The PSSC Coordinator and PBS team members should address these issues with the WRPTs, and where necessary provide training. **Current recommendations**: 1. Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PSB plans by evaluating and implementing appropriate behavioral interventions. 2. Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately evaluated for behavioral interventions.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Integrate all behavioral interventions with other treatment modalities, including drug therapy. **Findings:** This monitor's interview of the PSSC Coordinator and documentation review (structural and functional assessments and progress notes) found that PBS teams take into consideration the influence of and integration of other treatment modalities when developing PBS plans. According to the PSSC Coordinator, PBS team members meet with the WRPT members before and during the assessment and plan development phases. The PSSC Coordinator attends the weekly trigger meetings, and at these meetings psychiatrists were said to discuss pharmacological interventions. PBS team members attend the WRPT meetings when the conference involves individuals with maladaptive behaviors, at which time the PBS team members meet with the

		psychiatrist to discuss the individual's behaviors and treatment modalities. This process did not work during this review period because, as indicated earlier, psychology interns acting as PBS psychologists were involved in other assignments. Using item 11 (*Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy*) from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample (n=2) of the PBS plans developed and implemented during this review period (February to July 2008), reporting mean compliance of 19%. This monitor reviewed a number of progress notes (for example, DY, JG, KR, MCL, PW and TP) that dealt with the PBS team members' discussion of treatment modalities with the psychiatrist and WRPTs. These older PBS plans which continue to be in effect with revisions had multiple progress notes across time on the same individuals indicating ongoing communication between disciplines. In discussion with the PSSC Coordinator, this monitor believes that now that the PSSC meets weekly, interdisciplinary discussion on multimodal therapy would become a routine procedure. The PSSC meetings are represented by professionals from a variety of disciplines, especially Psychiatry and Psychology. However, this monitor's review of the PSSC attendance log found that the meetings were not well attended by the team members representing the individuals discussed at the meetings. MSH should ensure that attendance is high from all relevant disciplines at these meetings. **Current recommendation**: Integrate all behavioral interventions with other treatment modalities, including drug therapy.

F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual. **Findings:** According to the Chief of Psychology and the PSSC Coordinator, PBS team members attend the WRPC and work with the WRPT members to ensure that PBS plans are discussed at the WRPC and document the plan in the individual's WRP. This monitor's review of the WRPs of individuals who have had a PBS plan found that the WRPs (DY, FR, JG, KR, ML, PW, RL, TP and TS) were not properly updated with data documented in the Present Status section. This monitor's documentation review found that PBS team members have the data analyzed and graphed for the PBS plans as part of their procedure to evaluate the individual's progress. However, this monitor learned from the WPRT members that these data and/or graphs were not always made available to the WRPTs. It is this monitor's opinion that all data and graphs should be shared with the WRPTs for review, discussion, and documentation. This monitor's interview with the PSSC Coordinator revealed that MSH plans to have unit psychologists ensure that all behavioral interventions, including the behavior guidelines, get reported and documented in the Present Status sections of the individuals' WRPs. The PBS team members will continue to participate in WRPCs to discuss the data and assist the WRPTs in documenting the information in the Present Status sections of the individuals' WRPs.

		Current recommendation: Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.
F.2.c.ix	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation. **Findings:** Using item 13 (*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*) from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of all PBS plans and behavior guidelines developed and implemented during this review period (February to July 2008), reporting a mean compliance rate of 0%. This monitor's findings from review of WRPs of nine individuals with PBS plans (DY, FR, JG, KR, ML, PW, RL, TP and TS) are in agreement with the facility's data. WRPTs often mentioned that an individual had a PBS plan, but did not consistently report or update the individual's PBS plans using quantitative and/or qualitative data in the Present Status section of the individual's WRP. **Other findings:** This monitor's findings show that, beginning this review period, MSH has taken the initiative to include behavior guidelines as part of the auditing and reporting process for the cell/recommendations meant for PBS plans, and presented the data in a combined fashion (i.e. PBS data

		and behavior guideline data). Thus, mean compliance for these cells/recommendations is low because it has not been the practice at MSH to use behavior guidelines to answer these cells/ recommendations. The PSSC Coordinator has indicated that he will work with the unit psychologists, WRPTs, Clinical Administrator, Program Directors and Assistant Program Directors, as well as PBS teams to ensure that behavior guidelines follow the same reporting format as do PBS plans. This monitor encourages this practice of accountability for all behavioral interventions, especially now that the PBS teams are working with the unit psychologists to address even moderately severe maladaptive behaviors using behavior guidelines as a first step to interventions. However, this monitor suggests that the data be presented under separate tables, one for PBS plans and the other for behavior guidelines. Such reporting will reflect the merits of PBS plans and behavior guidelines independently and not skew the averages. **Current recommendation**: Update all PBS plans as indicated by outcome data and document at every scheduled WRPC in the Present Status section of the individual's case formulation.
F.2.c.x	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Provide competency-based training to appropriate staff on implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions. **Findings:** Using item 14 from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans

developed and implemented during this review period (February to July 2008). The table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

14.	*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.*	98%
14.a	*There is a list of certified staff trained to implement the PBS plan,*	98%
14.b	*There is a training database with details of the training and competency scores for the certified staff,*	98%
14.c	*Staff not reaching competency standards have been retrained until competency is reached before they implement the PBS plan, and*	98%
14.d	*There is monthly fidelity of implementation or behavioral rehearsal data on each PBS plan.*	98%

This monitor's documentation review (training roster) of the PBS plans implemented during this review period (DY, FR, KR, ML, PW, RL, TP and TS) found that staff responsible for implementing these PBS plans was trained and integrity checks conducted on their implementation. In all cases, MSH's data showed performance at or above 85%. One of the PBS plans (CG) developed in July has yet to be implemented because the PBS team is awaiting administrative approval. The plan necessitates staffing reassignments and resource modification. MSH should look into streamlining the procedure to shorten the decision-making timeline. Delay in plan implementation causes service delay to the individual, places staff and other individuals at continued risk, and the intervention plan might become invalid due to changes in the individual's physical and mental health status, and changes in the

		immediate environment. **Current recommendation**: Continue current practice.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's interview of the Chief of Psychology, Senior Psychologists, and PBS team members found that PBS team members continue to have as their primary responsibility the provision of behavioral interventions. The PBS team members who had to work overtime did not report any conflict between their roles as PBS team members and their overtime duties. **Current recommendation**: Continue current practice.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendation:** **Recommendations 1 and 2, March 2008:** • Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. • Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan. **Findings:** Using item 16 from the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 20% sample of the Quarterly and Annual WRPs due for the month (February to July 2008). The

table below with its indicators and sub-indicators and their corresponding mean compliance is a summary of the data:

16.	*The BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan*	61%
16.a	*There is documentation that BY CHOICE point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan*	78%
16.b	*There is documentation that the individual determines the point allocation*	65%

Mean compliance for the previous review period was 29% and the mean compliance of this review period is 61%. Compliance for the last month of the previous review period was 34% and compliance for the last month of this review period is 90%.

This monitor reviewed 13 WRPs (AMB, CBT, CW, DAC, DMS, JS, LL, PH, RAP, SDE, THE, WRP and YH). There was documentation on the individual's point allocation, and indications that the individual was a participant in determining the point allocation in the Present Status section of eight WRPs (AMB, CW, DAC, DMS, LL, RAP, SDE, and YH). The documentation in the remaining five WRPs (CBT, JS, PH, THE and WRP) did not have proper documentation.

This monitor's documentation review (WRPs and facility progress report), visit to the SNF units and observation of the bed-bound individuals and DE) (BP, DE, HS and JP), and interview of the BY CHOICE coordinator found that MSH continues to include bed-bound individuals and individuals whose primary language is not English in the plan. According to the BY CHOICE Coordinator, MSH uses a modified BY CHOICE program on the SNF unit, by which bed-bound individuals are not required to maintain a point card but benefit from incentives on

		a weekly basis. In addition, MSH has re-developed BY CHOICE point cards in Chinese, Vietnamese, Korean, and Spanish to assist individuals whose primary language is not English. According to the BY CHOICE Coordinator, Gretchen Hunt, the plan for improvement is for her and her team to continue to review WRPs and give feedback to WRPTs. This monitor also learned that the BY CHOICE Coordinator is working through the Senior Psychologists, with support from the Chief of Psychology, to assist unit/WRPT psychologists to follow proper documentation in order to achieve compliance with this recommendation. This is a good approach to interdisciplinary functioning. MSH should consider similar approaches to engage the PSSC and the Mall Director with BY CHOICE incentives and treatment planning. **Current recommendations**: 1. Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. 2. Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.
F.2.d	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	**Current findings on previous recommendations:** **Recommendation 1 and 2, March 2008:** • Hire all members of the DCAT. • Ensure that all DCAT team members receive appropriate training. **Findings:** This monitor's interview of the Chief of Psychology and the PBS/DCAT teams revealed that MSH has two of the five team members to make a full DCAT team. Currently, MSH has a Registered Nurse and a Psychiatric Technician in the DCAT team. The team still lacks a Clinical Psychologist, a Social Worker, and a Behavior Specialist/Data Analyst.

	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.	MSH is actively recruiting to fill the vacant positions, and is at various stages of position announcement and interviews for the different positions. This monitor's documentation review (training log) and interview of the Chief of Psychology and the PSSC Coordinator found that the DCAT members have been attending the same training sessions held for the PBS team members. The Psychology Specialty Services Coordinator and his team have conducted numerous PBS/DCAT training sessions during this review period (July 18, 21, 23, 24, 25, 28, 29, 30, and 31, 2008; and August 1, 5, 8, 13, and 26, 2008). **Compliance:** Partial. **Current recommendations**: 1. Hire all members of the DCAT. 2. Ensure that all DCAT team members receive appropriate training.
F.2.e	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all standing members of the BCC attend every meeting. **Findings:** This monitor's interview of the Chief of Psychology and the PSSC Coordinator and documentation review (PSSC minutes) found that the BCC did not formally meet during this review period. Instead, MSH has adapted the recommendation of its CRIPA Consultant (supported by the Court Monitor) to reconstitute the BCC and the PSSC to better address the needs of the individuals and the unit staff. Thus, the PSSC will include all the tasks previously assigned to the BCC.

	clinical administrator of the facility.	According to the Chief of Psychology and the Coordinator of the PSSC, the composition of the PSSC membership is as follows: PSSC Coordinator and co-chaired by the Chief of Psychology and the Chief of Psychiatry (who were Chair and Co-Chair of the BCC respectively), relevant senior staff from Psychiatry, Psychology, Social Work, Rehabilitation Therapy Services, Nursing, and the individual's PBS team leader and WRPT. The PSSC has been meeting on a weekly basis. The PSSC's main goal is to review trigger data, review PBS plans, and to suggest courses of action for each case. This monitor's review of the PSSC meeting minutes found that PSSC has been meeting on a regular basis. It appears that attendance at these meetings is irregular, especially that of the unit staff. For example, a number of individuals (CJ, MJ, RM, TK and TR) were not represented by their team members at the June 20, 2008, meeting; the same was the case for AM, JM, KO, MJ, PS, RM, TK, TR and TR-2 at the June 27, 2008 meeting and for TR and TR-2 at the July 3, 2008 meeting. The individual is not well served if the team members representing the individuals are not present at these meetings to present the individual's current status and to receive feedback from the multidisciplinary team. **Compliance:** Partial. **Current recommendation:** Ensure that all standing members and those involved in the cases/plans to be reviewed for the week attend the weekly PSSC meetings.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that Neuropsychology referrals are addressed in a timely

illness.

manner.

Findings:
This monitor's interview with the Senior Psychologist, Edwin Poon, and the Chief of Psychology, Swati Roy, found that the average turn-around time for completion of neuropsychological referrals was around 22 days. The table below showing the number of neuropsychological referrals received in the month (February to July 2008), the number of assessments completed in the month, and the average time taken to complete referrals is a summary of the facility's data.

		Feb	Mar	Apr	May	Jun	Jul	Mean
18.a.i	*Number of neuro-psychological assessments due for completion in the review month*	5	7	11	15	13	16	11
18.a.ii	*Of those in 18.a.i, number completed*	4	6	9	13	13	16	10
18.a.iii	*Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period*							22

The number of referrals and the number of completed assessments in the six-month review period has increased in comparison to the previous review period. In addition, the time taken to complete the referrals has decreased in comparison to the previous review period.

MSH should review its referral process and referral criteria to ensure that individuals needing neuropsychological assessments are referred for the assessment. The number of referrals and assessments completed is small given the nature of the population in the facility. In addition, Neuropsychologists should attend the Psychology Specialty Services Meetings to add their expertise to the cases discussed and

		determine neuropsychology assessment needs for the individuals. Neuropsychologists should also provide active treatment hours in their specialty area, including the cognitive remediation programs. **Compliance:** Substantial. **Current recommendation**: Ensure that neuropsychology referrals are addressed in a timely manner.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor's interview with the Chief of Psychology revealed that the AD 1051 (authority for writing orders) is still in effect, and the psychologists with privileges 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. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Services		
	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.	**Methodology:** <u>Interviewed</u>: 1. Albert Olmos, Standards Compliance 2. Alfred Johnson, RN 3. Aubri Griffis, Acting NC 4. Aurora Hendricks, Nurse Administrator 5. Gary Bruben, Nursing Education 6. Greg Mercado, RN 7. Jeannie Rvovarnik, Psychiatric Technician 8. Lisa Rimland, WRP Trainer 9. Mila Rose Gaffund, RN 10. Xanthia Strong, RN <u>Reviewed</u>: 1. MSH's progress report and data 2. NP 528, PRN Orders; 530, Stat Orders; 710, Change of Shift Report 3. Inter-rater reliability data 4. Unit Supervisors/Nurse Coordinators Meeting minutes dated 4/30/08, 7/30/08 5. Central Nursing Services/Nurse Coordinator Meeting minutes dated 5/19/08, 6/11/08, 6/25/08, 7/16/08 6. Training rosters for PRN/Stat Medications and Nursing Policies; WRP training; Change of Shift; PBS; Nursing Updates 7. Medication Variance Report tracking form 8. Agenda for Nursing WRP Process & Documentation Requirements Workgroup 9. Nursing WRP Curriculum Content Outline 10. Medication Treatment Records for Program III 11. Medical records for the following 61 individuals; AL, AM, AT, BE,

		BJL, CG, CGu, CMG, DAC, DC, DGG, DJG, DL, DT, DY, EA, EHV, FN, GDS, GP, GT, JF, JG, JL, JM, JMT, JND, JP, KS, LAB, LP, MBJ, MDB, MJK, MM, MVN, NSO, OG, PAA, PD, PJL, PW, RJD, RLH, RR, RWL, SB, SDH, SJW, SNM, SS, SW, SY, TAL, TJE, TK, TL, VA, WAR, WH and YDH Observed: 1. Shift report on Unit 405 2. 8 a.m. medication administration pass on Unit 413
F.3.a	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:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's compliance data from the MSH Medication Administration Monitoring based on an average sample of 21% of the number of level of care nursing staff who are licensed and medication certified (February-July 2008) indicated: 3. *Nursing are following the appropriate medication administration protocol* — 100% From observations of 8 a.m. medication administration on Unit 413, this

		monitor found that the appropriate medication administration protocol was followed. **Other findings:** From observation of medication administration, there was little to no medication education provided to individuals. In addition, when questions were asked regarding certain medication side effects, the information provided was not accurate. **Current recommendations**: 1. Ensure that staff administering medications are familiar with individuals' medications. 2. Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Increase inter-rater reliability to an acceptable level (85% or above). **Findings:** MSH's inter-rater reliability data demonstrated that inter-rater agreement increased from 76% to 90%. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** MSH implemented a new PRN/Stat audit tool February 2008. The DMH statewide tool for F.3 has not been finalized as of yet. Training rosters verified that MSH provided training for all HSS auditors. MSH revised Nursing Policies NP 528, PRN Orders and NP 530, Stat Orders in June, 2008 to include specifics regarding documentation responsibilities for the medication treatment records (MTRs) and interdisciplinary notes

(IDNs). Unit Supervisors provided training regarding these revised policies in July 2008.

MSH's compliance data from the MSH Nursing PRN Monitoring audit based on an average sample of 23% of PRNs administered each month (February-July 2008) indicated:

2.	*Documentation of all the circumstances requiring PRN administration of medication.*	67%
2a.	*In the MTR, there is a brief description of the circumstances and behavior requiring PRN medication.*	90%
2b.	*In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication.*	71%

MSH's analysis demonstrated that compliance with the requirement of documentation of the circumstances requiring the PRN increased from 47% in the first month of this review period (February) to 80% for the last month July. To increase compliance, MSH presents data results to Unit Supervisors and Nurse Coordinators to identify practice trends that need to be addressed. In addition, MSH implemented an accountability system to address performance issues with specific staff regarding documentation issues. Binders have been placed on all units that consist of the DMH-approved statewide nursing audit tools and instructions, to be used as a resource. MSH also indicated in its progress report that the number of incidents of psychotropic PRN medication use from August- January 2008 was 2,589. Psychotropic PRN medication use from this evaluation period (February-July 2008) consisted of 2,298 incidents; a decrease of 291 PRN medications (11%).

A review of 50 incidents of PRN medications for eight individuals (AT, DL, PW, SNM, SS, SW, SY and WH) found that 38 incidents included the documentation of circumstances requiring the PRN and 32 incidents

<table>
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<td>included a comprehensive assessment in the IDNs prior to the administration of the PRN.

MSH's compliance data from the MSH Nursing Stat Monitoring audit based on an average sample of 27% of Stats administered each month (February-July 2008) indicated:

<table>
<tr><td>2.</td><td>Documentation of all the circumstances requiring Stat administration of medication.</td><td>67%</td></tr>
<tr><td>2.a</td><td>In the MTR, there is a brief description of the circumstances and behavior requiring Stat medication.</td><td>83%</td></tr>
<tr><td>2.b</td><td>In the IDN, there is a comprehensive assessment of the individual prior to the Stat medication.</td><td>77%</td></tr>
</table>

MSH"s data showed that compliance for documentation of all the circumstances requiring Stat medication increased from 54% (February 2008) to 82% (July 2008). There has been a decrease of 112 Stat medications since the last review period.

A review of 50 incidents of Stat medications for eight individuals (AT, DT, DY, JL, LP, MM, SNM and WH) found that 28 incidents included the documentation of circumstances requiring the Stat and 31 incidents included a comprehensive assessment prior to the administration of the Stat in the IDNs.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.a.iii</td>
<td>documentation of the individual's response to PRN and Stat medication.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Evaluate current medication administration system.</td>
</tr>
</table>

Findings:
See F.3.a.ii under Recommendation 2.

Recommendation 2, March 2008:
Continue to monitor this requirement.

Findings:
MSH's compliance data from the MSH Nursing PRN and Stat Monitoring audit based on an average sample of 23% of PRNs and 27% of Stats administered each month (February-July 2008) indicated:

3.	*Documentation of the individual's response to PRN medications.*	68%
3a.	*In the MTR, there is a brief description of the individual's response to the administered PRN medication which was documented within one hour of the administration.*	82%
3b.	*In the IDN, there is a comprehensive assessment of the individual's response to the administered PRN medication.*	75%

MSH's data analysis showed that compliance with the requirement of documentation of the individual's response to PRN medication increased from 59% in February 2008 to 83% (July 2008). See F.3.a.ii for plan of improvement.

3.	*Documentation of the individual's response to Stat medications.*	66%
3.a	*In the MTR, there is a brief description of the individual's response to the administered Stat medication which was documented within one hour of the administration.*	81%

		3.b — *In the IDN, there is a comprehensive assessment of the individual's response to the administered Stat medication.* — 75% MSH's data analysis showed that compliance with the requirement of documentation of the individual's response to Stat medication increased from 54% in February 2008 to 80% in July 2008. See F.3.a.ii for plan of improvement. This monitor's review of 50 incidents of PRN medications for eight individuals (AT, DL, PW, SNM, SS, SW, SY and WH) found that 31 incidents included a comprehensive assessment of the individual's response and 37 were assessed within one hour. This monitor's review of 50 incidents of Stat medications for eight individuals (AT, DT, DY, JL, LP, MM, SNM and WH) found that 33 incidents included a comprehensive assessment of the individual's response and 38 were assessed within one hour. **Current recommendation**: Continue to monitor this requirement.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH implemented a new MVR form in February 2008 that assigns a log number to each medication variance. The Central Nursing Services department reviews the Controlled Medication List each month, checks for missing signatures and notifies the Program Managers if an MVR is required. An MVR log book is maintained to track all initiated MVRs.

		MHS's progress report indicated that from February through July 2008, 144 MVRs were reported for missed signatures or initials on the MTRs and 132 MVRs were received (91%). 24 MVRs were reported for missing signatures on the controlled medication log and 20 MVRs were received (83%). MSH indicated an awareness of the fact that there is an under-reporting of MVRs. The Medical Director has met with the Unit Supervisors and the Nursing Coordinators to address the importance of reporting all MVRs and as a way to reach best practice in nursing and improve performance. From review of MTRs for Program III and Program V, eight individuals were found to have missing initials. No associated MVRs were provided by the facility. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.3.c	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	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Increase inter-rater reliability to an acceptable level (85% or above). **Findings:** MSH reported that inter-rater reliability increased from 73% to 89% and that since February 2008, CNS auditors are completing the audits to ensure accurate results.

required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.

