

REPORT 8

ATASCADERO STATE HOSPITAL

April 19-23, 2010

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

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Atascadero 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 Atascadero 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 Court Monitor reports:

AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure

CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
COVR	Classification of Violence Risk
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CSW	Clinical Social Worker
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms

ETRC	Enhanced Trigger Review Committee
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan

MAR	Medication Administration Record
MDO	Mentally Disordered Offender
MFT	Marriage and Family Therapist
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy

NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	<ul style="list-style-type: none"> • Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
R&R	Rule(s) and Regulation(s)

RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test

URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
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 the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Atascadero State Hospital (ASH) from April 19 to 23, 2010 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the 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 and strengthen practice. 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 and 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

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

identify the factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by ASH at the time of this review indicate stable or improved performance in a number of domains over the past six months.

2. Monitoring, mentoring and self-evaluation

a. 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.

ASH presented its self-assessment data and data comparisons as requested above.

b. ASH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.

c. The facility has made further progress in self-monitoring processes. In general, the data was well-organized and internally consistent; any exceptions are noted in the body of the report.

d. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.

e. 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.

3. Implementation of the EP

- a. Since the last review, ASH has continued to make steady and strong progress in the implementation of the EP. This progress is outlined in each corresponding section of the body of the report. As of this tour, the facility appears to have achieved substantial compliance with the vast majority of EP requirements. The facility's leadership, both administrative and clinical, and its clinical staff deserve much credit for their achievements thus far.
- b. ASH has continued to use a facility-developed information system to support its incident and risk management functions. The Data Dashboard provides a listing of all incidents (including date, type, location and SIR #) for each individual making it easier for WRPTs to ensure each incident is referenced in the WRP and addressed as appropriate. Triggers and high risk determinations are easily accessible as well. All Risk Management Committees are functioning, and senior staff are providing counsel to the Program Review Committees to strengthen their reviews, thereby working to avoid an over-reliance on higher level committees.
- c. At this point in the process, ASH and the DMH need to jointly reevaluate current status and future direction to ensure that the facility will sustain and build on its progress. As part of this process, the facility needs to respond to concerns expressed by some clinical disciplines about the processes created in response to the EP, particularly regarding the structured templates and other formats. On the one hand, the use of these templates and formats has enabled the facility to make many process improvements. However, sustained progress will be based on the ability to strike a balance between the need for structure in the documentation of services and clinicians' need for reasonable autonomy in their assessments and decision-making processes. This will require a thoughtful and creative review of all current instruments and self-monitoring requirements to ensure the following:
 - i) The format for the WRPs is simplified and streamlined to avoid unnecessary duplication within the document and with other disciplinary assessments. ASH has initiated meaningful guidelines towards this end during this review period, but more work is needed.
 - ii) ASH and other DMH facilities are empowered to make changes to templates and forms that enhance practitioners' ability to synthesize relevant information and to find ways to better balance time allocated to clinical practice and time spent in documentation of this practice.
 - iii) The issue of psychiatrists running groups for individuals who are not under their care must be resolved as soon as possible.
 - iv) The role of senior clinicians should not be limited to monitoring their staff and they should also participate in the review of difficult cases and provide support to their staffs in these situations.
- d. The key to ultimate success is the facility's ability to meet the challenge of leading and negotiating the reevaluation process skillfully. The clinical staff must have a role in this process and they are strongly encouraged to utilize established DMH communication channels. This monitor will support proposals for rational and thoughtful changes to reduce the documentation load on the clinical staff and in facilitating any transitions that may be needed from a monitoring perspective.

- e. Although much progress has been made, the DMH must continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
- f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. ASH has maintained and accelerated its progress towards this goal.

The following tables provide the minimum average number of hours of Mall services and suggested hours of participation by each discipline (as facilitators/co-facilitators) to meet EP requirements:

DMH PSR MALL HOURS

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

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.