Recommendation 2, March 2008:
Continue to monitor this requirement.

Findings:
MSH implemented a new audit tool for this requirement in February 2008.

Using the MSH Nursing Interventions Monitoring Form, MSH assessed its compliance based on an average sample of 19% of the individuals in the facility (average daily census) for the month (February-July 2008). The following table summarizes MSH's data:

1.	*If a DMH WRP Attachment was developed, it was filed with the previous WRP*	89%
2.	*If a DMH Attachment was developed, it has been reviewed and integrated into the current WRP.*	21%
3.	*There are interventions (both active treatment and in the therapeutic milieu) specific as to how nursing is going to assist the individual in meeting his or her goals for each open focus.*	10%
3.a	*Focus 1: Psychiatric and Psychological*	54%
3.b	*Focus 2: Social Skills*	53%
3.c	*Focus 3: Dangerousness and Impulsivity*	57%
3.d	*Focus 4: Hope and Spirituality*	46%
3.e	*Focus 5: Substance Abuse*	50%
3.f	*Focus 6: Medical, Health, and Wellness*	24%
3.g	*Focus 7: Legal*	44%
3.h	*Focus 8: School and Education*	51%
3.i	*Focus 9: Occupational Skills*	39%
3.j	*Focus 10: Leisure and Recreation*	55%
3.k	*Focus 11: community Integration*	40%
4.	*The nursing interventions include specific strategies*	68%

	to assist the individual in meeting his or her objectives.	
5.	*The nursing interventions align and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.*	46%
6.	*The nursing interventions are written in observable, behavioral, and/or measurable terms.*	11%
7.	*Only the approved DMH forms are used.*	100%
8.	*There are no Nursing Diagnoses (NANDA) statements in the WRP.*	100%

MSH's analysis of data demonstrated that compliance for nursing interventions increased from 35% in February 2008 to 56% in July 2008. MSH reported that due to changes made in the tool and auditors, the data are now more accurate. MSH now provides copies of audits to the Nurse Coordinators that include specific staff members' names to address training and performance issues. The MSH Treatment Enhancement Coordinator in conjunction with the Nursing Department and Nursing Education Department began meeting in May 2008 to address nursing needs regarding the WRPs. RN mentor were established to assist the unit RNs in the WRP process and during training.

See C.2.l.

Compliance:
Partial.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.

F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH implemented a new audit tool in February 2008. MSH's compliance data from the MSH Nursing Staff Familiarity Monitoring audit, based on an average sample of 19% of the total number of nursing staff indicated: 1. *Nursing staff working with an individual are able to discuss the individual's goals (foci of hospitalization).* 87% 2. *Nursing staff working with an individual are able to discuss the individual's objectives.* 80% 3. *Nursing staff working with an individual are able to discuss the individual's interventions in the therapeutic milieu.* 86% MSH's compliance regarding nursing staff familiarity decreased from 84% in February 2008 to 78% in July 2008. Since June 2008, CNS monitors/mentors are completing these audits and discussing the results with the staff to increase compliance. MSH reported that although the percentage of compliance has decreased from the beginning of the review period, the data are more reliable. Based on review of 40 admission and integrated assessments and WRPs (AL, AM, CG, CGu, CMG, DAC, DC, DGG, DJG, EHV, FN, GDS, GT, JF, JG, JM, JMT, JND, KS, LAB, MBJ, MJK, MVN, NSO, PAA, PD, RJD, RR, RWL, SB, SDH, SJW, SS, TAL, TJE, TK, TL, VA, WAR and YDH) and observations of WRPTs, there has been some slight overall improvement in staff's familiarity with individuals' goals and objectives. However,

<table>
<tr><td></td><td></td><td>this requirement continues to need attention in order to achieve compliance.

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.e</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Increase inter-rater reliability to an acceptable level (85% or above) for the Change of Shift monitoring tool.

Findings:
MSH's inter-rater data indicated that inter-rater reliability increased to 100% this reporting period. MSH initiated a new audit tool February 2008.

The facility reported data based on the MSH Triggers and Shift Change Monitoring form for an average sample of 45% of the number of incidents meeting criteria on change of shift/trigger list, minus weekends and holidays each month (February-July 2008).

<table>
<tr><td>6.</td><td>The nursing staff reports to the oncoming shift the target variable that the individual exhibited.</td><td>78%</td></tr>
<tr><td>7.</td><td>The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.</td><td>78%</td></tr>
</table>

MHS's data analysis showed that the compliance for nursing triggers and shift change decreased from 94% (February 2008) to 76% in July</td></tr>
</table>

2008. MSH Nursing Department has developed a new change of shift procedure and policy (NP 710), which was implemented in August 2008. Also, binders including WRPs were developed to use during change of shift. Members of Nursing management are observing change of shift and providing mentoring.

Observations of shift report on Unit 405 demonstrated that a significant lack of clinical information regarding the status of individuals was reported to the oncoming shift. It was evident that staff was unfamiliar with axis diagnoses and the symptoms associated with these diagnoses. This area continues to need attention to achieve compliance.

Recommendation 2, March 2008:
Ensure that nursing staff are documenting adequate assessments of individuals prior to and upon return from ER visits or hospitalizations.

Findings:
The facility reported data based on the DMH Medicine Medical Transfer Audit form for a 100% sample of individuals transferred to community hospitals each month (February-July 2008).

1.	*There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	65%
1.a	*There is an appropriate identification of the change in the individual's condition including vital signs.*	76%
1.b	*There is documentation of when the change in the individual's status changed.*	87%
1.c	*There is documentation of when the physician was notified and the physician's name.*	84%
1.d	*There is timely (immediate for emergent*	83%

	conditions and no later than one hour for urgent conditions) notification by the nurse to the physician.	
1.e	*There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time.*	88%

MSH's progress report indicated that Special Order 136, Provision of and Administration of Medical Care, is in development and will be initiated in mid-September 2008. Training will include both Physicians and Nurses and will target the statewide ADs including Provision of Medical Care to Individuals, Psychiatric and Medical Coverage, Medical Emergencies, Transfer to and Return from Facility, Physical Evaluation and/or Medical/Surgical Treatment and Registered Nurse and Physician Communication about Physical Status Change. In addition, joint medical/nursing policies will be implemented addressing triggers for prevention and early indicators for treatment. There will be Reference for Assessment and notifications for the nurses to include high-risk/high-volume cases for triage into non-urgent, urgent and emergent conditions. Also, meeting minutes from the Unit Supervisor/Nursing Coordinator meetings demonstrated that medical/ER documentation of transfers out of the facility is being addressed.

Recommendation 3, March 2008:
Continue to monitor this requirement.

Findings:
Same as above.

Other findings:
A review of ten individuals who were transferred to the community hospital/emergency room (BE, BJL, EA, FN, GP, JP, MDB, OG, PJL and

		RLH) found that overall there has been some improvement in the nursing documentation of the assessments when a change of status occurred. Areas that were not consistent included complete assessments prior to and upon return from the hospital; complete assessments of symptoms; and prompt notification of the physician when status changes occurred. With the implementation of MSH's training, this area should continue to improve by the next review. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement strategies addressing shift report to meet the elements of this requirement. 2. Implement training addressing the provision and administration of medical care. 3. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue to monitor this requirement. **Findings:** See below. **Recommendation 2, March 2008:** Increase audited sample size for this tool to 20%.

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Findings:
MSH's data indicated that for April, June and July 2008, the sample size was at least 20%.

The MSH Medication Administration Monitoring audit tool was implemented in February 2008. Based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, the facility presented the following:

<table>
<tr><td>1.</td><td>Nursing staff are knowledgeable regarding each individual's prescribed medications.</td><td>95%</td></tr>
</table>

Although MSH's compliance audit for this requirement indicated an increase from 93% in February 2008 to 96% in July 2008, observation of medication administration pass on Unit 413 did not support MSH's data. (See F.3.a.i.)

Current recommendation:
See F.3.a.i.

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<tr>
<td>F.3.f.ii</td>
<td>education is provided to individuals during medication administration;</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
See F3.f.i.

Findings:
The MSH Medication Administration Monitoring audit, based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, found the following:

<table>
<tr><td>2.</td><td>Education is provided to individuals during medication administration.</td><td>88%</td></tr>
<tr><td>2.a</td><td>If an individual asks a question, the nursing staff</td><td>97%</td></tr>
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<table>
<tr><td></td><td>is able to competently answer the question.</td><td></td></tr>
<tr><td>2.b</td><td>When an individual has been prescribed a new medication, the nursing staff provides education about the medication.</td><td>94%</td></tr>
<tr><td>2.c</td><td>Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.</td><td>91%</td></tr>
</table>

As noted in F.3.f.ii, observation of medication administration pass did not support items 2, 2.a and 2.b. (See F.3.a.i.)

Current recommendations:
See F.3.a.i.
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</tr>
<tr>
<td>F.3.f.iii</td>
<td>nursing staff are following the appropriate medication administration protocol; and</td>
<td>
Current findings on previous recommendation:

Recommendation, March 2008:
See F3.f.i.

Findings:
The MSH Medication Administration Monitoring audit, based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, found the following:

<table>
<tr><td>3.</td><td>Nursing staff are following the appropriate medication administration protocol.</td><td>100%</td></tr>
</table>

Observation of medication administration pass on Unit 413 verified compliance.

Current recommendation:
Continue current practice.
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<table>
<tr>
<td>F.3.f.iv</td>
<td>medication administration is documented in accordance with the appropriate medication administration protocol.</td>
<td>

Current findings on previous recommendation:

Recommendation, March 2008:
See F3.f.i.

Findings:
The MSH Medication Administration Monitoring audit, based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, demonstrated the following:

<table>
<tr>
<td>4.</td>
<td>Medication administration is documented in accordance with the appropriate medication administration protocol.</td>
<td>99%</td>
</tr>
</table>

Observation of medication administration pass on Unit 413 verified compliance.

Current recommendation:
Continue current practice.

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<td>F.3.g</td>
<td>Each State hospital shall ensure that individuals remain in a “bed-bound” status only for clinically justified reasons.</td>
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Current findings on previous recommendation:

Recommendation, March 2008:
Maintain current practice.

Findings:
MSH’s progress report indicated that there were no bed-bound individuals during the review period February-July 2008. However, documentation from the Skilled Nursing Unit indicated that two individuals (DC and JP) were bed-bound during the review period. Although one individual expired (JP) and the other was only temporarily bed-bound (DC), a review of these records indicated that there were no clinically justified reasons documented.

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		Compliance: Partial. **Current recommendations**: 1. Ensure that data regarding this requirement is accurate. 2. Continue to monitor this requirement.
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** Training rosters indicated that three new employees in April 2008 completed and passed competency-based training addressing this requirement (100%). **Current recommendation**: Continue current practice.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's training rosters indicated that 100% of new staff from

		February-July 2008 completed and passed competency-based training addressing this requirement. **Current recommendation**: Continue current practice.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's training rosters indicated that 100% of staff from February-July 2008 completed and passed the annual update for PBS competency-based training. Overall, 538 nursing staff out of 652 are currently in compliance with this requirement (83%). **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's training rosters indicated that 100% of staff from February-July 2008 completed and passed the nursing annual competency update. The facility's Nursing Annual Update class integrates competency-based curriculum on PRN and Stat medications and is an annual mandatory class for all nursing staff.

		Compliance: Substantial. **Current recommendation**: Continue current practice.

4. Rehabilitation Therapy Services		
	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.	**Methodology:** <u>Interviewed</u>: 1. Andrea Cirota, Acting Supervising Rehabilitation Therapist 2. Asha Vij, Occupational Therapist 3. Jack McClary, Supervisor for Vocational Services 4. Julia Hastings, Physical Therapist 5. Kelly Baker, Acting Supervising Rehabilitation Therapist 6. Mari Cobb, Rehabilitation Therapy Chief 7. Marion Paclibar, Physical Therapist 8. Rebecca McClary, Rehabilitation Therapy Program Assistant <u>Reviewed</u>: 1. DMH Rehabilitation Therapy Service Manual 2. DMH Rehabilitation Therapy F4 Audit Tool and instructions 3. POST monthly progress note 4. F.4 Audit data for July 2008 5. 24-Hour Rehabilitation Support Plan (implemented 7/1/08) 6. Criteria for 24-Hour Support Plan (implemented 7/1/08) 7. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 8. List of individuals with adaptive equipment and current adaptive equipment database 9. Records for the following 18 individuals participating in observed Mall groups: AAA, CE, CRO, DLG, FG, GB, IR, JAS, JOR, JR, KB, LMH, MAF, NM, PHS, RAP, SG and TAN 10. Records for the following individuals to compare Integrated Assessments-Rehabilitation Therapy Section with WRP documents: 11. List of individuals who received direct Physical Therapy services from January-May 2008 12. Records for the following six individuals who received direct

		Physical Therapy services between January-May 2008: ARB, CDJ, GB, MEB, TP and YFH 13. List of individuals who received direct Occupational Therapy services from January-May 2008 14. Records for the following five individuals who received direct Occupational Therapy services from January-May 2008: LMC, MJM, PS, SL and SMN 15. Training materials for 24-hour support plan and corresponding rosters and post-tests 16. Training rosters for Vocational Rehabilitation and POST team Progress Note training 17. Training materials, rosters and post-tests for "The Role of the Rehabilitation Therapist in the WRP" training 18. Training materials, rosters and post-tests for "Rehabilitation Therapy Alignment" training 19. Training rosters for Nursing training provided by Rehabilitation Therapists <u>Observed</u>: 1. Community Integration PSR Mall Group 2. Social Skills PSR Mall Group 3. Nutrition PSR Mall Group 4. Health and Nutrition PSR Mall Group 5. Arts in Mental Health PSR Mall Group 6. Conflict Resolution PSR Mall Group 7. Coping Skills 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 that address, at a minimum:	**Compliance:** Partial.

F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Develop and implement a procedure that specifies criteria for the need and implementation (including training and monitoring) of a 24-hour support plan related to physical and nutritional rehabilitation supports that is consistent between the state hospitals. **Findings:** This procedure was developed and implemented statewide in July 2008. The facility reports that four out of four POST team members were trained to competency on this procedure and criteria on 6/27/08; this training was verified by review of training roster and post-tests. **Recommendation 2, March 2008:** Develop and implement formats for progress notes for Vocational Rehabilitation, and Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice act requirements. **Findings:** A format for a statewide progress note for Vocational Rehabilitation direct treatment was completed on 7/18/08. A statewide progress note for POST team direct treatment was completed and finalized on 7/17/08, though implementation of the final draft of this progress note was initiated on 6/30/08. The facility reports that four out of four POST team members were trained to competency on the use of the progress note on 6/27/08; this training was verified by review of training roster and post-tests, as well as by review of records with evidence of new forms being used.

		Recommendation 3, March 2008: Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff, and POST team members) regarding the role of the RT as WRP liaison. **Findings:** The facility reported that 31 out of 31 Wellness and Recovery Plan Rehabilitation Therapists, four out of four Vocational Rehabilitation staff and four out of four POST team members were trained to competency regarding the Role of the RT as a WRP Liaison on 7/1/08, 7/2/08, and 7/16/08. This training was verified by review of post-tests. **Recommendation 4, March 2008:** Develop and implement an F.4 audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and group) and indirect supports (e.g., 24-hour plan, adaptive equipment). Implementation findings should also include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives in regards to Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed, and WRP inclusion. **Findings:** An F.4 Audit Tool to assess the adequate and timely provision of Rehabilitation Therapy Services was developed on 6/25/08, and implemented on 7/1/08. The facility reported that four out of four Supervising Rehabilitation Therapists responsible for performing the audits were trained to competency on 7/1/08. This training was verified by review of post-tests.

Recommendation 5, March 2008:
Establish inter-rater agreement among staff performing audit prior to implementation.

Findings:
This recommendation has not been met, though the process was initiated.

Other findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of records for individuals receiving Occupational and/or Physical Therapy direct treatment for the month of July (total of 5). The following outlines the indicators with corresponding mean compliance rates for July 2008:

1.	*The provision of direct services by rehabilitation therapy services staff*	
1.a	*There is an appropriate Focus of Hospitalization (typically Focus 6).*	80%
1.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.*	80%
1.c	*The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.*	80%
1.d	*There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.*	40%

No comparable data were available from the last evaluation period, as this tool was implemented in July 2008.

The facility analyzed the data and reported that the reason for low compliance in item 1.d was due to the Rehabilitation Therapist not acting as a liaison between the WRPT and the POST Team. The facility plan of correction is to perform a "fine grain analysis" of the data to identify whether the low compliance is due to individual therapist performance or systemic problems, and to develop a plan of improvement based on findings.

The data below presents the number of scheduled vs. actual hours of direct services provided by Occupational and Physical Therapy between 7/7/08 and 7/11/08:

	Scheduled	Provided
PT	27	22
OT	7	8
SLP	n/a	n/a

The facility analyzed the data and reported that the discrepancy between Physical Therapy hours scheduled and provided was due to individual refusal of treatment.

Other findings:
A review of five records of individuals receiving direct Occupational Therapy treatment (LMC, MJM, PS, SL and SMN) to assess for compliance with provision of direct services found all five records to be in partial compliance with F.4.a.i criteria. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Objectives are not consistently functional, behavioral, observable and measurable.
2. Foci, objectives and interventions are not consistently included in

		the WRP. 3. Documentation of progress in Occupational Therapy treatment is not consistently documented in the present status section of the WRP. A review of six records of individuals receiving direct Physical Therapy treatment (ARB, CDJ, GB, MEB, TP and YFH) to assess compliance with F.4.a.i criteria found two records (ARB and TP) to be in substantial compliance and four records (CDJ, GB, MEB and YFH) to be in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress in Physical Therapy treatment is not consistently documented in the present status section of the WRP. During an interview, a Physical Therapist reported that she has begun to enter foci, objectives, and interventions into the WRP herself to ensure integration. A review of records in which she had done this indicated substantial compliance with WRP inclusion of these areas. **Current recommendations**: 1. Ensure that data for F.4 audit tool is reliable and valid. 2. Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services are documented in the present status section of the WRP.

F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Develop and implement a procedure for RNA provision of indirect Physical and Occupational Therapy programs. **Findings:** This recommendation was partially met. The current system is a Restorative Nursing program that is implemented only in the SNF unit and without oversight of Physical or Occupational Therapists. Currently, the F.4.a.ii service is not available to individuals residing outside of the SNF unit. **Recommendation 2, March 2008:** Develop and implement a database to track individuals receiving RNA services, as well as when staff has received competency-based training/return demonstration, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. **Findings:** This recommendation has not been met. **Recommendation 3, March 2008:** Develop and implement an audit tool to provide oversight to individuals receiving Physical or Occupational Therapy programs implemented by nursing staff to assess for appropriateness of program, alignment with assessment/re-assessment findings, timeliness of re-assessment, and whether program is modified as needed. **Findings:** These elements have been incorporated into the F.4 monitoring tool.

Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of records for individuals receiving RNA services for the month of July (total of 18). The following outlines the indicators with corresponding mean compliance rates for July 2008:

2.	*The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.*	
2.a	*Nursing IDN specifies that the nursing staff is implementing the individual's physical therapy program provided by PT and/or OT.*	67%
2.b	*Nursing IDN addresses the individual's progress toward the OT and/or PT objective in functional terms.*	22%
2.c	*Nursing IDN documents re-assessment, as clinically indicated.*	0%
2.d	*Nursing IDN documents modification of the program by the PT and/or OT, as clinically indicated.*	0%
2.e	*There is documentation in the Present Status Section of the individual's WRP of the current status of the PT and/or OT interventions implemented by the nurses.*	0%

No comparable data were available from the last review period as the audit tool was implemented in July 2008. No facility data analysis was provided to explain noncompliance with items 2.c, 2.d, and 2.e.

Current recommendations:

1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs, with Physical and Occupational Therapy oversight that is available to all

		individuals who require it facility-wide. 2. Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program.
F.4.b	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed. **Findings:** The facility reported that 48 out of 50 nurses requiring training were trained to competency. The facility reported that a system will be developed and implemented for the tracking of all nurses required to attend competency-based training as well as all nurses trained. **Recommendation 2, March 2008:** Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment, 24-hour plans, track the need and provision of competence based training for individuals and/or staff. **Findings:** The facility reported that databases were developed for individuals receiving RNA services, individuals with 24-hour plans and individuals with adaptive equipment to track the occurrence of competency-based training as needed. However, databases for 24-hour plans and

		oversight of PT and OT programs have not been populated as these programs are pending implementation. **Compliance:** Partial. **Current recommendation**: Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives, and interventions are modified as needed. **Findings:** Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of records for individuals receiving PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff for the month of July (total of 134). The following outlines the indicators with corresponding mean compliance rates for July 2008: 4. *Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.* 4.a *There is an appropriate Focus of Hospitalization.* 91% 4.b *The objective aligned with this focus of hospitalization is functional for the individual and* 8%

	written in behavioral, observable, and/or measurable terms.	
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.*	10%
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	30%

No comparable data were available from the last review period as the audit tool was implemented in July 2008.

The facility analyzed the data and reported that groups and interventions did not appear to be updated from transfers between units and programs or updated to reflect the current Mall cycle. In addition, they found that while each individual had 20 hours of groups, few groups were listed in the WRP as interventions, and groups were often used for multiple objectives. The facility reported that interventions were often listed for inactive objectives and did not contain all required components.

The facility plan of correction is for the Senior RT staff to provide in vivo mentoring in the computer lab to the Rehabilitation Therapy and Vocational Services staff. Rehabilitation Therapy and Vocational Services staff will be instructed to assist the WRP recorder in the proper methods of addressing the WRP criteria. In addition, training will be provided to all RT staff on the new F.4 audit tool criteria.

The following outlines the average number of scheduled versus provided Rehabilitation Therapist-facilitated PSR Mall group hours

during the week of 7/13/08.

	Scheduled	Provided
RT	285	216
Voc Rehab	2	1

The facility reported that the discrepancy between scheduled versus provided hours was due to one staff out on injury, one staff out on illness, and one staff out on investigation.

Recommendation 2, March 2008:
Develop and implement a database to track individuals with 24-hour plans, as well as when staff has received competency-based training/return demonstration, and how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the plan.

Findings:
A 24-hour plan database was developed and includes documentation for implementation, competency-based training/return demonstration, and re-assessment date. However, this database was not populated and implemented as the facility reported that no new 24-hour support plans were been developed and implemented for this review period.

The facility plan is for subsequent reviews of the 24-Hour Rehabilitation Support Plan to occur at the monthly WRPC by the WRPT RN. If the plan is current, complete, and accurate, the WRPT RN will document this as well as the current status of the plan in the Functional Status of the Present Status section in the WRP. If it is decided by the team that an update or revision needs to occur, the WRPT will make a referral to the respective POST service(s) as identified on the WRP Task Tracking Sheet.

		Recommendation 3, March 2008: Develop and implement an audit tool to provide oversight to individuals with 24-hour plans to assess for appropriateness of program, alignment with assessment/re-assessment findings, timeliness of re-assessment, and whether plan was modified as needed. **Findings:** These elements were incorporated into the F.4 monitoring tool, which was implemented in July 2008. However, since no 24-hour support plans were completed during the review period, no monitoring was done in July. **Other findings:** The facility reports that 31 out of 31 Wellness and Recovery Rehabilitation Therapists, four out of four POST team therapists and four out of four Vocational Rehabilitation staff were trained to competency regarding the material presented in "Examples of Writing Clear, Measurable and Obtainable Objectives: Foci 5" and "Rehabilitation Therapy Alignment" trainings on 7/1/08, 7/2/08, and 7/16/08. This training was verified by review of post-tests. A review of the materials found that they did not appear to give optimal guidance as to writing quality foci, objectives and interventions that met the training needs of Rehabilitation Therapists (e.g., for Focus 2, Focus 10). The Rehabilitation Therapy staff may benefit from additional training on writing foci, objectives and interventions using the revised PSR Mall Manual (pending implementation). Upon observation of PSR Mall groups led by Rehabilitation Therapists, it was noted that four out of six observed had lesson plans in place and in use. A review of 18 records of individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups (AAA, CE, CRO, DLG, FG, GB, IR,

		JAS, JOR, JR, KB, LMH, MAF, NM, PHS, RAP, SG and TAN) to assess compliance with F.4.c found seven records to be in partial compliance (CE, FG, JOR, LMH, RAP, SG and TAN) and eleven records to be not in compliance (AAA, CRO, DLG, GB, IR, JAS, JR, KB, MAF, NM and PHS). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Documentation of progress in Rehabilitation Therapy PSR Mall groups is not consistently documented in the present status section of the WRP. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned. 2. Implement proposed plan of correction based on data analysis to improve compliance with Recommendation 1. 3. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual. 4. Convert all Rehabilitation Therapy PSR Mall group lesson plans, course outlines and curricula to the new format as this process is implemented. 5. Ensure that all individuals with Dining Plans and Physical Support

		Plans are reviewed to ensure that they meet the criteria for the new 24-hour Rehabilitation Support Plans, with conversion to the new format.
F.4.d	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Develop and implement a database to track all individuals with adaptive equipment, including when a piece of equipment is ordered compared to the date of implementation, level of assistance of individual with device, whether training was necessary, when training was provided if appropriate, and if/how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the equipment. **Findings:** The adaptive equipment database was developed and implemented in May 2008 with all of the required criteria included. **Recommendation 2, March 2008:** Develop and implement an audit tool to provide oversight to individuals with adaptive equipment to assess for appropriateness of equipment, use/repair of equipment, alignment with assessment/re-assessment findings, timeliness of re-assessment, and whether equipment was modified as needed. **Findings:** These criteria were included in the F.4 audit tool, which was implemented in July 2008. However, the facility did not present data regarding adaptive equipment or data analysis for this review period. **Compliance:** Partial.

		Current recommendations: 1. Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment. 2. Implement F.4 audit process to present data and data analysis regarding provision and re-assessment of adaptive equipment.

5. Nutrition Services		
	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.	**Methodology:** Interviewed: 1. Christina Marshall, Director of Nutrition Services 2. Ninfa Guzman, Hospital Administrative Resident 3. Portia Salvacion, Assistant Director of Nutrition Services Reviewed: 1. Nutrition Wellness and the Food Guide Pyramid (SNF) course outline, 10-week Lesson Plan drafts with corresponding research 2. Lists of individuals with Nutrition Care Assessments due from February-July 2008 for each assessment type 3. Records for the following 63 individuals with type a-j.ii. assessment from February-July 2008: AB, ARD, BE, BSK, BU, CC, CH, CMG, CRG, CWL, CWL-2, DF, DM, DT, FM, GLT, GR, GS, JAC, JCB, JDE, JDE-2, JDR, JG, JM, JM-2, KB, KCY, KLF, KSC, LK, MAF, MAO, MC, MCF, MDW, MG, MG-2, MGF, MJK, MR, MRA, NA, PD, PS, RAV, RDU, RLH, RML, RMT, RS, SB, SF, SFY, SG, SM, SR, SRF, TDW, TJ, TK, TL and WH 4. Records of the following three individuals participating in Nutrition PSR Mall group: BF, LM and SM 5. Meal Accuracy Report audit data from February-July 2008 6. Nutrition Care Monitoring Tool audit data from February-July 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 7. Audit data for February-July 2008 regarding WRP integration of Nutrition Services recommendations 8. Facility training data and competency scores for RN's and Dietitians, as well as raw data binders Observed: Nutrition PSR Mall group

F.5.a	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that PSR Mall 12-week lesson plans are in state-approved format and are followed by Nutrition group facilitators. **Findings:** A Nutrition PSR Mall group was observed and found to have a lesson plan in place, which was followed by the group facilitator. The PSR Mall lesson plan format has been updated, and work groups have been developed to teach each discipline how to convert 12-week lesson plans to the revised format. A proposed course outline, lesson plan and curriculum were developed for a Nutrition Wellness and the Food Guide Pyramid PSR Mall group and are pending approval. **Recommendation 2, March 2008:** Continue current practice. **Findings:** Current procedures for Nutrition services appear to meet generally accepted standards of practice. Nutrition Education and documentation of Medical Nutrition Training response are direct services provided by dietitians at MSH. Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with these indicators based on an average sample of 31% of Nutrition Assessments (all types) due each month for the review period of February-July 2008 (486 out of 1552) for item 7, and an average sample of 38% of Nutrition Assessments (all types) due each month for the review period of February-July 2008 (584 out of 1552) for item 8. The following table presents these indicators with corresponding mean compliance rates for February-July 2008:

		7. *Nutrition education is documented* — 97% 8 *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* — 97% According to a review of Meal Accuracy Report data, trays (regular and modified diets) audited from February-July 2008 (total of 771 out of 3858, for a 20% sample) were 100% accurate. **Other findings:** A review of 63 records (AB, ARD, BE, BSK, BU, CC, CH, CMG, CRG, CWL, CWL-2, DF, DM, DT, FM, GLT, GR, GS, JAC, JCB, JDE, JDE-2, JDR, JG, JM, JM-2, KB, KCY, KLF, KSC, LK, MAF, MAO, MC, MCF, MDW, MG, MG-2, MGF, MJK, MR, MRA, NA, PD, PS, RAV, RDU, RLH, RML, RMT, RS, SB, SF, SFY, SG, SM, SR, SRF, TDW, TJ, TK, TL and WH) to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found that 59 records were in compliance, three records were in partial compliance (DM, KB and NA), and one record (SFY) was not in compliance. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Convert all Nutrition Services PSR Mall group lesson plans, course outlines and curricula to the new format as this process is implemented.
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	**Current findings on previous recommendations:**

	individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Recommendation 1, March 2008:** Continue current practice. **Findings:** Nutrition Services revised the goal/objective section of the presentation on the "RN representing the RD in the WRP" to include "focus, objective and intervention process," and began training during the fourth hour of training from June 9-20/2008. According to facility report, 146 out of 164 (89% of) nurses requiring this training received the training. This is verified by review of training rosters and post-tests. The facility reports that prior to the revisions in this training, two out of two nurses were trained to competency in April 2008 regarding the RN's role in representing the RD in the WRP. This training was verified by review of training roster and post-tests. **Recommendation 2, March 2008:** Provide and implement training to Dietitians to write Nutrition recommendations in WRP format (focus, objective, and intervention) for report by nurse to the WRPT. **Findings:** Revisions to the Nursing training and the Nursing Process for WRP documentation training was provided to dietitians and DTRs on June 3, July 9 and August 14. According to facility report, six out of six dietitians and two out of two DTRs were trained to competency on the presented material; this was verified by review of rosters and post-test. Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 24% of Nutrition Assessments (all types) due each month for the review period of February-July 2008 (366 out of 1552). The following presents these indicators with corresponding mean compliance rates for

February-July 2008:

19.	*The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated*	88%
20.	*The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated*	77%

The mean compliance rate for Item 19 in the last review period was 85% compared to 88% in the current review period. The compliance rate during the last month of the previous review period (January 2008) was 91% compared to 87% in July 2008.

The mean compliance rate for Item 20 in the last review period was 68% compared to 77% in the current review period. The compliance rate during the last month of the previous review period (January 2008) was 74% compared to 75% in July 2008.

The facility analyzed the data and reported that compliance has stabilized just below acceptable levels. To enhance performance and improve compliance, extensive training was provided to the nurses in June 2008.

The facility plan of correction is to identify specific WRP leaders to in-service regarding the incorporation of the Axis III Focus 6 BMI triggers into the WRP.

Other findings:
A review of 63 records (AB, ARD, BE, BSK, BU, CC, CH, CMG, CRG, CWL, CWL-2, DF, DM, DT, FM, GLT, GR, GS, JAC, JCB, JDE, JDE-2, JDR, JG, JM, JM-2, KB, KCY, KLF, KSC, LK, MAF, MAO, MC, MCF, MDW, MG, MG-2, MGF, MJK, MR, MRA, NA, PD, PS, RAV, RDU, RLH, RML, RMT, RS, SB, SF, SFY, SG, SM, SR, SRF, TDW, TJ, TK, TL and

		WH) to assess compliance with WRP integration and quality of Nutrition foci, objectives and interventions found that 18 records were in substantial compliance (BSK, BU, DF, FM, GLT, GR, JAC, JCB, KLF, MAF, MAO, MGF, NA, PD, RAV, RLH, SF and SR); 16 records were in partial compliance (CH, JG, JM, KCY, KSC, LK, MG, PS, RML, RMT, RS, SFY, SKF, SM, TJ and TK); and six records were not in compliance (ARD, DM, JDE, KB, MDW and TDW) with having an adequate focus, objective and intervention integrated into the WRP. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not consistently aligned. A review of three records of individuals participating in Nutrition PSR Mall group (BF, LM and SM) to assess compliance with WRP inclusion of adequate focus, objective and intervention found that all three were not in compliance as none of the three had documentation of a focus, objective and intervention for the group listed in the WRP. **Compliance:** Partial. **Current recommendations**: 1. Continue current efforts to achieve compliance. 2. Provide training to dietitians on writing quality foci, objectives and interventions that meet WRP criteria and are aligned. 3. Ensure that for individuals participating in Nutrition PSR Mall groups, appropriate foci, objectives and interventions are present in the WRP.

F.5.c	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.d	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Ensure that all existing and new Clinical Dietitian and Dietetic Technician staff has received competency-based training in regards to the Dietitian's role in dysphagia management. **Findings:** According to facility report, no new Nutrition employees (RDs or DTRs) have been hired during the review period. At the time of the last review, it was noted that 100% of dietitians had received Dysphagia Training to competency. **Other findings:** The facility reports that eight out of eight dietitians attended a two-day continuing education seminar on June 4-5, 2008 on "Bedside

		Evaluation of the Dysphagia Patient." **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

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:	**Methodology:** Interviewed: 1. Glen Itow, PharmD, Director, Pharmacy Department 2. Harold Plon, PharmD, Assistant Director, Pharmacy Department Reviewed: 1. The charts of the following three individuals: CG, KB and RP 2. MSH monitoring data regarding recommendations made by the pharmacists and physicians' responses to those recommendations
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	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue to monitor this requirement. • Provide data analysis to explain why the pharmacists were concerned about the need for further laboratory testing for new orders. **Findings:** MSH has monitored all new medication orders, including changes in existing orders and assessed compliance with this requirement (February to July 2008). The following is a summary outline of the mean number of recommendations by type each month made by the Pharmacy Department:

1.	Drug-drug interactions	17
2.	Side effects	4
3.	Need for laboratory testing	33
4.	Dose ranges	28
5.	Indications	5
6.	Contraindication	0

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<tr><td>7.</td><td>Need for continued treatment</td><td>1</td></tr>
<tr><td>9.</td><td>Drug-food interaction</td><td>3</td></tr>
<tr><td>10.</td><td>Outside therapeutic drug level</td><td>4</td></tr>
<tr><td>11.</td><td>Formulation change</td><td>4</td></tr>
<tr><td colspan="2">Total number of recommendations</td><td>103</td></tr>
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Average total number of recommendations exceeds the sum of average number of recommendations by type due to rounding.

MSH did not present comparative data or offer any analysis of its data. Overall, the data showed a significant increase in the number of recommendations compared to the last review (103 vs. 60.5).

Recommendation 3, March 2008:
Ensure that current vacancies in pharmacy staff are filled.

Findings:
MSH reported that two pharmacists have been hired since the last review, but did not provide information regarding the current vacancies.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide data analysis to explain why the pharmacists were concerned about the need for further laboratory testing for new orders.
3. Provide specific information regarding current vacancies.
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<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical</td>
<td>Current findings on previous recommendations:</td>
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record an adequate clinical justification.

Recommendations 1 and 2, March 2008:

- Continue to monitor this requirement.
- Implement corrective actions to improve compliance.

Findings:

MSH has monitored this requirement based on a 100% sample. The data are summarized as follows:

Recommendations followed	66
Recommendations not followed, but rationale documented	6
Recommendations not followed and rationale/response not documented	31

MSH reported that efforts to improve physicians' responses to the recommendations have included the following:

1. The facility has identified and provided counseling to physicians who do not document clinical justifications when the pharmacist's recommendations are not followed.
2. The Medical Director is required to send a letter to the medical staff to accompany a monthly summary of the recommendations, instructing the physicians to follow the recommendations or justify why not.

Compliance:

Partial.

Current recommendations:

1. Monitor this requirement based on a 100% sample.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

7. General Medical Services		
		Methodology: Interviewed: 1. Bashir Shaw, MD, Physician and Surgeon 2. Dung Ngeyen, MD, Physician and Surgeon 3. Leonard Liu, MD, Physician and Surgeon 4. Michael Barsom, MD, Medical Director 5. Nae Kim, MD, Physician and Surgeon 6. Nghi Pham, MD, Physician and Surgeon 7. Niza Uy-Uyan, MD, Acting Program Director of Medical Services 8. Parvaneh Zolnouni, MD, Physician and Surgeon 9. Quynh Pham, DO, Physician and Surgeon 10. Raymond Flores, MD, Physician and Surgeon 11. Thai Vu, MD, Physician and Surgeon 12. Tuyen Le, MD, Physician and Surgeon Reviewed: 1. The charts of the following 11 individuals who were transferred to an outside medical facility during this reporting period: BE, BL, EA, FN, GP, JP, MB, OG, PL, RD and RH 2. MSH Medical Emergencies Policy and Procedure, revised July 1, 2008 3. MSH Medical Emergency Carts and Equipment Policy and Procedure, revised July 1, 2008 4. DMH Special Order #136, Provision of Medical Care to Individuals 5. DMH RN Significant Change in Condition Assessment Note template 6. DMH Initial Medical Assessment Template, revised August 2008 7. MSH Medical Emergency Response Monitoring Form 8. MSH Medical Emergency Response Monitoring summary data (February to July 2008) 9. DMH Medical Surgical Progress Notes Auditing Form 10. DMH Medical Surgical Progress Notes Auditing Form Instructions

		11. DMH Integration of Medical Conditions into the WRP Auditing Form 12. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions 13. MSH Integration of Medical Conditions into the WRP Auditing summary data (February to July, 2008) 14. DMH Medical Transfer Auditing Form 15. DMH Medical Transfer Auditing Form Instructions 16. MSH Medical Transfer Auditing summary data (February to July, 2008) 17. MSH medical and psychiatric night/weekend and holiday coverage schedule (February to July 2008) 18. DMH Diabetes Mellitus Auditing Form 19. DMH Diabetes Mellitus Auditing Form Instructions 20. MSH Diabetes Mellitus Auditing summary data (February to July 2008) 21. DMH Hypertension Auditing Form 22. DMH Hypertension Auditing Form Instructions 23. MSH Hypertension Auditing summary data (February to July 2008) 24. DMH Dyslipidemia Auditing Form 25. DMH Dyslipidemia Auditing Form Instructions 26. MSH Dyslipidemia Auditing summary data (February to July 2008) 27. DMH Asthma/COPD Auditing Form 28. DMH Asthma/COPD Auditing Form Instructions 29. MSH Asthma/COPD Auditing summary data (February to July 2008)
F.7.a	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	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure proper oversight of medical services to correct this monitor's findings of clinical deficiencies (listed in other findings above).

	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.	**Findings:** MSH has recruited a Chief of Medical Services effective September 15, 2008. **Recommendation 2, March 2008:** Continue implementation of the revised medical policies and procedures. **Findings:** MSH implemented the revised policies and procedures in January 2008 and has made further revisions to its policies regarding Medical Emergencies and Medical Emergency Carts and Equipment. The revisions included adequate formats for evaluation of the medical emergency response and the medical emergency response drills. The facility's policies and procedures are aligned with the DMH's Special Order 136, Provision of Medical Care to Individuals (draft). **Other findings:** This monitor reviewed the charts of 11 individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer and the reason for the transfer:

Initials	Date of MD evaluation	Reason for transfer
BE	04/22/08	R/O Seizures vs. NMS
BL	03/01/08	Change in mental status with S/P fall
EA	05/16/08	Altered mental status with hypotension and bradycardia
FN	07/25/08	Altered mental status with fever and hypotension
GP	02/19/08	Dizziness with unbalanced gait
JP	03/04/08	Acute bilateral pneumonitis

MB	04/01/08	Abdominal pain with elevated pancreatic enzymes
OG	07/14/08	Fever, abdominal pain, vomiting and dehydration
PL	04/04/08	Abdominal pain R/O perforation
RD	03/07/08	Acute mental status change
RH	06/17/08	R/O pneumonia

The review found evidence of timely and appropriate care in most charts. However, a persisting pattern of deficiencies was found as follows:

1. The medical assessment of an individual who was possibly experiencing manifestations of neuroleptic malignant syndrome and the communications with the external facility were inadequate. As a result, this individual did not receive needed work-up for this condition.
2. There was evidence of inadequate assessment by nursing regarding the time frames of the individual's complaints and status regarding the onset of abdominal pain and vomiting.
3. There was evidence of inadequate initial assessment by nursing and differential diagnosis by medicine regarding a significant change in vital signs of an individual receiving clozapine.
4. There was evidence of delay in the transfer of an individual who complained of abdominal pain while receiving divalproex and later diagnosed with acute pancreatitis.
5. There was no documentation of a formulation of possible factors, other than illicit drug use, that may have contributed to the occurrence of delirium in an individual. The chart did not document corrective actions regarding possible illicit drug use on the unit.
6. There was evidence of inadequate documentation of physician's assessments of frequent changes in the status of an individual.
7. In almost all cases reviewed, the charts included incomplete

		records from the outside facility upon the return transfer of the individual. In addition, this monitor reviewed the mortality review of WH. This review did not provide adequate analysis of contributing factors and the recommendations for corrective actions were limited because the process did not include an external independent review or a final review by the interdisciplinary mortality review committee. These deficiencies must be corrected to achieve substantial compliance with this section. **Compliance:** Partial. **Current recommendations**: 1. Ensure proper oversight of medical services to correct this monitor's findings of clinical deficiencies (listed in other findings above). 2. Finalize DMH SO #136.
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, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Standardize the monitoring tool regarding the initial admission assessments for use across facilities. **Findings:** A new format for the Initial Medical Assessment has been finalized

		and implemented as of August 2008. If properly implemented, this format can enhance compliance with EP requirements regarding the initial medical assessments, including the plan of care. DMH has yet to finalize a standardized monitoring tool based on the revised format. **Recommendations 2 and 3, March 2008:** • Monitor this requirement based on a 100% sample using the DMH Initial Medical Assessment Audit Form (when completed) and the DMH Medical Surgical Progress Notes Audit Form. • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). **Findings:** The facility's findings and comparative analysis were presented in D.1.c.i. **Recommendation 4, March 2008:** Implement corrective actions to address the lack of documentation of follow-up when individuals refuse the examination or parts of the examination. **Findings:** MSH reported that its Medical Services has implemented a computerized tracking log of all refusals and missed appointments for all individuals. This automated system is accessible at any time to the WRPT members on each unit. The report is run weekly by Medical Services and is updated to include all individuals with current refusals. When three or more refusals have occurred, Central Nursing Services (CNS) is required to complete an audit on the inclusion of this condition in the WRP and report data to the Nursing Coordinators. CNS also tracks appropriate follow-up.