- i. **Progress notes:** ASH has made sufficient progress in ensuring that providers of Mall groups complete the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs.
- ii. **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. Although ASH has made much progress in this area, more work is needed.
- iii. **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. 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.
- iv. **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 ASH as of February 28, 2010:

Atascadero State Hospital Vacancy Totals as of 2/28/10				
Identified Clinical Positions	Budgeted Positions		Vacancies	Vacancy Rate
	09/10 FY	Filled Positions		
Assistant Coordinator of Nursing Services	1	1	0	0.00%
Assistant Director of Dietetics	4	4	0	0.00%
Audiologist I	0	0	0	0.00%
Chief Dentist, CF	1	1	0	0.00%
Chief Physician & Surgeon, CF	1	1	0	0.00%
Chief Central Program Services	1	1	0	0.00%
Chief of Police Services & Security	1	1	0	0.00%
Clinical Dietician	12.3	9.9	2.4	19.51%
Clinical Laboratory Technologist (Safety)	2.5	1.5	1	40.00%
Clinical Social Worker (Health Facility/S)	66.5	54	12.5	18.80%
Communications Supervisor	1	1	0	0.00%
Communications Operator	10	8	2	20.00%
Coordinator of Nursing Services	1	1		0.00%
Coordinator of Volunteer Services	0	0	0	0.00%
Dental Assistant D/MH & DS	3	3	0	0.00%
Dentist, D/MH & DS	3	3	0	0.00%
Dietetic Technician (Safety)	5.6	5.6	0	0.00%

**Atascadero State Hospital Vacancy Totals
as of 2/28/10**

Identified Clinical Positions	Budgeted Positions			
	09/10 FY	Filled Positions	Vacancies	Vacancy Rate
E.E.G. Technician (Psych Tech)	1	1	0	0.00%
Food Service Technician I	54.5	44.5	10	18.35%
Food Service Technician II	31	31	0	0.00%
Hospital Police Officers	111	105	6	5.41%
Hospital Police Sergeant	15	13	2	13.33%
Hospital Police Lieutenant	4	4	0	0.00%
Hospital Worker	0	0	0	0.00%
Health Record Technician	4.3	4	0.3	6.98%
Health Record Technician II (Spec)	7	5	2	28.57%
Health Record Technician II (Supv)	1	0	1	100.00%
Health Record Technician III	0	0	0	0.00%
Health Services Specialist (Safety)	26	27	-1	-3.85%
Institutional Artist Facilitator	1	0	1	100.00%
Licensed Vocational Nurse (Safety)	2	2	0	0.00%
Medical Technical Assistant	0	0	0	0.00%
Medical Transcriber	12	12	0	0.00%
Nurse Instructor	12	12	0	0.00%
Nurse Practitioner (Safety)	21	21	0	0.00%
Nursing Coordinator (Safety)	9	7	2	22.22%
Office Technician	55	52	3	5.45%
Pathologist	0	0	0	0.00%
Pharmacist I, D/MH & DS	14	13.6	0.4	2.86%
Pharmacist II	1	1	0	0.00%

**Atascadero State Hospital Vacancy Totals
as of 2/28/10**

Identified Clinical Positions	Budgeted Positions			
	09/10 FY	Filled Positions	Vacancies	Vacancy Rate
Pharmacy Services manager	1	1	0	0.00%
Pharmacy Technician, D/MH & DS	15	14	1	6.67%
Physician & Surgeon (Safety)	17	16.5	0.5	2.94%
Podiatrist D/MH & DS	0	0	0	0.00%
Pre-licensed Pharmacist	0	0	0	0.00%
Pre-licensed Psychiatric Technician (Safety)	2	2	0	0.00%
Pre-Registered Clinical Dietician	0	0	0	0.00%
Pre-Registered Nurse (D/MD & DS)	0	0	0	0.00%
Program Assistant (Mental Dis-Safety)	8	5	3	37.50%
Program Consultant (Psychology)	0	0	0	0.00%
Program Consultant (Rehab. Therapy)	0	0	0	0.00%
Program Consultant (Social Work)	0	0	0	0.00%
Program Director (Mental Dis. - Safety)	9	8	1	11.11%
Psychiatric Nursing Education Director	1	1	0	0.00%
Psychiatric Technician (Safety)	601	581.1	19.9	3.31%
Psychiatric Technician Trainee (Safety)	48	35.1	12.9	26.88%
Psychiatric Technician Assistant (Safety)	1	1	0	0.00%
Psychiatric Technician Instructor	1	0	1	100.00%
Psychologist-HF, Clinical (Safety)	62.1	51.5	10.6	17.07%
Public Health Nurse I (D/MH & DS)	0	0	0	0.00%
Public Health Nurse II	3	2	1	33.33%
Radiologic Technologist	0	0	0	0.00%
Registered Nurse (Safety)	285	277.3	7.7	2.70%