		Other findings: MSH did not present monitoring data based on the DMH Medical Surgical Progress Notes Auditing Form. **Compliance:** Partial. **Current recommendations**: 1. Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. 2. Implement the quarterly medical reassessments and monitor implementation, using the DMH Medical Surgical Progress Notes Auditing Form based on a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.b.ii	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities. **Findings:** The DMH has yet to implement this recommendation. **Recommendation 2, March 2008:** Monitor this requirement using the DMH standardized tools: Medical Emergency Response System (when completed), Medical Transfers and Integration of Medical Conditions into the WRP Audit Forms. **Findings:** As mentioned earlier, the DMH has yet to develop a standardized tool

to address the Medical Emergency Response System. The facility has updated its current tool (February 2008) and presented monitoring data regarding this system (February to July 2008). The average sample was 100% of actual emergencies and drills (the facility's report indicated that the target population was limited to actual emergencies, but the analysis addressed both actual and drill responses). The data showed almost 100% compliance with all indicators, except for the following:

2.	*EMS was activated immediately*	82%
4.	*HSS arrived within 15 minutes*	92%
5.	*Paramedics arrived within 15 minutes*	86%
12.	*There were no difficulties with the EMS activation*	81%

In the process of data analysis, the facility identified a discrepancy between the nursing documentation and the telephone operator's recorded time regarding the documented time of EMS activation and arrival. In addition, there was discrepancy in the notification of the HSS and accurate documentation of time. Corrective actions included in-service training by CNS. Due to misinterpretation of some indicators, the facility recognized the need to separate actual emergency data from drill data.

MSH used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance (March to May 2008). The average sample was 17% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	39%
2.	*The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form*	40%

3.	*There is an appropriate focus statement for each medical condition or diagnosis*	43%
4.	*There is an appropriate objective for each medical condition or diagnosis*	17%
5.	*There are appropriate intervention(s) for each objective*	9%

No comparative data were available. The facility reported that low compliance was due to inadequate communication between the Physician and Surgeon and the Psychiatrist. The departmental monthly meetings have reportedly addressed this issue. In May 2008, MSH initiated RN mentors in each program in the hospital to enhance the quality of objectives and interventions for medical problems and training was provided to these mentors and all registered nurses in the facility to improve compliance.

MSH used the DMH Medical Transfer Auditing Form to assess compliance (February to July 2008). The average sample was 100% of the transfers. The following is a summary of the data:

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	65%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	28%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	11%
4.	*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.*	74%

5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	83%
6.	*Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	80%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	14%

No comparative data were available.

MSH reported a number of corrective actions, including that the Medical Services RN contacts outside facilities prior to discharge to MSH to attempt to obtain all possible information. Other corrective actions did not clearly address the deficiencies.

Compliance:
Partial.

Current recommendations:
1. Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.
2. Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample.
3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH has continued current practice. The facility has aligned its Medical Policies and Procedures with DMH Special Order #136, Provision of Medical Care to Individuals. The Policies and Procedures were implemented January 2008. The Special Order has yet to be finalized. **Compliance:** Partial. **Current recommendations**: Continue current practice.
F.7.b.iv	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH has continued current practice. Since August 2007, the facility has maintained after-hours onsite coverage by a psychiatrist and a physician and surgeon. **Compliance:** Substantial. **Current recommendations**: Continue current practice.

F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in F.7.b.ii. **Findings:** Same as in F.7.b.ii. **Compliance:** Partial. **Current recommendations**: Same as in F.7.b.ii.
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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Standardize monitoring instruments regarding the management of specific medical conditions including diabetes mellitus, dyslipidemia, hypertension and asthma/COPD. • Ensure that the monitoring instruments regarding diabetes mellitus and dyslipidemia address the use of new generation antipsychotic medications. This indicator should require documentation of justification of treatment, risks and benefits for the individuals and attempts to use safer alternatives, as clinically indicated. **Findings:** The DMH has implemented both recommendations. The standardized tools were finalized and implemented in February 2008. **Recommendation 3, March 2008:** Monitor this requirement using the standardized instruments.

Findings:
MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD (February to July 2008). The average samples were 20% (diabetes mellitus), 18% (asthma/COPD), 21% (hypertension) and 29% (dyslipidemia) of individuals diagnosed with these disorders. MSH did not present comparisons with the last review period because monitoring using these tools was initiated in February 2008. However, many of the indicators were also included in the previous tool and comparative analysis could have been performed on these indicators. The following is a summary of the facility's data and data analysis:

Diabetes Mellitus

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	100%
2.	*HgbA1C was ordered quarterly.*	100%
3.	*The HgbA1C is equal to or less than 7%.*	100%
4.	*Blood sugar is monitored regularly.*	100%
5.	*Urinary micro albumin is monitored annually.*	100%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	100%
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	100%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	86%
9.	*Blood pressure is monitored weekly.*	100%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	100%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	100%

12.	*Podiatry care was provided by a podiatrist at least annually.*	100%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	96%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	96%

The facility attributed lower compliance with item 8 to the possibility that the individual may have been newly diagnosed to have elevated lipids and just started on medications and/or the possibility of non-compliance with treatment, diet and exercise programs.

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	88%
3.	*If a rescue inhaler is being used more than two days a week, the individual has been assessed and an appropriate plan of care has been developed.*	88%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	98%
5.	*Asthma or COPD is addressed in Focus 6 of the WRP.*	87%
6.	*Focus 6 for asthma/COPD has appropriate objectives and interventions.*	87%
7.	*The individual has been assessed for a flu vaccination.*	100%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	100%

To improve compliance, MSH reportedly updated all physicians and surgeons on expectations regarding the treatment of asthma/COPD, and ordering and reordering radiological testing.

Hypertension

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*Blood pressure is monitored weekly.*	100%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	99%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	77%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	90%
6.	*Focus 6 for hypertension has appropriate objectives and interventions.*	87%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	99%
8.	*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.*	45%
9.	*An exercise program has been initiated.*	98%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	93%

To improve compliance, MSH has reportedly informed staff psychiatrists of expectations regarding individuals with high BMIs. Subsequently, referrals to the dietary service for weight management have increased.

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*A lipid panel was ordered at least quarterly.*	100%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	61%
4.	*The LDL level is ≤ or a plan of care is in place.*	96%
5.	*The triglyceride level is ≤ 200 of a plan of care is in place.*	90%
6.	*Dyslipidemia is addressed in Focus 6 of the WRP.*	84%
7.	*Focus 6 for dyslipidemia has appropriate objectives and interventions for this condition.*	83%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%
9.	*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.*	45%
10.	*An exercise program has been initiated.*	100%
11.	*If non-pharmacological interventions have been ineffective to control dyslipidemia, medications have been considered or initiated.*	99%

To improve compliance, MSH has reportedly encouraged participation by the individuals in exercise programs and reminded physicians and surgeons to address dyslipidemia in focus 6 and to refer individuals who refuse treatment on three occasions to the WRPT for interventions to address treatment refusal.

Other findings:
Although the facility's data show substantial compliance with the majority of the indicators, findings by this monitor (see Other Findings

		in F.7.a) indicate a persistent pattern of process deficiencies that must be corrected to achieve substantial compliance with this requirement. As a corrective action, the DMH has initiated the development of medical and nursing protocols and new templates for nursing documentation. If properly implemented, these tools can facilitate communications between medical and nursing staff in the assessment and management of specific medical conditions. **Compliance:** Partial. **Current recommendations**: 1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample. 2. Monitor preventive care and care of cardiac disease using NSH indicators. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Continue to identify trends and patterns based on clinical and process outcomes. • Provide corrective actions to address problematic trends and patterns. **Findings:** MSH provided further data regarding the trends/patterns of MRSA skin infections (2004 to 2008) to assess antibiotic susceptibility testing. The facility's report included appropriate analysis and

		recommendations for performance improvement. The facility did not provide information regarding process and clinical outcomes for medical care. **Recommendation 3, March 2008:** Expedite efforts to automate data systems to facilitate data collection and analysis and provide information on current status regarding these efforts. **Findings:** MSH did not address this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Implement a Physician Performance Profile for physicians and surgeons and utilize the data in the processes of reappointment and reprivileging. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. 3. Provide peer review data analysis regarding practitioner and group trends, with systemic corrective actions as indicated. 4. Develop and implement process and clinical outcomes to assess medical care. 5. Finalize efforts to automate data systems to facilitate data collection and analysis.

8. Infection Control		
	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.	**Methodology:** Interviewed: 1. Adella Davis-Sterling, SRN 2. Aurora Hendricks, Nurse Administrator 3. Charlene Hooper, PHN 4. Loraine Clinton, PHN 5. Mila Rose Gaffud, RN 6. Niza Uyuyan, MD, Acting Chief of Medical Services Reviewed: 1. MSH Interdepartmental Performance Improvement Committee minutes dated 2/26/08, 3/25/08, 4/22/08, 5/27/08, 7/22/08 2. Infection Control Committee Meeting minutes dated 2/27/08, 4/30/08, 5/28/08, 6/25/08, 7/30/08, 3. Nursing policy/Procedure 1728.1, Hepatitis C Virus (HCV); 1733, Gastroenteritis; 1731, Immunization 4. Tuberculin Skin Testing: Program 2 dated 4/15/08 5. Memos regarding Immunizations dated 4/15/08 and 4/16/08; Admission Labs dated 4/29/08 and 4/30/08; Competency for Nurses for Hepatitis C dated 4/28/08; Public Health Database dated 4/9/08; MRSA dated 5/20/08; Vaccine Refusals dated 6/16/08; MRSA Outbreak dated 7/8/08 and 7/10/8 6. Training rosters for MRSA/ORSA 7. WPP training curriculum including Public Health Issues 8. MSH's progress report and data 9. Medical records for the following 76 individuals: AA, AB, AFA, AL, AV, BH, CG, CLP, DAC, DAK, DC, DJG, DLG, DMS, DTS, ES, FN, FP, FR, FT, GCS, GG, GK, GRS, GS, GSD, HC, JAS, JB, JC, JDS, JG, JL, JM, JOE, JOL, JRP, JS, JT, KAS, KDC, KO, KS, LMT, LS, LT, MO, MP, MSP, MY, NA, NSO, PD, PS, PSS, RAJ, RCM, REG, RH, RJ, RK, RL, RM, RP, RRJ, SB, SDA, SH, SJD, SMC, SMc, SS, SW, TJE, TK

		and VTM
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Reconcile inconsistencies between current Infection Control policies/procedures and indicators for monitoring. **Findings:** The Statewide Infection Control (IC) monitoring tools have been revised in February and July 2008, addressing inconsistencies in the facility's policies/procedures. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings (by test/disease):** **<u>Admission PPD</u>** The DMH IC Admission PPD Auditing Form, based on an average sample of 37% of individuals admitted to the hospital with a negative PPD in the review month (February-July 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the admission procedure.*	97%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	95%
4.	*1st step PPDs were read by the nurse within 7 days of*	100%

	administration.	
5.	*2nd step PPDs were read by the nurse within 48-72 hours of administration.*	99%

F.8.a.ii: Assesses these data for trends
MSH's analysis indicated that compliance was at or close to 100% during the evaluation period. No comparison data from the last review was presented.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH indicated that there were no problematic tends for these items.

F.8.a.iv: Identifies necessary corrective action
No corrective action was required from MSH's analysis of the data.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor these items for compliance.

A review of the records of 20 individuals admitted during the review period (AL, BH, CG, DAC, DMS, FN, FT, JAS, JG, JM, JOL, KAS, KS, PD, RL, RM, RP, SDA,SMC and TK) found that 18 were in compliance.

Annual PPD
The DMH IC Annual PPD Auditing Form, based on an average sample of 50% of individuals needing an annual PPD during the review month (February-July 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	96%
2.	*PPDs were ordered by the physician during the annual review procedure.*	96%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	95%

4.	*PPDs were read by the nurse within 48-72 hours of administration.*	100%

F.8.a.ii: Assesses these data for trends
MSH's analysis indicated that compliance was at or close to 100% during the evaluation period. No comparison data from the last review was presented.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH reported that there were no problematic trends.

F.8.a.iv: Identifies necessary corrective action
MSH indicated that no corrective action was required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor these items for compliance.

A review of the records of 40 individuals who needed an annual PPD (AA, AB, AL, AV, CG, DAK, DC, DJG, ES, FN, FP, FR, GG, GK, GS, GSD, JC, JDS, JG, JM, JOE, JS, JT, KS, LS, LT, MO, MP, MY, NSO, PSS, RAJ, RM, RP, SB, SH, SMc, SS, TK and VTM) found that 38 were in compliance.

Hepatitis C
The DMH IC Hepatitis C Auditing Form, based on an average sample of 71% of individuals admitted to the hospital who are positive for Hepatitis C in the review month (February-July 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing*	96%

	the individual that he/she has a positive Hepatitis C Antibody test.	
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	93%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	92%
5.	*A Focus 6 is opened for Hepatitis C.*	74%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	8%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual*	11%

F.8.a.ii: Assesses these data for trends
MSH's analysis indicated that compliance was at or close to 100% for items 1-4 and the compliance rates for items 5-7 were lower due to inconsistencies in incorporating hepatitis C into the individuals' WRPs. No comparison data from the last review was presented.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH's data analysis showed that while physicians noted the problem on the Medical Conditions list, it was not consistently translated into a Focus 6 statement. Minutes from the Interdepartmental Performance Improvement Committee and Infection Control Committee verified that this issue was discussed.

F.8.a.iv: Identifies necessary corrective action
MSH has begun to share the IC audit data with the senior nursing mentors to ensure that a Focus 6 is opened for individuals who have hepatitis C. Training rosters indicated that in June 2008, nursing was provided training regarding accessing WaRMSS and writing WRP objectives and interventions focused on IC issues. In addition, WRP

and IC issues have been enhanced in the annual update trainings that were implemented in August 2008.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH reported that the audits conducted after the above-mentioned training in June 2008 showed little positive effect on writing IC objectives and interventions. Audit results will be compared after the annual updated training is implemented.

A review of the records of 19 individuals with hepatitis C (AFA, CG, CLP, DLG, GCS, JB, JC, JL, JRP, JS, KS, LMT, MP, PD, PS, REG, RH, RM and TJE) found that 16 had had a Focus 6 opened, and none had appropriate objectives and interventions in the WRPs. Regarding lab notification to the unit and to the IC Department, all 19 were in compliance. These results are similar to MSH's data.

HIV Positive
The DMH IC HIV Positive Auditing Form, based on a 100% sample (five individuals) of individuals who were positive for HIV antibody in the review month (February-July 2008), demonstrated the following:

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	100%

5.	*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.*	80%
6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	100%
7.	*Appropriate objective is written to address the progression of the disease.*	60%
8.	*Appropriate interventions are written.*	60%

F.8.a.ii: Assesses these data for trends
MSH's data analysis indicated that compliance was at or close to 100%. However, items 5, 7, and 8 regarding clinic follow-up and WRP objectives and interventions were not addressed by the facility. No comparison data from the last review was presented.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH's progress report indicated that there were no problematic trends. However, MSH's data regarding clinic follow-up and WRP objectives and interventions indicate otherwise.

F.8.a.iv: Identifies necessary corrective action
MSH reported that no corrective action was required and did not address items 5, 7, and 8.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor these items for compliance.

A review of the records of two individuals with HIV (AFA and RH) found that both were in partial compliance due to inadequate WRP objectives and interventions, similar to MSH's data findings.

Immunizations
The DMH IC Immunization Auditing Form, based on an average sample

of 35% of individuals admitted to the hospital during the review month (February-July 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	83%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	93%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	90%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	93%

F.8.a.ii: Assesses these data for trends
MSH's analysis indicated that the compliance for items 1 and 2 during the initial three months of the current review period was low. No comparison data was presented.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH initiated an audit of the computer data from February to April 2008 and found that not all data were being added to the database.

F.8.a.iv: Identifies necessary corrective action
MSH initiated a comparison of the database to the chart audits to ensure accurate information. In the cases in which the information is inconsistent, Medication Variance Reports are completed. In addition, the physicians were given access to the public health database and are prompted by public health when the report on non-immunity is received. If the vaccine is not ordered by the time of the audit, another reminder is given.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Overall, the current monitoring data demonstrated that the remedies

have been effective in increasing compliance. MSH will continue to monitor these items for compliance.

A review of the records of 19 individuals (AL, BH, CG, DAC, DMS, FN, FT, JAS, JG, JM, JOL, KS, PD, RL, RM, RP, SDA, SMC and TK) found that two were in partial compliance (DAC and KS).

Immunization Refusals

The DMH IC Immunization Refusal Auditing Form, based on a 100% sample (six individuals) of individuals in the hospital who refused to take their immunizations during the review month (February-July 2008), demonstrated the following:

1.	*Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s*	67%
2.	*There is a Focus 6 opened for the refusal of the immunization(s).*	0
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	0
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	0
5.	*The unit notified the Infection Control Department when the individual consented and received the immunization(s).*	NA

F.8.a.ii: Assesses these data for trends

MSH's data analysis demonstrated that compliance with item 1 increased from 0% in the last review period to 67% in the current review period. Items 2, 3 and 4 remained unchanged at 0% compliance.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH identified that refusal of immunizations was not being addressed during the WRPTs.

F.8.a.iv: Identifies necessary corrective action
MSH has begun to share the IC audit data with the senior nursing mentors to ensure that a Focus 6 is opened for individuals who have Hepatitis C. Training rosters indicated that in June 2008, nursing was provided training regarding accessing WaRMSS and writing WRP objectives and interventions focused on IC issues. MSH has also implemented the completion of a Medication Variance Report for missing documentation.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor these items for compliance.

A review of the records of four individuals who refused immunizations (CG, KO, MSP and SJD) found partial compliance due to the lack of an open Focus 6 and WRP objectives and interventions, in alignment with MSH's data results.

MRSA
The DMH IC MRSA Auditing Form, based on a 100% sample (seven individuals) of individuals in the hospital who test positive for MRSA during the review month (February-July 2008), demonstrated the following:

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 the individual that a positive culture for MRSA was obtained*	83%

3.	*The individual is placed on contact precaution per MRSA policy.*	75%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	83%
6.	*A Focus 6 is opened for MRSA.*	43%
7.	*Appropriate objective is written to include prevention of spread of infection*	33%
8.	*Appropriate interventions are written to include contact precautions.*	33%

F.8.a.ii: Assesses these data for trends
MSH's data analysis demonstrated an increase in compliance for item 2 from 60% in the last review period to 80% currently. Issues continue regarding the lack of documentation in IDNs of notification of MRSA.

Compliance for item 3 increased from 67% to 75%. Issues affecting compliance include that not all individuals with MRSA are placed on contact precautions and individuals that are colonized with MRSA do not warrant contact precautions/isolation.

Compliance for item 6 increased from 40% to 43%. The primary issue contributing to low compliance continues to be the lack of documentation of an opened Focus 6.

Compliance for item 7 also increased from 0% during the last review period to 33% in the current review period. Issues continue to be the lack of documentation of objectives and interventions in the WRPs.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH reported that the documentation in the WRPs regarding MRSA is

the problematic trend.

F.8.a.iv: Identifies necessary corrective action
See Hepatitis C F.8.a.iv objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH will continue to monitor these items for compliance.

A review of the records of seven individuals with MRSA (AB, CG, FR, GRS, JG, JM and SW) found that two were in compliance since they had a history of MRSA (CG and JG) and five were in partial compliance due to the lack of documentation in the WRPs as found in MSH's data..

Positive PPD
The DMH IC Positive PPD Auditing Form, based on an average sample of 44% of individuals in the hospital who have a positive PPD test during the review month (February-July 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	92%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	92%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	NA
5.	*If LTBI is present, there is a Focus 6 opened.*	50%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	25%
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	36%

F.8.a.ii: Assesses these data for trends
MSH's analysis showed an increase in compliance for item 3 (evaluation from Med/Surg Physician) from 85% during the last review period to 92% in the current period. The opening of a Focus 6 and establishment of objectives and interventions (items 5-7) continue to have low compliance rates.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH found that latent tuberculosis infections (LTBI) were not being addressed during the WRPC, therefore a Focus 6 statement was not being opened.

F.8.a.iv: Identifies necessary corrective action
See hepatitis C F.8.a.iv objectives and interventions

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH reported that current monitoring shows that the implemented remedial actions have been minimally effective and that additional training is scheduled. MSH will monitor the effects of this training.

A review of the records of 12 individuals who had a positive PPD (AJ, CG, HC, JOE, KDC, LS, NA, RAJ, RCM, RK, RRJ and VTM) found all in partial compliance due to documentation regarding Focus 6 and WRP objectives and interventions, similar to MSH's data.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
The DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 100% sample of individuals in the hospital who refuse their admission lab work, admission PPD, or annual PPD during the review months, demonstrated the following:

1.	*Notification by the unit that the individual refused*	60%

	his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.	
2.	*There is a Focus opened for the lab work or PPD refusal*	6%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	7%
4.	*There are appropriate interventions written for the lab work or PPD refusal.*	7%

F.8.a.ii: Assesses these data for trends
MSH's data analysis demonstrated that item 1 compliance increased from 50% in the last review period to 60% in the current evaluation period. The facility reported that the continued low compliance was due to issues in only one month (February 2008) regarding the unit notifying IC about refusals. However, since February, the compliance rate has been 100%.

F.8.a.iii: Initiates inquiries regarding problematic trends
MSH found that there was an issue with removal of admission labs from the active chart, which was scored as noncompliance since the auditor was unable to identify immune status.

F.8.a.iv: Identifies necessary corrective action
Memos verified notification that the physicians were to include hepatitis B & C, varicella and rubella when reordering admission labs. In addition, MSH has initiated a system when admission labs are not found in the individual's record to ensure that they are placed in the active record.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
MSH's data demonstrated that the remedial actions have been effective by increased compliance rates for the rest of the review

period. MSH will continue to audit clinical records for documentation and immunization.

A review of the records of five individuals who had refused PPDs (AB, DTS, GG, RJ and RM) found that all were in partial compliance due to lack of documentation of an open focus and WRP objectives and interventions in alignment with MSH's data.

Sexually Transmitted Diseases

The DMH IC Sexually Transmitted Disease (STD) Audit, based on an average sample of 37% of individuals in the hospital who tested positive for an STD during the review month, demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	100%
3.	*An RPR is ordered during the admission process for each individual.*	94%
4.	*An HIV antibody test is offered to every individual upon admission.*	55%
5.	*A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals*	80%
6.	*If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.*	NA
7.	*Focus 6 is opened for an individual testing positive for an STD.*	100%
8.	*Appropriate objective(s) are written.*	100%
9.	*Appropriate interventions are written.*	100%

F.8.a.ii: Assesses these data for trends

MSH's analysis showed an increase in compliance for item 4 (HIV antibody testing is offered) from 33% during the last review period to

		55% in this review period. Also, there was an increase in compliance regarding item 5 (chlamydia and gonorrhea test are ordered during the admission process for all females) from 39% to 80%. <u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> MSH reported that the only problematic trend is related to the critical issue of the lack of documentation regarding offering HIV testing on admission. MSH has been unable to locate some of the documentation of HIV testing. <u>F.8.a.iv: Identifies necessary corrective action</u> A memo sent by the Acting Program Director of Medical Services to the physicians in the admission suite verified that they were to document offering HIV testing or if the individual refuses. MSH meeting minutes indicated that this issue was presented to the IC Committee and at the medical staff meeting. <u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH continues to compare the database with documentation contained in the clinical records. The facility will continue to monitor these items for compliance. **Other findings:** The data continue to indicate that systems within the Infection Control (IC) Department are consistent. However, compliance continues to be low when IC activities are dependent on implementation at the unit level in particular, open focuses and WRP objectives and interventions. Overall, this monitor's findings supported MSH findings in each of the above areas. **Current recommendations**: 1. Evaluate the need to secure an additional RN to facilitate IC activities between the IC Department and the units.

		2. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:** **Recommendations 1 and 2, March 2008:** • Provide data in a format that demonstrates compliance with this requirement. • Continue to monitor this requirement. **Findings:** Data regarding trends for PPDs and TST conversions were identified from review of MSH's IC Committee meeting minutes. Facility trends for immunizations, WRPs for hepatitis C, HIV and MRSA, and pneumonia were also included in the minutes. See F.8.a.ii. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as F.8.a.ii. **Findings:** MSH's IC Committee meeting minutes and memos validated that the problematic trends found on the IC audits (See data in F.8.a.i) were being addressed by the facility. MSH meeting minutes validated that additional inquires were made into problematic trends regarding employees' vaccinations, housekeeping procedures, HIV notification, annual physicals, and standard and contact precautions for MRSA.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, March 2008:** See F.8.a.i. **Findings:** Review of the minutes of the MSH Interdepartmental Performance Improvement Committee, the Infection Control Committee Meeting minutes, memos regarding Immunizations, Admission Labs, Competency for Nurses for Hepatitis C, Public Health Database, Vaccine Refusals, and MRSA Outbreak indicate that corrective actions and recommendations were documented and implemented regarding issues noted in the IC data. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** See F.8.a.i.

		Findings: Review of a number of meeting minutes addressing IC issues as well as interviews with the IC staff indicated that MSH is implementing a number of interventions to increase areas of low compliance and is regularly monitoring the data regarding the effectiveness of the interventions. The facility is evaluating the need to secure a RN to work with the unit staff regarding refusals and WRP issues related to IC, which continue to show low compliance rates. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Provide data/reports/minutes addressing this requirement. **Findings:** MSH provided reports and minutes of meetings, adequately addressing this recommendation. A review of the minutes of the IC committee meetings, memos and the MSH Interdepartmental Performance Improvement Committee found that a number of IC issues have been discussed and plans of action integrated into the different departments and into the facility's Performance Improvement program. Some of these include: 1. Infection Tracking Grid for Environmental Conditions 2. Nursing and Public Health improving documentation in WRPs 3. IC refusals 4. TST tracking

		5. Tracking Pneumonia/MRSA and Environment of Care More 6. WRP training for nursing regarding IC issues **Compliance:** Substantial. **Current recommendation**: Continue current practice.

9. Dental Services		
	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.	**Methodology:** Interviewed: 1. Adella Davis-Sterling, SRN 2. Aurora Hendricks, Nursing Administrator 3. Niza Uyuyan, MD, Acting Chief of Medical Services 4. Rung Tan, DDS 5. Toni Nguyen, DDS Reviewed: 1. MSH's progress report and data 2. Medical records for the following 76 individuals: AA, AB, AF, AL, ARF, AV, AW, BEA, BKS, CBH, CCB, CG, CGL, CR, DAE, DAK, DC, DJC, DJG, ES, EV, FN, FP, FR, GG, GK, GNS, GS, GSD, HFE, JAC, JAS, JC, JEG, JG, JM, JOE, JRB, JS, JS-2, JT, KAS, KS, LM, LS, LT, MC, MM, MO, MP, MY, NSO, PAD, PSS, QHV, RAJ, RAL, RAN, RH, RK, RM, RP, RS, RT, RW, SB, SCG, SDA, SH, SM, SMc, SS, TC, TCD, TK and VTM
F.9.a	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** At the time of this review, MSH has two full-time dentists, one part-time annuitant dentist and two full-time Registered Dental Assistants. MSH does not have a position for a Dental Hygienist or for a Chief Dentist. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Substantial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Develop and implement a system to ensure that the medical record contains the same dental progress notes as the Dental Clinic record. **Findings:** MSH's progress report indicated that the Dental Clinic will be implementing the EagleSoft dental management software program, digital x-rays (Panorex and intra-oral x-rays), intra-oral camera and CASEY (Patients' Dental Educational Program) to maintain the dental records electronically. This will ensure that the medical records will contain the same dental progress notes as the Dental Clinic records. At the time of this review, the software had not yet been implemented. Consequently, dental progress notes in the medical records were not the same as those from the Dental Clinic. **Recommendation 2, March 2008:** Implement statewide dental monitoring tools. **Findings:** MSH implemented the statewide monitoring tools in February 2008. **Recommendation 3, March 2008:** Continue to monitor this requirement.

Findings:
MSH's data from the DMH Dental Services Audit Form based on an average sample of 64% of individuals scheduled for comprehensive dental exams during the review month February-July 2008) is summarized below:

1.a	*Comprehensive dental exam was completed*	95%

Comparable data are not available from last review period.

MSH's data from the DMH Dental Services Audit Form based on an average sample of 69% of individuals who have been hospitalized for 90 days or less during the review month is summarized below:

1.b	*If admission examination date was 90 days or less*	96%

MSH's data analysis demonstrated an increase in mean compliance from 89% from the last review period to 96% in the current period.

A review of the records of 20 individuals (AL, AV, CG, DC, FN, FP, GS, JG, JM, JS, JS-2, JT, KS, MY, RM, RP, SH, SMc, SS and TK) found that two did not have a comprehensive dental exam or were not seen timely due to refusals (JS, KS.)

MSH's data from the DMH Dental Services Audit Form based on an average sample of 60% of individuals due for annual routine dental examinations during the review month is summarized below:

1.c	*Annual date of examination was within anniversary month of admission*	93%

MSH's mean compliance increased from 92% in the last review period to 93% in this review period.

A review of the records of 20 individuals (AA, AB, DAK, DJG, ES, FR, GG, GK, GSD, JC, JOE, LS, LT, MO, MP, NSO, PSS, RAJ, SB and VTM) found that two were not timely seen (ES and VTM).

MSH used the DMH Dental Services Audit Form based on an average sample of 21% of individuals with identified dental problems on admission or annual examination and on a 100% sample of individuals with identified problems during their hospital stays other than on admission or annual examination. The data are summarized below:

1.d	*Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner*	91%

Comparable data are not available from the last reviewed period.

1.e	*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*	91%

MSH reported a slight decrease in mean compliance from 96% in the last review period to 91% in this review period. The decrease in compliance was due to the holidays taken in July by the dental staff. MSH indicated that due to their small staff, an absence of staff affects compliance results.

A review of the records of 40 individuals (AA, AB, AL, AV, CG, DAK, DC, DJG, ES, FN, FP, FR, GG, GK, GS, GSD, JC, JG, JM, JOE, JS, JS-2, JT, KS, LS, LT, MO, MP, MY, NSO, PSS, RAJ, RM, RP, SB, SH, SMc, SS, TK and VTM) found that four individuals did not receive follow-up care as indicated (JOE, JS, KS and LT).

		Current recommendation: Continue current practice.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Report data for each element of this requirement separately. **Findings:** MSH's data verified that the data for each element is collected and reported separately. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** MSH's data from the DMH Dental Services Audit Form based on an average sample of 21% of individuals scheduled for follow-up dental care during the review month is summarized below: 2.a *The current status* 96% 2.b *Findings of the examination* 96% 2.c *Plan of care* 96% 2.d *The plans of care are consistent with examination findings* 96% MSH's data analysis demonstrated that the MSH Dental Staff have improved compliance regarding documentation of the findings in the comprehensive exam from 93% in the previous review period to 96% for this review period. A review of the records of 40 individuals (AA, AB, AL, AV, CG, DAK,

		DC, DJG, ES, FN, FP, FR, GG, GK, GS, GSD, JC, JG, JM, JOE, JS, JS-2, JT, KS, LS, LT, MO, MP, MY, NSO, PSS, RAJ, RM, RP, SB, SH, SMc, SS, TK and VTM), found that two were noncompliant with this requirement due to refusals. **Current recommendation**: Continue current practice.
F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's data from the DMH Dental Services Audit Form based on an average sample of 78% of individuals due for annual routine dental examination during the review months (February-July 2008) is summarized below: 3.a — *Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application* — 90% 3.b — *Oral hygiene instruction* — 90% MSH analysis showed that overall there was significant improvement in compliance from 68% from the last review period to 90% for this period. In addition, the Dental Department noted that those individuals found who did not have preventive treatments have been scheduled for treatments in the upcoming weeks. MSH's data from the DMH Dental Services Audit Form based on a 100% sample of individuals scheduled for Level I restorative dental care during the review months (February-July 2008) is summarized

<table>
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<td>below:

<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>92%</td></tr>
</table>

MSH's analysis demonstrated a significant increase in mean compliance with this item from 48% during the last review to 92% during this reviewed period. MSH reported that low compliance for July (60%) was due to staff vacations. In addition, the Dental Department noted that those individuals found who did not have restorative treatments have been scheduled for treatments.

A review of the records of 40 individuals (AA, AB, AL, AV, CG, DAK, DC, DJG, ES, FN, FP, FR, GG, GK, GS, GSD, JC, JG, JM, JOE, JS, JS-2, JT, KS, LS, LT, MO, MP, MY, NSO, PSS, RAJ, RM, RP, SB, SH, SMc, SS, TK and VTM) found that four were noncompliant regarding preventative care (JOE, JS, KS and LT).

A review of the records of 25 individuals (AW, BEA, BKS, CBH, CCB, CGL, DAE, GNS, JAS, JEG, JM, JRB, KAS, MC, PAD, QHV, RAL, RK, RS, RT, RW, SDA, SM, TC and TCD) found that two were noncompliant regarding restorative care (SM and TC).

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2008:
Continue to monitor this requirement.

Findings:
MSH's data from the DMH Dental Services Audit Form based on a</td>
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<td>100% sample of individuals who had a tooth extraction during the review months (February-July 2008) is summarized below:
<table>
<tr><td>4.a</td><td>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</td><td>100%</td></tr>
<tr><td>4.b</td><td>If none of the above reasons is included, other reason stated is clinically appropriate</td><td>NA</td></tr>
</table>
A review of the records of 26 individuals (AF, ARF, AW, BEA, CCB, CR, DJC, EV, GNS, HFE, JAC, JM, JRB, LM, MC, MM, QHV, RAN, RH, RK, RM, RS, RT, RW, SCG and TC) found that all were in compliance regarding documentation of clinical justifications for extractions.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.9.c</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendation 1, March 2008:
Implement use of the statewide Dental monitoring tools.

Findings:
See F.9.b.i under Recommendation 2.

Recommendation 2, March 2008:
Monitor compliance with this requirement.

Findings:
MSH's data from the DMH Dental Services Audit Form based on an average sample of 21% of individuals who had a tooth extraction during the review month (February-July 2008) is summarized below:
<table>
<tr><td>5.a</td><td>Physical health impact on dental service</td><td>99%</td></tr>
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<td></td>
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<table>
<tr><td>5.b</td><td>Medications</td><td>91%</td></tr>
<tr><td>5.c</td><td>Allergies that impact on dental service</td><td>97%</td></tr>
<tr><td>5.d</td><td>General condition of current oral environment</td><td>100%</td></tr>
<tr><td>5.e</td><td>When individual compliant is noted within the findings, there is documentation related to exam results</td><td>95%</td></tr>
</table>

Comparable data were not available from the last period because the data were not reported separately.

A review of the records of 40 individuals (AA, AB, AL, AV, CG, DAK, DC, DJG, ES, FN, FP, FR, GG, GK, GS, GSD, JC, JG, JM, JOE, JS, JS-2, JT, KS, LS, LT, MO, MP, MY, NSO, PSS, RAJ, RM, RP, SB, SH, SMc, SS, TK and VTM) found that four were in partial compliance with this requirement (JOE, JS, KS and LT).

Compliance:
Substantial.

Current recommendation:
Continue current practice.
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<td>F.9.d</td>
<td>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.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, March 2008:
See F.9.e.

Findings:
See F.9.e.

Recommendation 2, March 2008:
Continue to monitor this requirement.
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Findings:
MSH's data from the DMH Dental Services Audit Form based on a 100% sample of individuals scheduled for a dental appointment during the review month (February-July 2008) is reported below:

<table>
<tr><td>6.a</td><td>The individual attended the scheduled appointment</td><td>51%</td></tr>
</table>

MSH reported that the attendance rate for dental appointments remains low as noted from the data. The data from the Dental Clinic appointment logs verified that the majority of the missed appointments were from individual refusals, not transportation or staffing issues.

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.9.e</td>
<td>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</td>
<td>
Current findings on previous recommendations:

Recommendations 1-3, March 2008:
• Provide training to unit staff regarding procedures for refusals that includes addressing this issue in the WRPs.
• Develop and implement policy/procedure regarding refusals.
• Monitor compliance with this requirement.

Findings:
MSH has implemented a computerized tracking log for refusals and missed appointments. The process includes Central Nursing Services completing an audit of the individuals' WRPs when three or more consecutive refusals have occurred. No data was provided regarding this process.
</td>
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</table>

		Compliance: Partial. **Current recommendations**: 1. Provide data regarding this requirement. 2. Formalize process addressing refusals. 3. Continue to monitor this requirement.

G. Documentation		
G	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.	Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. MSH has implemented several strategies that have eliminated the use of side rails as a restraint. 2. MSH has implemented the statewide Seclusion/Restraint auditing tools. 3. All competency-based trainings for seclusion/restraint and PRN and Stat medications have been implemented and integrated into orientation and annual update trainings. 4. Days free of seclusion and/or restraint have significantly increased since the last review period.
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.	**Methodology:** <u>Interviewed</u>: 1. Aubri Griffis, Acting Nurse Coordinator 2. Aurora Hendricks, Nurse Administrator 3. Carmen Fayloga, HSS Standards Compliance 4. Christine A. Robinson, Assistant Unit Supervisor 5. Cynthia Lusch, Clinical Administrator 6. Edmon Sapinoso, Program VI 7. Gloria Figueroa, Unit Supervisor 8. John Lusch, Program I Director 9. John Nallira, Unit Supervisor 10. Karen Chong, Program II Director 11. Loida Marquez, HSS 12. Mary Granadu, Nurse Coordinator Program VI 13. Michael Nunley, RN, Standards Compliance Director 14. Rachel B. Potts, Unit Supervisor 15. Renee Kelly, Program VI 16. Rose B. Mizae, SRN Program I

		Reviewed: 1. MSH's progress report and data 2. AD 3306, Behavioral Seclusion or Restraint 3. AD 3138, Falls Prevention/Management Program 4. California Department Of Mental Health Special Order 119.06, Seclusion and Behavioral Restraint 5. Training rosters for DMH Seclusion/Restraint Audit; NP 528, PRN Orders; NP 530, Stat Orders; Preventive Management of Assaultive Behavior (PMAB); Nursing Orientation and Updates 6. Seclusion and Restraint inter-rater reliability data 7. Minutes for Central Nursing Services/Nursing Coordinator/Unit Supervisor meeting dated 6/25/08 8. MSH list of current triggers 9. NP 528, PRN Orders 10. NP 530, Stat Orders 11. Trigger Response WRP Conference Tracking form 12. Medication Variance Reporting and Monitoring form with Psych PRN limit for 14 days 13. Lesson plans for Fall Risk Assessment 14. Medical records of the following 37 individuals: AB, AF, AT, BMY, CAS, CG, CH, CLP, CMW, CR, DT, DY, EV, FR, HC, JG, JR, KCM, KR, LD, LP, LS, MAQ, MJ, ML, PAW, PD, RL, RWL, SN, SS, SW, SY, TS, VB, VF and WH Observed: Unit 418 and 419
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice.

	In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Findings:** MSH continues to implement SO 119.06 and AD 3306. A review of MSH's documentation found no incidents of prone restraints, prone containment or prone transportation. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that seclusion and restraints forms are accurate and complete. **Findings:** MSH's training rosters verified that training was provided to Unit Supervisors and Nursing Coordinators regarding the seclusion and restraints (S&R) forms that were revised and implemented in February, 2008. In addition, MSH has also implemented S&R Documentation Reviews that provides findings and feedback to the Unit Supervisors and Nursing Coordinators. **Recommendation 2, March 2008:** Ensure that all auditors are consistently following the monitoring tool instructions.

Findings:
MSH implemented the statewide DMH Seclusion/Restraints Audit tool on July 1, 2008. Training rosters indicated that training was provided to the auditors and a system of consultation between the auditors and Standards Compliance was also implemented. MSH reported inter-rater agreement testing among the seven auditors at 92%.

Recommendation 3, March 2008:
Continue to monitor this requirement.

Findings:
Only data for July 2008 will be presented for MSH for since the statewide tool was initiated at that time and any comparison data could not be accurately interpreted.

The facility reported the following data from the DMH Restraint Audit based on an 83% sample of restraint events for July 2008:

2.	*Restraints and seclusion are used in a documented manner.*	79%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	84%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	90%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	90%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	79%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions*	90%

	were not used.	
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	79%

MSH reported that overall, there was a decrease in compliance due to implementing a more reliable process by the auditors and using the statewide tool.

A review of 40 episodes of restraints for 16 individuals (AB, BMY, CAS, CG, CH, CLP, CMW, DY, JR, LS, MAQ, MJ, PAW, PD, RWL and WH) found that the overall documentation regarding behaviors prior to the use of restraints had improved. The documentation for 29 incidents described behaviors indicating that the use of restraints was in response to behaviors that demonstrated an imminent danger to self or others. The physician orders for 28 incidents included specific behaviors and 16 incidents included the use of less restrictive measures.