**Atascadero State Hospital Vacancy Totals
as of 2/28/10**

Identified Clinical Positions	Budgeted Positions			
	09/10 FY	Filled Positions	Vacancies	Vacancy Rate
Rehabilitation Therapist S.F., Art-Safety	4	4	0	0.00%
Rehabilitation Therapist S.F., Dance-Safety	0	0	0	0.00%
Rehabilitation Therapist S.F., Music-Safety	15	14	1	6.67%
Rehabilitation Therapist S.F., Occup-Safety	2	2	0	0.00%
Rehabilitation Therapist S.F., Rec.-Safety	46.9	37	9.9	21.11%
Senior Psychiatrist (Specialist)	3	2	1	33.33%
Senior Psychiatrist, CF, (Supervisor)	13	12	1	7.69%
Senior Psychologist, HF (Specialist)	11	9	2	18.18%
Senior Psychologist, CF (Supervisor)	12	9	3	25.00%
Senior Psychiatric Technician (Safety)	94	78	16	17.02%
Sr. Radiologic Technologist(Specialist-Safety)	1	1	0	0.00%
Senior Special Investigator I, D/MH & DS	2	2	0	0.00%
Senior Vocational Rehab Counselor	3	1	2	66.67%
Special Investigator I, D/MH & DS	3	0	3	100.00%
Speech Pathologist I D/MH & DS	0	0	0	0.00%
Staff Psychiatrist (Safety)	68.9	21	47.9	69.52%
Supervising Registered Nurse (Safety)	2	1	1	50.00%
Teacher-Adult Educ.	20.8	12	8.8	42.31%
Teaching Assistant	7	7	0	0.00%
Unit Supervisor (Safety)	31	23	8	25.81%
Vocational Services Instructor	4	4	0	0.00%
Vocational Rehabilitation Counselor	0	0	0	0.00%

Key vacancies at this time based on this data include special investigators, psychiatric technicians, clinical social workers, rehabilitation therapists, psychologists and unit supervisors. The data indicate a critical number of vacancies for staff psychiatrists, but do not reflect positions filled on a contract basis.

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 to adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends.
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any facility maintains substantial compliance with all requirement of any section of the EP for 18 months (four consecutive tours), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital October 18 to 22, 2010.
2. The Court Monitor's team is scheduled to tour Patton State Hospital June 7 to 11, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively “therapeutic and rehabilitation services”) for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. ASH has achieved substantial compliance with all requirements of Section C.1. 2. ASH has achieved substantial compliance with the requirements in Section C.2, except for one requirement regarding proper formulation of objectives of treatment/rehabilitation. 3. ASH has maintained effective training and mentoring programs, and made further and appropriate refinements in these programs, in order to ensure continued progress in the implementation of EP requirements in sections C.1 and C.2. 4. Progress note completion and timeliness has improved significantly. 5. ASH has reduced the Mall cancellation rate. 6. ASH has increased the number of strategies, activities, and incentive systems to reduce non-adherence and to encourage/motivate individuals to adhere to their scheduled Mall groups. 7. ASH has increased the offerings of supplemental activities, improved its organization and methods of delivery, and completed a high percentage of the schedule supplemental activities. 8. ASH has improved its assessment and services for family therapy/education.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Charlie Joslin, Clinical Administrator 2. Donna Nelson, Director, Standards Compliance Department 3. Jan Alarcon, PhD, WRP Master Trainer <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The Streamlined Wellness and Recovery Plan Guidelines, two documents 2. ASH WRP Observation Monitoring summary data (September 2009-February 2010) 3. ASH Clinical Chart Auditing Form summary data (September 2009-February 2010) 4. ASH WRP Team Facilitator Observation Monitoring Form summary data (September 2009-February 2010) 5. ASH data regarding staffing ratios on admissions and long-term units (September 2009-February 2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 1A) for monthly review of JJC 2. WRPC (Program I, unit 1A) for quarterly review of HLC 3. WRPC (Program I, unit 12B) for monthly review of LCC 4. WRPC (Program I, unit 12B) for monthly review of REN 5. WRPC (Program I, unit 17) for quarterly review of MJE 6. WRPC (Program III, unit 14) for quarterly review of AG 7. WRPC (Program III, unit 21B) for monthly review of FT 8. WRPC (Program IV, unit 16A) for 7-day review of ES 9. WRPC (Program IV, unit 16A) for annual review of AED 10. WRPC (Program IV, unit 2A) for quarterly review of DRM 11. WRPC (Program VI, unit 18A) for quarterly review of SDH 12. WRPC (Program VI, unit 7A) for quarterly review of KVK 13. WRPC (Program VII, unit 23A) for monthly review of WCB