The facility reported the following data from the DMH Seclusion Audit based on a 75% sample of seclusion events for July:

2.	*Restraints and seclusion are used in a documented manner.*	67%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	100%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	67%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	100%
3.a	*The justification for restraints or seclusion was to prevent harm to self or to others, and*	100%

3.b	*Did not include prevention of harm from others.*	100%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	0%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	0%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	0%

MSH reported that overall, they had noted a decrease in compliance due to implementing a more reliable auditing process.

A review of four incidents of seclusion for four individuals (KCM, PAW, RWL and VB) found that the documentation for all incidents described specific behaviors, indicating the seclusion was in response to behaviors that demonstrated an imminent danger to self or others. The physician orders for two incidents included specific behaviors and none of the incidents included documentation regarding the use of less restrictive measures.

Other findings:
Additional data provided by MSH demonstrated that the total number of S&R-free days has increased from 42 days in the last review period to 55 days in the current review period. Also, the mean number of restraint hours has decreased from 92.3 hours compared to 60.17 hours. The mean number of seclusion hours has also decreased from 3.16 hours to 1.83 hours. Interviews with staff who work on the units that have the most use of seclusion and/or restraint articulated a

		number of strategies that they have implemented to decrease the use of restrictive measures and were committed to continuing to decrease its use. **Current recommendations**: 1. Present data for next review in alignment with the Court Monitor's requirements. 2. Continue to monitor this requirement.
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:** **Recommendation, March 2008:** See H.2.a. **Findings:** The facility reported the following data from the DMH Restraint Audit based on an 83% sample of restraint events for July 2008:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	100%
6.	*Restraints and seclusion are not used as punishment.*	
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	100%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	84%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	100%
6.d	*The staff did not use restraints or seclusion as coercion.*	100%
7.	*Restraints and seclusion are not used for the convenience of staff.*	
7.a	*Staff used and documented the use of information*	72%

	in the Seclusion and Restraint Preference and Family Notification Form (MSH 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.	

A review of the records of 16 individuals who were placed in restraints (AB, BMY, CAS, CG, CH, CLP, CMW, DY, JR, LS, MAQ, MJ, PAW, PD, RWL and WH) found that all had documentation in the WRP addressing behaviors, objectives and interventions. For 28 incidents out of 40, the documentation indicated that the individual was not released when calm.

The facility reported the following data from the DMH Seclusion Audit based on a 75% sample of seclusion events for July 2008:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	
5.a	*There is a Focus of Hospitalization that targets the behavior that required the individual to be placed in restraints or seclusion, and*	67%
5.b	*A linked objective, and*	67%
5.c	*A linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in restraints or seclusion.*	67%
6.	*Restraints and seclusion are not used as punishment.*	100%
7.	*Restraints and seclusion are not used for the convenience of staff.*	
7.a	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of*	100%

				behavior as provided by the individual, or there is clinical justification as to why they were not used.	| A review of the records of four individuals who were placed in seclusion (KCM, PAW, RWL and VB) found that two had documentation in the WRP addressing behaviors and objectives and interventions and none of the incidents indicated that the individual was not released when calm. **Current recommendation**: See H.2.a.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that the practice of fading restraints is prohibited. **Findings:** MSH reported that the practice of fading restraints is disallowed by policy and MSH practices are aligned with this policy. The facility indicated that they found no practice of fading restraints during this evaluation period, which was verified by this reviewer. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Psychology Services Monitoring Audit based on a 100% sample (n=4) of new or revised Behavior Guidelines and PBS Plans implemented in the review month (July 2008): 8. *Behavioral interventions, which include Positive Behavior Support Plans, are based on a positive* — 100%

		behavior support model, and do not include the use of aversive or punishment contingencies.
		8.a *The Behavior Guidelines and PBS Plans meet the criteria on the DMH PBS Plan Monitoring Form, and* — 100%
		8.b *The Behavior Guidelines and PBS Plans do not include any aversive or punishment contingencies.* — 100%
		MSH reported 100% compliance for the last review period as well as this review period for this requirement. A review of seven individuals' PBS plans (DY, FR, JG, KR, ML, RL and TS) found that none contained seclusion or restraint as part of a behavioral intervention. **Current recommendation**: Continue current practice.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Identify and document specific exit criteria for seclusion and restraints. **Findings:** In response to this recommendation, MSH revised and implemented MSH 1172A, Physician Order for Behavioral Seclusion and Restraint to include, under Criteria for Release, the specific behavior the individual must display to show that he/she is no longer a danger to self or others. Also, MSH 1029, Observation Record for Behavioral Seclusion and Restraint was revised and implemented in February 2008 to include documentation every 15 minutes regarding the individual's specific behaviors requiring continued use of Seclusion or Restraint.

Recommendation 2, March 2008:
Continue to monitor this requirement.

Findings:
The facility reported the following data from the DMH Restraint Audit based on an 83% sample of restraint events for July 2008:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	58%
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	63%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	68%
9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	90%
9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	84%
9.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	74%
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	84%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say*	84%

		he/she is sorry for his/her actions.

The facility reported the following data from the DMH Seclusion Audit based on a 75% sample of seclusion events for July 2008:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	100%

See also H.2.b findings.

Current recommendation:
See H.2.a.

H.3	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH reported that there was generally an overall decrease in compliance for this data, again due to due to implementing a more reliable auditing process and decreasing the number of auditors to increase reliability. The facility reported the following data from the DMH Restraint Audit based on an 83% sample of restraint events for July 2008: 10. *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.* 79% 10.a *The order was obtained within 15 minutes from* 95%

	the initiation of restraints or seclusion.	
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	84%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	100%

A review of 40 episodes of restraints for 16 individuals (AB, BMY, CAS, CG, CH, CLP, CMW, DY, JR, LS, MAQ, MJ, PAW, PD, RWL and WH) found that orders were obtained within 15 minutes for 37 episodes; in 34 episodes the RN conducted a timely assessment; and for 38 episodes, the physician conducted a timely face-to-face evaluation.

The facility reported the following data from the DMH Seclusion Audit based on a 75% sample of restraint events for July 2008:

10.	*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.*	67%
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	100%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	67%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	100%

A review of four incidents of seclusion for four individuals (KCM, PAW, RWL and VB) found that orders were obtained within 15 minutes for all episodes; in two episodes the RN conducted a timely assessment; and for all episodes, the physician conducted a timely face-to-face evaluation.

MSH's training rosters verified 100% compliance regarding staff training for Preventive Management of Assaultive Behavior (PMAB) as shown below:

Annual PMAB Training Competency Report							
	Feb	Mar	Apr	May	Jun	Jul	Mean
N	36	37	65	52	59	54	51
n	36	37	65	52	59	54	51
%C	100	100	100	100	100	100	100

N = total number of nursing staff who attended PMAB training
n = total number of nursing staff who completed and passed the training

MSH's PMAB training is a mandatory class provided to all newly hired nursing staff and to all nursing staff annually. The Office of Professional Education and Training maintains the training logs. The revised Statewide PMAB Manual, Therapeutic Strategies and Interventions (TSI) have been approved for implementation.

Compliance:
Partial.

Current recommendations:
See H.2.a.

H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue inter-rater agreement testing until an acceptable level (85% or above) is achieved. **Findings:** MSH's data indicated that inter-rater agreement testing among the seven auditors was 92% using the new DMH Seclusion/Restraints Monitoring tool, compared to 84% in the last evaluation period using the MSH Seclusion/Restraints Audit. The mean inter-rater agreement for the DMH PRN/Stat Monitoring tool during this evaluation period is 90% compared to 76% during the last evaluation period using the MSH PRN/Stat Medication Audit tool. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** MSH's Standards Compliance Department has implemented reviews of the Seclusion/Restraints database monthly, coordinating with the Programs and the IT Department to identify and correct any discrepancies. The HSS Daily 24-Hour Report on Seclusion/Restraints and PRN/Stat and the PLATO Data Analyzer are also used to ensure reliability and reconcile Seclusion/Restraint and PRN/Stat data. However, MSH did not present any data regarding the effectiveness of these processes. **Compliance:** Partial. **Current recommendations:** 1. Provide supporting data to verify compliance.

		2. Provide data addressing accuracy of seclusion/restraint and PRN/Stat data. 3. Continue to monitor this requirement.
H.5	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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Reconcile trigger indicators in alignment with the EP for this requirement. **Findings:** A review of criteria for trigger indicators verified that MSH reconciled the indicators for this requirement with the EP in June 2008. **Recommendation 2, March 2008:** Monitor compliance with this requirement. **Findings:** MSH's data for restraints regarding trigger data could not be accurately interpreted since the trigger indicator criteria was revised in June and the facility had just implemented the DMH statewide auditing tool in July. MSH indicated that there were no individuals who met the trigger criteria for seclusion during the review period. A review of the records of 16 individuals who met the trigger criteria for restraints during the review period (AB, BMY, CAS, CG, CH, CLP, CMW, DY, JR, LS, MAQ, MJ, PAW, PD, RWL and WH) found only partial compliance in all cases. MSH's progress report indicated that to improve compliance in this area, the facility will address the issue with the Clinical Administrator and Program Directors, as well as in the performance improvement

		meetings with Unit Supervisors, Nursing Coordinators, Senior Clinical WRP Mentors, Nursing Instructors, WRP Trainers and Health Services Specialists/auditors. **Compliance:** Partial. **Current recommendations**: See H.2.a.
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:	**Compliance:** Partial.
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.	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that documentation for PRN and Stat medication in the ID notes is in alignment with generally accepted standards of nursing practice. **Findings:** MSH revised NP 528, PRN Orders and NP 530, Stat Orders in June 2008 to include: 1. Standard nursing documentation for injection 2. Designation of documentation for behavior that warrants the use of PRN or Stat medication 3. Designation of documentation in the IDNs and Medication and Treatment Record (MTR)

Training rosters verified that training regarding the policy revisions was provided to nursing staff and the minutes of the Unit Supervisor/ Nursing Coordinator Performance Improvement meetings demonstrated that audit results are being discussed.

Recommendation 2, March 2008:
Continue to monitor this requirement.

Findings:
See F.1.b.

In addition, the facility presented the following data pertaining to PRN and Stat medication triggers:

PRN Medication Triggers							
	Feb	Mar	Apr	May	Jun	Jul	Mean
N	30	25	27	28	23	18	25
n	15	15	19	28	23	17	20
%C	50	60	70	100	100	94	80

N = total number of identified PRN Medication Triggers sent out to the WRPTs
n = number of PRN Medication Trigger Responses received back from the WRPTs at Standards Compliance Dept.

MSH's data analysis showed a significant increase in compliance from 37% during the last review period to 80% in the current review period. The compliance rate during the last month of the previous review period (January 2008) was 38% compared to 94% in July 2008.

Stat Medication Triggers							
	Feb	Mar	Apr	May	Jun	Jul	Mean
N	16	9	8	21	12	8	12
n	7	5	5	17	11	8	9
%C	44	56	63	81	92	100	75

		N = total number of identified Stat Medication Triggers sent out to the WRPTs n = number of Stat Medication Trigger Responses received back from the WRPTs at Standards Compliance Dept. MSH's compliance rate increased from 50% during the last review period to 75% in the current review period. The compliance rate during the last month of the previous review period (January 2008) was 63% compared to 100% in July 2008 of this period. MSH has shown improvement in the number of trigger responses received back from the WRPTs. The trigger data does not address the appropriateness and timely implementation of adjustments to individuals' treatment, which are adequately addressed by the current Psychiatry Monthly PPN Audit. **Current recommendations**: 1. Same as F.1.b. 2. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data based on the DMH Psychiatry Monthly PPN Audit based on a 7% average sample of individuals with a Length of Stay equal to or greater than 90 days (February-July 2008):

		7. *The use of PRN describes the rationale/specific indication for all PRN orders.* — 91% MSH's analysis showed that the mean compliance rate increased from 69% during the last review to 91% for this review. Compliance during the last month of the previous review period (January 2008) was 74% compared to 88% in July 2008. A review of the records of 23 individuals (AB, AT, BMY, CAS, CG, CH, CLP, CMW, DY, EV, JR, LD, LP, LS, MAQ, MJ, PAW, PD, RWL, SN, SY, VF and WH) found that 18 contained documentation demonstrating compliance with this requirement. **Current recommendation**: Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** MSH continues to follow Policy and Procedure 528, PRN Orders which designates that all orders for psychotropic PRN medications are limited to 14 days. MSH reported that during the last review period, August 2007 – January 2008, there were two Medication Variances pertaining to this cell requirement. However, during this review period, February 2008 – July 2008, there were no Medication Variances regarding PRN time limits. A review of the records of 23 individuals (AB, AT, BMY, CAS, CG, CH, CLP, CMW, DY, EV, JR, LD, LP, LS, MAQ, MJ, PAW, PD, RWL, SN, SY,

		VF and WH) found that all PRN orders were limited to 14 days. **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Nursing PRN Monitoring Audit based on a 23% average sample of PRN medications administered each month (February-July 2008): 3. *Documentation of the individual's response to PRN medication.* 68% 3.a *In the MTR, there is a brief description of the individual's response to the administered PRN medication, which was documented within one hour of the administration.* 82% 3.b *In the IDN, there is a comprehensive assessment of the individual's response to the administered PRN medication.* 75% MSH's data analysis demonstrated only a slight increase in compliance from 67% for the last review period to 68% in the current period. The compliance rate from the last month of the previous review period (January 2008) was 61% compared to 83% in July 2008. See F.3.a.iii. The facility reported the following data from the DMH Nursing Stat

<table>
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<td>Monitoring Audit based on a 27% average sample of Stat medications administered each month (February-July 2008):
<table>
<tr><td>3.</td><td>Documentation of the individual's response to Stat medication.</td><td>66%</td></tr>
<tr><td>3.a</td><td>In the MTR, there is a brief description of the individual's response to the administered Stat medication, which was documented within one hour of the administration.</td><td>81%</td></tr>
<tr><td>3.b</td><td>In the IDN, there is a comprehensive assessment of the individual's response to the administered Stat medication.</td><td>75%</td></tr>
</table>
MSH's analysis demonstrated a decrease in the mean compliance rate from 76% in the previous review period to 66% in the current review period. However, compliance during the last month of the previous review period (January 2008) was 79%, compared to 80% in July 2008.

See F.3.a.iii.

Current recommendation:
Continue to monitor this requirement.</td>
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<tr>
<td>H.6.e</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, March 2008:
Same as in D.1.f, F.1.b and H.6.a.

Findings:
Same as in D.1.f, F.1.b and H.6.a.

Current recommendation:
Same as in D.1.f, F.1.b and H.6.a.</td>
</tr>
</table>

H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation 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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** MSH's training rosters verified that the new nursing staff hired during the review period (5) have completed and passed the Nursing Orientation Competency and that 100% of existing staff who attended the Nursing Annual Update Competency have completed and passed. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
H.8	Each State hospital shall:	**Compliance:** Substantial.
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	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Continue implementation of this system. **Findings:** MSH has implemented a number of strategies which have eliminated the use of side rails as a restraint. MSH no longer uses full side rails; any side rails currently in use are the half side rails. MSH has also secured low beds for six individuals on Unit 418. In addition, on Unit 419, 26 out of 32 individuals are using low beds. The remaining six low beds are currently being acquired. MSH's Falls Prevention/ Management Committee continues to review individuals based on fall

		triggers, referrals, and falls data to assist teams in implementing needed interventions. Also, the Fall Risk Assessment and Intervention is included in MSH's Nursing Orientation Curriculum and Nursing Annual Update. From observations on Units 418 and 419, there were no side full side rails on either unit. **Recommendation 2, March 2008:** Continue to monitor this requirement. **Findings:** Same as above. **Current recommendation**: Continue current practice.
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, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor this requirement. **Findings:** See H.8.a. **Current recommendation**: Continue current practice.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The quality of investigations completed by the Office of Special Investigations has substantially improved, putting the facility in substantial compliance with many of the cells of the Enhancement Plan related to the quality of investigations. 2. The facility has hired a Supervising Special Investigator to oversee investigations by his office. This should improve the timeliness of investigations as he will be reviewing progress as investigations are underway. 3. The Standards Compliance Department is producing studies of high-risk situations/individuals under the direction of the Chair of the Performance Improvement Committee. Falls, swallowing foreign objects, origins of aggression, repeat victims and repeat aggressors are some of the topics. Several of the studies explicitly address clinical questions and offer suggestions. 4. The facility has demonstrated the ability to collect and sort data by type of incident, time of occurrence, day of the week, and location. This information is reviewed by the Performance Improvement Committee. 5. MSH has developed a procedure for alerting WRPTs when an individual has reached a trigger and has a procedure whereby the team completes and returns a form indicating the intervention(s) taken. The form contains a menu of possible interventions. 6. Standards Compliance is monitoring the responses from the WRPTs to triggers. The response rate has improved considerably. 7. Guidelines have been developed to assist WRPTs in addressing several types of triggers, including aggression and the need for one-to-one observation. 8. All hospital police (with the exception of one man who is on military leave) and Special Investigators have been trained on Incident Management.

		9. The facility is monitoring on a sample basis the implementation of the interventions reported to have been initiated by the WRPT in response to an individual hitting a trigger. 10. Beginning in October 2008, the facility will be implementing an Incident Review Committee to review allegations of abuse and neglect. The workings of this committee will be guided by AD 0205: Incident Review Committee adopted on July 31, 2008. 11. The common areas and most of the bedrooms and bathrooms toured were clean and odor-free. Individuals had access to personal hygiene items.

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.	**Methodology:** Interviewed: 1. M. Nunley, Director, Standards Compliance 2. L. Dieckmann, Standards Compliance Lead Psychologist 3. G. Hahn, Hospital Administrator 4. C. Loop, Supervising Special Investigator 5. M. McNeil, Standards Compliance 6. H. Mears, Chief of Hospital Police Reviewed: 1. 19 investigations completed by the Office of Special Investigations 2. 13 Headquarters Reportable briefs 3. Five clinical records for implementation of corrective measures following an incident 4. Six Special Incident Reports 5. Incident Review Committee Minutes 6. Aggregate incident and investigation data 7. 18 clinical records for signed Rights Notification 8. AD 0205: Incident Review Committee 9. Investigation Compliance Monitoring Data 10. Portions of the personnel records of 16 staff members 11. Training records of 26 staff members
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:	**Compliance:** Partial.

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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Proceed with plans for the HR Director, Program Directors and Discipline Chiefs to meet to ensure that all programmatic recommendations are implemented in a timely fashion. **Findings:** The facility reports that these meetings are occurring. **Other findings:** Review of the programmatic responses implemented as a result of an incident investigation revealed variable performance as follows: • The WRPC following four incidents of inappropriate touching of females by SO in May 2008 failed to identify any objectives or interventions related to this behavior. Staff on SO's unit reported that SO is still exhibiting this behavior. • Following the alleged sexual assault of KB, enhanced hall monitoring was recommended. During this monitor's observation of the unit (during a time when individuals were on the unit), no hall monitor was in place. • Following the transfer of WP to another unit after he was allegedly sexually assaulted by another individual, the WRPC held on the new unit several days after the transfer made no mention of the sexual assault. • In contrast, following the allegation of sexual assault by JR, the aggressor was transferred to another unit. The WRPC following the aggressor's transfer references the incident under Risk Factors and includes an objective related to inappropriate sexual behavior (although the use of the term "inappropriate" in describing the behavior is misleading).

		Current recommendation: Develop a reliable system whereby an appropriate treatment response follows a serious incident.
I.1.a.ii	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** Facility documents show that Standards Compliance staff continue to review the accuracy of SIRs as they come into the office. These documents list the type and source of the errors. **Other findings:** There is still some confusion regarding the distinction between sexual abuse and sexual assault. In investigations completed by the Office of Special Investigations, sexual incidents involving an individual and anyone other than another individual should be identified as sexual abuse. Individual-to-individual nonconsensual sexual incidents are to be classified as sexual assaults. See the Hospital Police log for case numbers 07-088H, 080-436 and 08-014S for examples of misidentification. The incident involving FW on 2/22/08 is misidentified as a sexual assault and should be classified as a sexual abuse allegation. The failure to consistently identify these incidents correctly has also resulted in an incorrect count on the Key Indicator Report for Alleged Abuse/Neglect/Exploitation. Similarly, identification of the role of an individual who has made a suicide attempt is problematic. In the 4/12/08 suicide attempt by AB, AB's involvement is coded as "aggressor" in one part of the SIR and as

		"victim" in another. In the 5/3/08 suicide attempt by MJ, MJ's involvement is coded as "aggressor." **Current recommendations**: 1. Clarify with the other facilities the correct role designation for the individual in incidents involving suicide attempts and advise staff and reviewers accordingly. 2. Check SIRs, investigations and logs to ensure that sexual incidents are correctly coded. 3. Ensure all facilities are using the same business rules for counting individuals who have made allegations of abuse, neglect or exploitation for Performance Indicator data.
I.1.a.iii	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Whenever an investigation report states that an individual has a history of making false allegations, cite the source of this assertion and include information as to whether this issue is a focus in the WRP. **Findings:** None of the investigations reviewed made the assertion that an individual had a history of making false allegations in the absence of supporting information that included whether the problem was identified in the WRP. **Other findings:** In all of the investigations reviewed that involved an allegation of abuse/neglect or exploitation of an individual, there was documentation that the named staff member was removed from contact with individuals in a timely manner pending the conclusion of the investigation.

		In the 5/19/08 incident involving a sexual assault, the victim was immediately moved to another unit for his protection. In response to the 6/17/08 allegation of sexual assault, the alleged perpetrator was transferred from a co-ed unit to an all male unit. **Current recommendation**: Continue current practice.
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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that all staff completes required competency-based annual training. **Findings:** Review of the training records of 16 staff members found that annual Abuse/Neglect Recognition training was current for 15 of the 16 staff members. However, the review of the training records of 10 randomly selected physicians and psychiatrists revealed that four had never attended Patients' Rights or Abuse/Neglect Recognition training, two were overdue for annual training, and the remaining four had completed the training within the last 12 months. **Recommendation 2, March 2008:** Standardize the documentation of the length of the Individuals' Rights annual training. **Findings:** This recommendation has been implemented, and annual training is now standardized at one hour. **Current recommendation**: Ensure that training requirements are adhered to for all staffing

		positions.
I.1.a.v	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in I.1.a.i. **Findings:** Past reviews have found that the facility has ensured that staff members have signed an acknowledgement of their mandatory reporting responsibilities. **Other findings:** The investigations reviewed revealed several instances in which MSH took action in response to a staff member's failure to report an incident in a timely manner. Specifically, in the 1/28/08 allegation of the psychological abuse of CG, the facility counseled the staff member for failure to write an incident report and to document the incident in the clinical record and provided training on reporting responsibilities. Review of the policy regarding the timely completion of an incident report was required of the staff member who failed to complete the SIR by the end of the shift in the incident involving FW on 2/22/08. **Current recommendation**: Continue current practice.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to ensure that signing the Rights Notification is part of the annual Wellness and Recovery planning process and whenever there is a change in legal status.

		Findings: The review of 18 clinical records (three from each unit toured) revealed that with one exception (JM), all individuals had signed the Rights Notification within the last year. **Current recommendation:** Continue current practice.
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice of notifying individuals that their complaints have been received and forwarded. Ensure the individual learns the disposition of the complaint/grievance. **Findings:** The facility reports that individuals are advised in writing of how their grievance will be handled. **Other findings:** Each unit reviewed had a rights poster on the wall of a common area. **Current recommendation:** Continue current practice.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Discontinue the practice of IRC reviewing an allegation before handing it off to the Hospital Police. **Findings:** This practice has been discontinued; the IRC reviews only cases where

		the investigation has been completed. **Recommendation 2, March 2008:** Develop procedures whereby relevant incidents are immediately reported to the Office of the Special Investigator and are assigned for investigation promptly. **Findings:** Review of the Hospital Police Log indicates that of the 37 incidents alleging abuse/neglect in the period 4/1/08 through 8/19/08, 84% were received by the hospital police/Office of Special Investigator within 72 hours. The remaining six incidents were received late as follows: • Three incidents were received 6-8 days after the date of the incident, • Two were received 11-13 days after the incident and • One was received 30 days after the incident. Full utilization of the Hospital Police's Record Management System should improve timeliness. **Other findings:** The investigation of the sexual assault of WP was forwarded to the District Attorney for consideration of prosecution. The DA rejected the case—a not infrequent result, according to the hospital Chief of Police. Similarly, the investigation of the sexual assault of JR was also sent to the Office of the District Attorney. **Current recommendation**: Follow up with units when incident reports are not received within the time limits set by policy to remind them of the importance of timely reporting and completion of the incident report and the negative impact

		that late reporting has on the investigation.
I.1.a.ix	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, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** This monitor found no instances in the investigations reviewed in which retaliatory action was taken or threatened in response to a person reporting an allegation of abuse or neglect. **Current recommendation**: Continue current practice.
I.1.b	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:	**Compliance:** Partial. While there has been significant improvement in the quality of investigations performed by the Office of Special Investigations, there has not been commensurate improvement in the review of deaths. For this reason, the compliance rating remains unchanged.
I.1.b.i	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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Complete Headquarters Reportable Briefs on all injuries of unknown origin that require medical treatment and ensure their investigation by trained personnel not associated with the individual. **Findings:** Overall, Headquarters Reportable Briefs are not being completed as required by policy. As reported in I.1.d.vi, none of the 13 Headquarters

		Reportable Briefs for May incidents had been completed at the time of the tour. **Recommendation 2, March 2008:** Ensure that "old business" is carried forward in the Mortality Review Committee minutes so that issues are not forgotten and dropped. **Findings:** The Mortality Review Committee minutes and the minutes of the Mortality Interdisciplinary Review Committee indicate that several deaths occurring many months ago have not been reviewed because, according to the minutes, the facility has not received autopsies. These include the death of DR (11/07), LW (9/07), CG (11/07) and DH (12/07). A preliminary review of the death of JP (5/08) has not yet occurred. **Recommendation 3, March 2008:** Implement to the degree possible the procedures for the review of deaths described in SO 205.04: Mortality Review. **Findings:** The Mortality Review Committee has met regularly through 2008 and the Mortality Interdisciplinary Review Committee has begun tracking recommendations from the Mortality Review Committee, Nursing Death Reviews and Special Investigations of deaths. However, most of the tracking sheet is blank, identifying various concerns, but no corrective actions suggested or implemented. To date there has been no independent review of unusual deaths and the lack of autopsies has hampered the review of several deaths. **Other findings:** Beginning in October 2008, the Incident Review Committee will become fully functional. Deliberations in this committee should include

		consideration of some of the items needed to complete Headquarters Reportable Briefs, particularly the Analysis section. **Current recommendations**: 1. Diagnose and then fix the system for completing Headquarters Reportable Briefs. 2. Use the Incident Review Committee as a forum for identifying and discussing elements in the Headquarters Reportable Briefs. 3. Take appropriate action to get the autopsies for individuals who died many months ago. Implement procedures for ensuring Mortality Interdisciplinary Review Committee members receive copies of autopsies in a timely manner, as referenced in the Executive Risk Management Committee minutes of July 31. 4. Ensure that the letter referenced in those same minutes is written and made available to all external facilities informing them that all deaths of MSH individuals are coroner's cases. 5. Implement to the degree possible the procedures for the review of deaths described in SO 205.04: Mortality Review.
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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Train the remaining officers as they become available and any other staff who may be called upon to conduct incident investigations. **Findings:** According to the Chief of the Hospital Police, all hospital police officers and investigators in the Office of Special Investigations have completed Incident Management Training, except one staff member on extended military leave. **Current recommendation**: Continue current practice.

I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** The investigations reviewed indicate that the facility continues to safeguard photos and other evidence. New locks that record the access codes of persons entering the evidence storage area have been installed. **Current recommendation:** Continue current practice.
I.1.b.iv	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:	**Current findings on previous recommendation:** **Recommendation, March 2008:** Provide feedback and guidance to officers completing investigations, using the monitoring form as a tool when an investigation fails to meet monitoring standards. **Findings:** The 19 investigations reviewed were of substantively better quality than during previous reviews. Positive elements of these investigations are identified in the succeeding cells. **Current recommendation**: Continue current practice.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, March 2008:** Develop procedures whereby the Hospital Police are immediately

		advised of an incident that requires their investigation. **Findings:** See Findings in I.1.a.viii. **Current recommendation:** Continue current practice wherein the Office of Special Investigations scans the CNS daily report looking for incidents that would require an investigation by that office.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Revise procedures so that incidents are reported to the Hospital Police quickly and are assigned for investigation in a timely manner. **Findings:** See Findings in I.1.a.viii. **Recommendation 2, March 2008:** Discontinue the practice of the IRC reviewing incidents before they are handed over to the hospital police, thus delaying the start of an investigation. **Findings:** This practice has been discontinued. The IRC now reviews only investigations that have been closed. **Other findings:** Facility data indicates that 49% of the investigations conducted by the Office of Special Investigations in the period February through July 2008 were completed within 30 business days.

Six of the 19 investigations reviewed (32%) were completed within 30 business days.

Individual involved	Date of Incident or Date Reported	Date Closed
TP	5/24/08	Report not dated
FW	2/22/08	5/29/08
CG	1/28/08	6/26/08*
JP	5/6/08	5/13/08
WH	5/19/08	7/30/08
TS	3/29/08	5/7/08
LW	4/7/08	6/5/08
AF	3/21/08	5/12/08
CG	4/18/08	7/18/08
VA	4/29/08	6/23/08
SO	5/28/08	6/12/08
GB	5/5/08	7/29/08
JR	4/19/08	5/27/08
KR	7/28/08	Awaiting autopsy
AG	4/10/08	6/26/08
AG	4/23/08	6/30/08
GF	3/11/08	6/11/08
Unit 401 individuals	5/7/08	8/14/08
MV	6/9/08	7/18/08

*Investigator left to attend training for several months.

A Supervising Special Investigator was hired for the Office of Special Investigations in May 2008 and the Office is fully staffed with investigators. This should make it possible for the Office to improve timeliness in completing investigations.

		Current recommendation: The Supervising Special Investigator should monitor investigations as they are progressing to offer assistance and guidance as necessary and to ensure they are completed in a timely manner.
I.1.b.iv. 3	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:	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Discontinue the practice of the IRC closing investigations. **Findings:** This recommendation has been implemented, and the IRC is reviewing only those investigations that have been closed by the Office of Special Investigations. **Recommendation 2, March 2008:** See also the recommendation in I.1.c. **Findings:** See findings in I.1.c. **Other findings:** In all of the investigations reviewed, the written report provided sufficient facts to support the conclusion drawn. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Investigate all aspects of a compound allegation. Complete two SIRs when the victims are different people.

		Findings: One investigation reviewed failed to investigate the complete allegation. In the allegation made by VA on 4/29/08, VA alleged she was sexually assaulted by an individual from another unit (named) who had a goatee and wore glasses. VA also alleged she was the victim of sexual abuse by three staff members. The allegation against the staff members was investigated and was unfounded—a reasonable determination. There was no investigation of the alleged sexual assault by another individual. **Other findings:** In the remaining 18 investigations, all allegations were investigated. However, the investigation of the 5/7/08 allegation that a staff member picks on, demeans, and threatens to put negative comments in individuals' records was substantiated as a violation of AD 2109 which relates to Staff/Individual Relationships. It should have been a founded determination of both verbal and psychological abuse. This case is still being reviewed for appropriate corrective action. **Current recommendations**: 1. Investigate all aspects of a compound allegation. 2. Ensure that investigators recognize abuse/neglect/exploitation and investigate it as such. Ensure that corrective actions reflect the seriousness of the substantiated charge.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** See the recommendation in I.1.b.iv.2. **Findings:** These recommendations have been implemented.

		Recommendation 2, March 2008: Look for additional witnesses among individuals as well as staff during investigations. **Findings:** Several of the investigations reviewed specifically identified efforts to find additional witnesses. For example, in the investigation of the allegation of physical abuse by AF on 3/21/08, the investigator interviewed several staff members and individuals who could possibly have seen the physical intervention that resulted in the allegation. In the allegation of physical abuse made by MV on 6/8/08, the investigator interviewed all staff members present during the shift when the incident occurred. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** With the exception of the investigation of the 4/29/08 allegation made by VA in which there was no attempt to identify the individual who allegedly committed a sexual assault, all investigations reviewed accurately identified the alleged victims and the alleged perpetrators. **Current recommendation**: Continue current practice.

I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** The names of all persons interviewed and a summary of the content of the interview were clearly presented in each of the investigations reviewed. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Interview all relevant parties and provide a summary of each interview that addresses the issue under investigation. **Findings:** In the investigations reviewed, this recommendation was appropriately implemented. **Recommendation 2, March 2008:** Discontinue the practice of closing incident review prior to the completion of the investigation. **Findings:** This recommendation has been implemented; incidents are reviewed by the IRC only after the investigation has been closed. **Recommendation 3, March 2008:** Encourage investigators to ask direct questions (in second interviews if

		necessary) to solicit information that will help reconcile conflicting information. **Findings:** In the investigation of the 6/8/08 allegation of physical abuse by MV, the investigator conducted a second interview of a witness to clarify conflicting information. In the investigation of the 4/7/08 allegation of physical abuse made by LW, the investigator interviewed the author of the HSS note that stated, "no such action [occurred] per all staff," asking the author if he/she had interviewed all staff. The author stated he/she had not. The two agreed that the author would be more careful in the language he/she used. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice of including copies or excerpts of relevant documents in the investigation reports as well as a listing of documents on the face sheet. **Findings:** Investigators have continued to include copies of relevant documents in the investigation files. Many investigations reviewed included copies of WRPs. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their	**Current findings on previous recommendations:**

	results, involving the alleged victim(s) and perpetrator(s);	**Recommendation 1, March 2008:** Continue current practice of documenting the results of the review of staff members' personnel and training records and individuals' incident histories as appropriate. **Findings:** The practice of documenting the training records (when relevant), the personnel history of the named staff member and the incident history of the individual was evident in the investigations reviewed. **Other findings:** In the investigation of the allegation of physical abuse made on behalf of LW on 4/7/08, the investigator appropriately sought expert opinion. The investigation concerned the use or misuse of a self-protection technique by the named staff member. The investigator asked the opinion of a PMAB trainer. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Write a short paragraph at the close of each investigation stating critical points that support the determination, acknowledging conflicting testimony and citing the relevant portion of the revised incident definition. **Findings:** The investigations reviewed cited the relevant portions of the revised definitions of abuse/neglect in making determinations. With the exception of the investigation discussed in I.1.b.iv.3(i) in which the determination failed to address the actual level of staff misconduct, all

		of the investigations reviewed reasonably supported the determinations with findings. **Current recommendation**: Continue current practice.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that investigations fairly weigh the evidence to determine preponderance in making determinations. **Findings:** This monitor found no evidence of failure to weigh evidence fairly in the investigations reviewed. **Recommendation 2, March 2008:** See also recommendation in I.1.b.iv.3(viii). **Findings:** This recommendation was adequately implemented in the investigations reviewed. **Current recommendation**: Continue current practice.
I.1.b.iv. 4	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 further inquiry in the investigation and/or report shall be	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice. **Findings:** With the exception of the investigation of VA on 4/29/08 in which

	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.	there was no investigation of alleged sexual assault by an individual with a goatee, all other investigations reviewed were thorough and complete, although many were not completed in a timely fashion, as reported in I.1.b.iv.2. **Current recommendation**: Investigation Supervisors should ensure that all allegations of abuse/neglect, sexual assault and serious injury incidents are investigated.
I.1.c	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue current practice of HR identifying and tracking the completion of recommendations from incident review and meeting with Program Directors and Discipline Chiefs to ensure the implementation of recommendations. **Findings:** Variable results were evident in the review of disciplinary actions taken in response to incidents. For example, during the investigation of the 5/5/08 verbal and physical abuse allegation make by GB, one staff member answered investigators' questions and then said she wanted to retract everything she had said since her answer indicated she had witnessed abuse and failed to report it. During a second interview, she denied witnessing the abuse she had recalled during the first interview. The investigator made the finding that the staff member failed to report abuse and was not truthful during the investigation. Review of the personnel record of the staff member indicated she was not disciplined but was given a "needs improvement" rating on her performance evaluation. In the investigation of the 3/21/08 allegation of physical abuse by AF,

		the investigator found that the named staff member had used an unapproved restraining technique. In the review by facility leadership, it was suggested that the staff member receive formal counseling for use of a one-person containment. No counseling following this incident appears in the staff member's personnel file. In contrast, counseling is pending for one staff member who failed to write an incident report, counseling was provided to another staff member who failed to write an incident report, and counseling is pending for two staff members who used unapproved methods to protect themselves. Finally, in the substantiated allegation of verbal abuse, the investigation is still under review and disciplinary action has yet to be determined. (This incident was reported on 5/7/08, but the investigation was not closed until 8/14/08.) These findings are not consistent with the hospital's findings. MSH's self-assessment indicates 100% compliance with prompt implementation of disciplinary action in the period February through July 2008. **Compliance:** Partial. **Current recommendations**: 1. Follow recommendations for disciplinary action and training closely and document their implementation. 2. Ensure that at a minimum, all staff who have been found not to have reported an incident in a timely manner be required to review reporting responsibilities. 3. Consider the appropriate corrective measure for staff members who fail to cooperate in an investigation.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results.	**Compliance:** Partial.

	Trends shall be tracked by at least the following categories:	
I.1.d.i	type of incident;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Expand the production, analysis and review of reports using incident data as the technology becomes available. **Findings:** The hospital police Record Management System is not able to provide useful reports at the present time. DMH will be meeting with the vendor to discuss this issue and come to an understanding of the capabilities of the system. The statewide incident management information system (WaRMSS) is not yet operational. The fact that these systems are not yet able to produce pattern and trending reports is negatively impacting on the hospital's ability to meet the requirements of several of the following cells of the Enhancement Plan. **Other findings:** The SIR database is capable of producing a listing of incidents by type, but it cannot produce pattern and trending reports related to incident type. This listing of incident type did not use the revised SIR definitions. The hospital's data indicates that in the period August 2007 through January 2008, nearly a quarter of all incidents (23.91%) were peer-to-peer aggression. **Current recommendations**: 1. Continue work on the statewide incident management system and with the vendor of the Record Management System, so the facilities develop the ability to track incident patterns and trends. 2. Produce and distribute on a regular basis more current information

		on incident type, using the revised definitions.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to document the incident history of individuals and the discipline/counseling/training history of named staff members. **Findings:** In most of the investigations reviewed, the investigator documented the findings of his/her review of the named staff member's personnel file and of the incident history of the individual. **Other findings:** The facility does not presently create a report of the staff members named in incidents. Creation of this kind of report will not be possible until the statewide incident reporting system is in place and/or the hospital police's Record Management System can be manipulated to produce the report. The facility presented data on the number and percent of <u>investigations</u> that identified the staff members present and involved. This does not address compliance with this cell, which is concerned with tracking and trending of staff members present and involved in incidents. This same problem (relating the cell to investigations rather than to tracking) shows in succeeding cells dealing with tracking individuals involved, location, date and time, cause and outcome. **Current recommendations**: 1. Continue work on the statewide incident reporting system and work with the vendor of the Record Management System to determine if it can produce pattern reports. 2. Produce tracking and trending reports on the variables required by

		this section of the Enhancement Plan. If these are not available, indicate progress toward meeting this goal.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Document the actions agreed upon in response to these reports in the minutes of the Performance Improvement Committee and track implementation. **Findings:** Review of the Performance Improvement Committee minutes yields little information on how and by whom the findings of the studies done by Standards Compliance will be disseminated and how the facility will assess if WRPTs are using the information, addressing the issues raised and recommendations made. The facility reports that it will identify actions to be completed in the minutes beginning in June 2008. **Recommendation 2, March 2008:** Introduce the fishbone analysis to teams serving individuals with very high needs that place them and/or others in danger. **Findings:** The facility reports that it has introduced the fishbone analysis method to teams serving individuals with high needs. **Other findings:** The facility has produced listings of individuals repeatedly involved in incidents as aggressors and those repeatedly involved as victims. See I.2.a.ii for a description. **Current recommendation:** Identify methods for evaluating whether the findings of studies and

		tracking and trending are informing treatment decisions.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue the production of incident trend reports and the conduct of focused studies. Ensure that the minutes of the Performance Improvement Committee reflect discussion of these findings and the identification of action steps. **Findings:** The facility produced a review of incidents occurring between August 1, 2007 and January 31, 2008 by location and type. Day halls, bedrooms and hallways were the locations for approximately 62% of the incidents. **Current recommendation**: Update the information presented to cover the current review period.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue the current practice of tracking the time of occurrence of incidents and determine what, if any, measures are required to address the findings in the Performance Improvement Committee or other appropriate forum. Document the discussion and the action steps. **Findings:** The hospital's review of SIRs for August 2007 through January 2008 indicates that incidents frequently occur in the afternoon and early evening. Forty-four percent of incidents occurred between 1 PM and 7 PM.

		Current recommendation: Update this report with more current information and provide some analysis.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Finalize Special Order 227.08. **Findings:** Special Order 227.08 has been finalized. **Recommendation 2, March 2008:** Review Headquarters Reportable briefs for completeness and thoroughness under the broader timeframes. **Findings:** It had been agreed quite a while ago that compliance with this cell would be judged on the completion of the analysis section of the Headquarters Reportable briefs, particularly relating to contributing factors. Special Order 227.08 provides that the briefs will be completed within 60 business days of the incident report date. Review of 13 Headquarters Reportable briefs for incidents occurring in May 2008 revealed that none had been completed. In three incidents, this was because the investigations had not yet been completed. **Other findings:** As the Incident Review Committee becomes fully functional, its deliberations should include consideration of the questions in the Headquarters Reportable briefs. This will encourage discussion of recommendations for corrective actions and facilitate the completion of the briefs.

		Current recommendations: 1. Use the Incident Review Committee as a vehicle for the discussion of questions raised in the Headquarters Reportable briefs. 2. Take whatever other measures are necessary to complete the briefs in the timeframe required.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Produce and review a report on incident type and outcome. **Findings:** The hospital police/SSI log lists the investigations opened (by date) and the outcome (substantiated or unfounded). Review of the log reveals that of the 32 cases opened in the period May-July 2008, 14 remained open at the time of the tour and two cases were substantiated. The remainder were unsubstantiated. Providing a report on the outcome of investigations should become easier and more reliable when the hospital police's Record Management System is in full operation. **Current recommendation**: As soon as practicable, use the Record Management System to produce reports for the Incident Review Committee and other relevant bodies.
I.1.e	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	**Current findings on previous recommendation:** **Recommendation, March 2008:** Discontinue the practice of closing cases before the investigation is complete.

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.

Findings:
This practice is no longer permitted in the hospital.

Other findings:
Review of the criminal background checks of 16 staff members yielded the following results:

Staff initial	Date of hire	Date of clearance
_A	5/97	3/97
_H	11/06	5/06
_J	4/78	Not available
_K	2/79	Not available
_L	12/91	12/91
_M	9/07	8/07
_M	6/97	Not available*
_N	12/05	11/05
_O	10/98	8/98
_P	2/01	9/00
_P	1/97	Not available*
_R	2/07	1/07
_S	10/99	9/99
_U	12/05	7/05
_V	9/86	Not available
_Z	12/05	10/05

Only last initials are provided to protect confidentiality.

The three individuals who began employment in the 1970s and '80s were hired before the requirement for criminal background checks. This is not the case, however, for the two staff members hired in 1997 for whom no criminal background check was available.

See also I.1.a.iii where it is reported that in the investigations

		reviewed, the named staff member was removed from contact with individuals and victims of sexual assaults by other individuals were separated from the alleged aggressors. **Compliance:** Substantial compliance, if the reason for the lack of a criminal background check for the staff members hired in 1997 can be ascertained and corrected. In previous tours, this has not been a problem. **Current recommendation:** As annual performance evaluations are received in the HR office, review the staff member's personnel file to ensure that criminal background clearance is present and take appropriate action.

2. Performance Improvement		
I.2	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:	**Methodology:** <u>Interviewed</u>: 1. R. Schneider, Central Nursing Services 2. C. Rivera, Standards Compliance 3. M. Mc Neil, Standards Compliance 4. M. A. Dehesa, Standards Compliance 5. S. Wang, Standards Compliance 6. J. Salumbides, Standards Compliance The staff members listed above were present during a group dialogue about performance indicators. Each staff member was not necessarily interviewed directly. 7. G. Hahn, Hospital Administrator 8. M. Nunley, Standards Compliance Director <u>Reviewed</u>: 1. Implementation of promised trigger responses in the clinical records of 10 individuals 2. Performance Improvement Committee minutes 3. Standards Compliance aggression study 4. Minutes of the Falls Committee 5. Study on Swallowing Foreign Objects 6. Repeat aggressor and repeat victim data 7. Aggregate trigger data
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:** Partial.

I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Increase the number and kind of reports that shed light on high-risk situations and individuals. Document the discussion of these report and the action steps identified. **Findings:** See I.2.a.ii and I.2.a.iii for a description of the facility's efforts to identify and analyze high-risk situations and guide an effective response. **Current recommendation**: Continue to undertake studies of high-risk situations and individuals. Review implementation of interventions for effectiveness with specific individuals.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Review the data and target the WRPT responses for individuals who are most frequently victimized and those who are the most frequent aggressors as a starting point to ensure an appropriate clinical response has been implemented. **Findings:** The facility produced lists by unit of individuals who were aggressors (peer-to-peer or individual-to-staff) more than once during the period February through July 2008. A similar list of individuals who were repeat victims was produced for the same period. During the review period, 74 individuals were repeat aggressors and 39 individuals were repeat victims. Of the 39, 15 (38%) required first aid or more serious medical attention.

		Recommendation 2, March 2008: Track individuals who are aggressors and victims multiple times to determine if interventions are effective. **Findings:** In addition to the lists of individuals who were repeat aggressors and repeat victims, the facility charted the aggression of seven individuals over a 19-month period and reviewed their diagnoses, type of assaults, medications, current status, and participation in Mall groups. **Other findings:** While the facility does not yet have a systematic procedure for designating interventions commensurate with level of risk, it has developed written aids for WRPTs in addressing aggression to self or others and for review of persons who trigger because of the need for one-to-one observation or for use of three or more Stat medications in seven consecutive days. Each guideline consists of a series of questions for consideration by the WRPT. Each concludes with the suggestion to seek consultation from senior clinical staff, the PBS team and BCC team as appropriate, if corrective actions have not been successful. **Current recommendations**: 1. Continue working with the other state facilities to develop and implement a risk management system that aligns interventions with the level of risk. 2. Continue the current practice of reviewing specific high-risk individuals to provide longitudinal data to the WRPT and assistance in planning interventions.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:**

		Recommendation 1, March 2008: Continue the work being done by Standards Compliance in studying high-risk situations and individuals who constitute a high risk to themselves and others. **Findings:** The Standards Compliance Department has produced an analysis of peer-to-peer aggression at the facility from April 1 through June 30, 2008. This study categorizes incidents of aggression into four types: those resulting from psychosis, impulsive, organized and undetermined. The data reveals that facility-wide, the majority (58%) of the 189 incidents were impulsive actions, with approximately equal numbers in the other three categories. Admission units had the highest prevalence of assaults, and units with individuals with borderline characteristics had the highest number of impulsive assaults. A companion study of assaults on staff by individuals was conducted. In this study also, the majority of the 154 assaults (77%) were impulsive. The authors of the studies recommended that SIRs be completed more legibly and with greater detail. The facility has not yet implemented an effective way to monitor whether WRPTs are using this information and directing interventions at the problems. The Standards Compliance study of falls continues. The July minutes of the Falls Committee report a reduction in the number of falls from 42 in the period January through March 2008 to 32 in the following three months, April through June. A Failure Mode and Effect Analysis on individuals who swallow foreign

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<td>objects was conducted comparing the number of individuals who swallowed objects and the number of swallowing incidents in October 2006 and October 2007 with the following results.

<table>
<tr><td></td><td>October 2006</td><td>October 2007</td></tr>
<tr><td># individuals who swallowed foreign objects</td><td>14</td><td>13</td></tr>
<tr><td># of swallowing events</td><td>18</td><td>19</td></tr>
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Five of the individuals who swallowed foreign objects in each of the months studied were men. Sixteen of the 27 individuals had a diagnosis of borderline personality disorder. Five individuals appear on both lists. This study concluded with a discussion of barriers to effective treatment learned from interviews with MSH staff members.

The findings from these studies are discussed in the minutes of the Performance Improvement Committee.

Current recommendations:
1. Continue the work being done by Standards Compliance in studying high-risk situations and individuals.
2. Report recommendations from studies and the review of reports like those described above from the Performance Improvement Committee to the Executive Risk Management Committee for distribution and action.
3. Develop strategies to ensure that WRPTs are using the information made available through these studies to inform treatment interventions.
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<td>I.2.b</td>
<td>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals.</td>
<td>Compliance:
Partial.</td>
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	These mechanisms shall include, but not be limited to:	
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, March 2008:** See I.2.b.ii. **Findings:** See I.2.b.ii. **Other findings:** The facility has expanded the menu of possible responses on the Trigger Response WRP Conference Tracking Form to include review of medications by the Senior Psychiatrist, review of and/or modifications to WRP foci, objectives and interventions and an "other" category (to be specified). These additions raise the number of suggested interventions to 40 items divided into five categories: assessment/ consultation, behavioral, medical, environmental and WRP. These are a menu of interventions and are not presented in a hierarchical order. See also I.2.a.ii. **Current recommendations**: 1. Continue efforts to provide guidance to WRPTs in implementing a hierarchy of interventions as the risk level for an individual rises. 2. DMH should continue efforts to develop the Protection from Harm Special Order that will provide the foundation for a hierarchy of interventions by clinical teams that correspond to triggers and thresholds.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendation:**

		Recommendation, March 2008: Implement the plan to produce and distribute a monthly report on triggers by unit with the expectation that this will increase the number of responses. **Findings:** There has been a substantive increase in the number of responses to trigger alerts from WRPCs, as reported by the hospital. During the first three months of the six-month period February through July 2008, 50% of the WRPTs responded back. During the later three-month period, the response rate was 82%. **Other findings:** The facility is not yet regularly identifying patterns and trends in trigger data, except in those instances in which Standards Compliance has undertaken a study. **Current recommendation**: Ensure that WRPTs receive information on repeat aggressors and repeat victims and other study findings relevant to the individuals they support, with the expectation that they will document their discussions of the problem and their responses, including consultations with senior clinicians and the use of enhanced psychology services.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in I.2.b.ii. **Findings:** The facility has a formalized system for notifying teams that an individual has reached a trigger. Suggested responses are printed on the bottom of the tracking form. See I.2.b.i for a description of some

		of these suggested responses. This form asks the team to identify what intervention it will implement, who will be responsible for implementation, by when the implementation will have occurred and where in the chart the intervention will be documented. This form should be shared at the Weekly Trigger Meeting with the Senior Psychiatrist. **Current recommendation**: The Senior Psychiatrist should review the form, ensuring that it is complete and that the interventions identified are adequate and commensurate with the level of risk.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, March 2008:** Same as in I.2.b.ii. **Findings:** See I.2.b.ii. **Other findings:** While the response rate from WRPTs increased substantially in the last three months of the review period (May, June, July), the facility reports in its self-assessment that there has been no corresponding increase in implementation of the promised intervention. Specifically, MSH audited 137 interventions (this represents approximately seven percent of the total number of interventions reported) in the five-month period March through July 2008 and found documentation in the individual's clinical record verifying that approximately 40% had been implemented. Review of the implementation of 10 trigger responses during June and

July yielded the following results, which are consistent with the results reported by the hospital.

Individual	Date of Response	Intervention	Documentation of implementation
KB	6/08	Adjust meds	Yes
MB	7/08	Adjust meds	Yes
NB	7/08	Teaching	Yes
CH	6/08	Implement behavior guidelines	Yes
CJ	7/08	Adjust meds	Yes
PD	7/08	Implement behavior guidelines	No
ML	7/08	Psych assessment	Yes
KS	7/08	Suicide risk assessment	No
JT	7/08	TRC consult	No
TD	7/08	Consult with senior clinical staff	No

Current recommendations:

1. Increase the number of trigger responses monitored and provide direct feedback to the teams of the results of the monitoring.
2. Report patterns and trends to the Performance Improvement Committee in order to elicit suggestions for improving performance to be forwarded to the Executive Risk Management Committee for approval and implementation.

I.2.b.v

monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.

Current findings on previous recommendation:

Recommendation, March 2008:
Same as in I.2.b.ii.

		Findings: See Findings and Recommendation in 1.2.b.ii. **Other findings:** See Findings and Recommendations in I.2.b.iv. **Current recommendation**: See I.2.b.iv.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue implementation of plans to address the facility's priorities. **Findings:** The facility has completed its Performance Improvement Plan. This document begins with mission and vision statements and lists core values that will guide the facility's provision of care and services. The purpose and duties of the Executive Risk Management, Medical Executive Committee and the Interdepartmental Performance Improvement Committee are delineated. The responsibilities of the medical and clinical/support staff are listed. The facility is working toward full implementation of this plan. **Compliance:** Partial. **Current recommendation**: Continue work on implementing the plan.

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:	**Methodology:** Interviewed: 1. H. Mears, Chief of Hospital Police 2. D. Hill, Health and Safety 3. K. Moran, Health and Safety 4. R, Washington, CSIII 5. G. Hahn, Hospital Administrator 6. B. Langley, Health and Safety The staff members listed above provided information during the tour of the residential units. Each was not necessarily interviewed independently. Reviewed 1. Environment of Care Inspection Checklists 2. Clinical records of seven individuals with the problem of incontinence. 3. Incontinence monitoring forms for February through July 2008 4. Sexual contact monitoring forms for February through July 2008 5. Clinical records for follow-up on four sexual incidents Toured: Six residential units: 407, 409, 410, 412, 414 and 416
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;	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Alert unit staff to the suicide hazard created by the ventilation screens, particularly those directly above toilets and in other private areas where furniture could be moved to access them.

		Findings: The facility reported that all Program Directors, Unit Supervisors and Nursing Coordinators were made aware of the suicide potential of the ventilation screen. In July, the Program Directors were instructed to ensure that all staff were made aware of this hazard. These same ventilation screens were still positioned over objects that could be used to facilitate threading a ligature through them, creating a suicide hazard. The temperature control knobs in some of the showers also present a suicide hazard if unattended during times the shower rooms are open. **Recommendation 2, March 2008:** Continue efforts to keep the environment clean. **Findings:** For the most part, the units toured were clean. Exceptions included one bathroom on Unit 410, which had a strong urine odor, and the bathroom on Unit 407. The shower in the female bathroom on Unit 409 was littered with paper on the floor, and there was no toilet paper and no paper towels. Urinals that needed to be cleaned were found near two beds on Unit 407. **Recommendation 3, March 2008:** Investigate the bedroom on Unit 412 discussed above and take measures to restore full bedding to the individuals. Ensure that there are no other units in the facility with restrictions that have not been approved by the Executive Director. **Findings:** This monitor found no issues related to restrictions on bedding during this tour. This is consistent with MSH's assertion that the issue was quickly resolved and no other units impose such measures.

		Recommendation 4, March 2008: Clarify procedures for getting approval for additional restrictions on individuals, so that there is documentation that approval had been received from the proper authority. **Findings:** The facility reported that in raising this issue it was determined that there was no need for such a procedure because no additional restrictions are allowed. **Recommendation 5, March 2008:** Secure the Rehabilitation building and allow individuals to fully participate in therapies until a permanent solution is provided. **Findings:** This recommendation has not yet been implemented. The Rehabilitation building remained open and some individuals' participation in rehabilitation therapies is compromised because of restraints they are required to wear. The facility reports, however, that it has taken some steps to reduce the number of individuals housed within the compound who need to use the building. Specifically, annual physical exams, asthma and hypertension clinics are now consistently conducted within the compound, thus eliminating the need for transporting individuals in shackles. **Other findings:** Review of selected items on the Environment of Care Inspection Checklists for the units inspected during the period May through July 2008 reveals the following.

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<tr><td></td><td>401</td><td>407</td><td>409</td><td>410</td><td>412</td><td>415</td><td>418</td><td>419</td></tr>
<tr><td>Bathrooms are clean</td><td>No</td><td>Yes</td><td>Yes</td><td>No</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Medical equipment is clean</td><td>No</td><td>No</td><td>NA</td><td>NA</td><td>NA</td><td>NA</td><td>Yes</td><td>No</td></tr>
<tr><td>Area free of devices for hanging</td><td>No</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Bathroom fixtures designed for suicide prevention</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td><td>No</td></tr>
<tr><td>Cut down instruments are available</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
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These findings are not inconsistent with this monitor's observations.

Compliance:
Partial.

Current recommendations:
1. Consider solutions to the ventilation placement problem.
2. Secure the Rehabilitation building and allow individuals to fully participate in rehabilitation therapies until a permanent solution is provided.
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<td>I.3.b</td>
<td>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be</td>
<td>Current findings on previous recommendation:</td>
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</table>

	promptly corrected;	**Recommendation, March 2008:** Continue current practice. **Findings:** The facility reported that in the period February through July 2008, all of the 87 work orders related to temperature were resolved on the same day they were received. All units were a comfortable temperature on the days that this monitor toured and no individuals mentioned temperature as a problem. **Other findings:** The thermometers on several units toured did not accurately record water temperature. The water in the bathroom sinks was particularly hot on Unit 407, but the thermometer reading was only 97degrees. **Compliance:** Substantial. **Current recommendations**: Replace unit thermometers for measuring water temperature.
I.3.c	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;	**Current findings on previous recommendation:** **Recommendation, March 2008:** Continue to monitor the support provided to individuals with incontinence and share this information with the programs so that they can take action to ensure adequate care and support. **Findings:** The hospital's self-assessment indicates that during the period February through July 2008, in monitoring 85% of the individuals with the problem of incontinence, 62% had the problem identified under Focus 6 and 48% had interventions that promoted decreased episodes

		of incontinence. These numbers are not inconsistent with this monitor's findings provided below. Nursing staff's ability to describe the assistance they provide to individuals received much higher ratings (91%) on the self-assessment. **Other findings:** Review of the clinical records of seven individuals named as having the problem of incontinence yielded the following results: • There were no objectives or interventions related to the problem for two individuals (EL and FG). • The WRP speaks of bladder training for MC (see note dated 9/7/08) but for the three weeks preceding that note, there was no mention in nursing documentation of bladder training. • The WRPs of the remaining four individuals contained objectives and interventions related to incontinence. **Compliance:** Partial. **Current recommendation**: Continue providing mentors to nurses in using the WaRMSS system for completing interventions in WRPs, including methods for addressing incontinence in Focus 6.
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 monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the	**Current findings on previous recommendations:** **Recommendation 1, March 2008:** Ensure that auditors are aware of the circumstances that require a SOC 341. **Findings:** The facility reports that 91% of all staff at MSH have been trained in

	individual's charts in response to instances of sexual contact; and	Abuse/Neglect reporting and 91% of the managers/supervisors have been trained in Incident Management. These figures are consistent with findings reported in I.1.a.iv for non-physician staff members. **Recommendation 2, March 2008:** Conduct a look-behind audit of a sample of cases to test the reliability of the data. Identify problems, if any, and provide the necessary training to correct the problems. **Findings:** The facility reports that some changes in the language used in the form for monitoring the hospital's response to sexual incidents may be necessary as some auditors are using "No" when "Not Applicable" would be a more accurate answer. **Other findings:** The hospital's monitoring of its response to sexual incidents indicates greater than 85% compliance in many of the activities monitored. The provision of medical and psychological assessments, the provision of psychological services and discussion by the WRPT of the need for additional action were among those activities that all fell below the 75% compliance rate. These findings are not inconsistent with this monitor's report of the follow-up on four sexual incidents reported in I.1.a.iii. **Compliance:** Partial. **Current recommendation:** Continue efforts to train staff members of specific disciplines on their responsibilities in response to sexual incidents.

I.3.e	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.	**Current findings on previous recommendation:** **Recommendation, March 2008:** Identify a method whereby the remaining staff can be trained expeditiously. **Findings:** The facility has completed the training of all non-clinical staff facilitating Mall groups, using the curriculum designed for that purpose. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The facility continues to encourage the work of the Individuals' Council, with facility leadership often attending and answering questions. 2. The Council continues to hold orderly and productive meetings and track issues through their minutes. 3. Council members continue to participate on several committees to both provide information to the staff participants and carry information back to the facility population.
J	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.	**Methodology:** <u>Interviewed</u>: 1. Several individuals while touring residential units 2. Individuals in leadership positions in the Individuals' Council <u>Reviewed</u>: 1. Petition to add several items to the "Allowables List" 2. Minutes of the Individuals' Council Meetings 3. Individuals' Council Survey results (June 2008) <u>Observed</u>: Council Senate meeting
J		**Current findings on previous recommendations:** **Recommendation 1, March 2008:** DMH should continue to exercise any influence it has in increasing the capacity of CONREP.

		Findings: The facility reported several measures that have been undertaken by MSH and DMH to work with CONREP. These include ongoing communication and the development in DMH of a centralized database that lists all individuals recommended for CONREP to track any delays and assist in placement. **Recommendation 2, March 2008:** Hold a Council meeting for the express purpose of discussing the "allowables" list. Advertise the purpose of the meeting in advance and ensure the presence of administrators, the Chief of Police, and anyone else needed to answer questions. **Findings:** The facility reported that the "allowables" list was the focus of discussion at the July meeting and a follow-up meeting would be held in September. This is consistent with the discussion that occurred during the Senate meeting that this monitor attended. **Recommendation 3, March 2008:** Ensure that procedures are in place and are working effectively to advise individuals of the results/outcome of their grievances. **Findings:** The facility reports that individuals are advised in writing of the outcomes of their grievances. During interviews, two individuals said they have received letters telling them that their problem has been forwarded to the appropriate body for resolution. **Other findings:** During the Senate meeting, one main focus of discussion was the treatment Mall. The individuals expressed their appreciation for the present scheduling pattern that gave them sufficient time to attend to

their personal needs. Individuals expressed the hope that during the one-week break between Mall sessions, individuals would be given a short vacation in which attendance at groups would not be compulsory and bedroom doors would be unlocked, permitting more rest time. It was determined that some accommodations along these lines could be made.

The June Individuals' Council Survey results indicate that 64% of the 136 individuals who completed the survey said they felt safe. Other responses are as follows:

	% positive response	
	06/08 survey	1/08 survey
Environment is clean, neat, safe	71%	78%
Have and can access personal hygiene supplies	83%	91%
Able to communicate freely with your family, attorneys and advocates	77%	
Grievance process works	46% 36% unsure	73%
Advised how grievance was resolved	44% 25% unsure	
Able to report abuse/neglect/violation of rights	83%	86%
Been taught what constitutes abuse/neglect	63%	
Ever restrained or secluded as punishment (No is a positive answer to this question)	57%	

		The percentages provided by the facility are not consistent with the raw numbers, and in all cases, except the last question on restraint and seclusion, are higher than the percentages in the chart above. The percentages in the chart are based on the raw numbers provided. **Compliance:** Substantial—based on receipt of no information indicating restrictions on First Amendment rights.