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		14. WRPC (Program VII, unit 26A) for annual review of RLH
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. • Continue to monitor this requirement. <p>Findings:</p> <p>During this review period, ASH has developed and implemented (in February 2010) guidelines to WRPTs to streamline the structure of the WRPs and the review by the teams of these plans. The guidelines were intended to minimize duplication and redundancy in the teams' reviews and documentation of the reviews while providing the needed information. The guidelines addressed documentation in the following areas:</p> <ol style="list-style-type: none"> 1. Diagnosis; 2. Legal status; 3. Case formulation (pertinent history; predisposing, precipitating and perpetuating factors; previous treatment and response; and present status); 4. Life goals; 5. Discharge criteria; 6. Focus of hospitalization; 7. Objectives; and 8. Interventions. <p>In general, these guidelines were appropriate and meaningful. However, some more work is needed to further optimize the WRP review process and the documentation workload (e.g. the review of all medical conditions during the meetings, the discussion of all risk factors regardless of</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

relevancy to the individual's clinical condition and the duplication of information in the sections regarding discharge criteria and barriers to discharge).

In addition, the facility's actions included the following:

1. Created new case examples (with worksheets) in the areas of engagement of the individual, case formulation, foci, objectives and interventions, and Mall integration; and
2. Refined the training module regarding the Case Formulation (to align with the guidelines for streamlining), including new templates for documentation of treatment refusals; use of restraint/seclusion, advanced directives and end of life concerns; and the review of risk factors.

The facility continued to monitor WRP training. The following is a summary of the data for this review period:

Overview training		
Discipline	Previous review	Current review
MD	95%	96%
PhD	97%	98%
SW	100%	99%
RT	99%	97%
RN sponsors	99%	99%
PT sponsors	99%	99%

Engagement		
Discipline	Previous review	Current review
MD	92%	98%
PhD	98%	98%
SW	100%	99%

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		RT	100%	100%
		RN sponsors	97%	98%
		PT sponsors	97%	99%
Foci and Objectives				
		Discipline	Previous review	Current review
		MD	89%	98%
		PhD	98%	98%
		SW	100%	99%
		RT	100%	100%
		RN sponsors	98%	99%
		PT sponsors	97%	99%
Interventions and Mall Integration				
		Discipline	Previous review	Current review
		MD	93%	100%
		PhD	98%	98%
		SW	100%	99%
		RT	100%	100%
		RN sponsors	97%	99%
		PT sponsors	96%	99%
Discharge Planning				
		Discipline	Previous review	Current review
		MD	93%	100%
		PhD	98%	98%
		SW	100%	99%
		RT	100%	100%
		RN sponsors	98%	99%
		PT sponsors	97%	98%

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		Case Formulation		
		Discipline	Previous review	Current review
		MD	92%	97%
		PhD	98%	98%
		SW	100%	99%
		RT	100%	100%
		RN sponsors	98%	100%
		PT sponsors	97%	99%
		<p>Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WPRCs held each month (September 2009-February 2010):</p>		
		1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	99%
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	98%		
<p>Comparative data indicated improvement in compliance since the previous review period:</p>				
		period	Current period	
Mean compliance rate				
1.		65%	99%	
2.		74%	98%	

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		<p>Other findings: This monitor and his experts attended 14 WRPCs. In general, the meetings indicated that ASH has maintained substantial compliance with EP requirements regarding the process of WRP reviews.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue efforts to streamline the process (and content) of WRP review and documentation of this review. 3. Continue to monitor this requirement. 			
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1227 1892 1305"> <tr> <td data-bbox="993 1227 1087 1305">1.</td> <td data-bbox="1087 1227 1793 1305"><i>Each team is led by a clinical professional who is involved in the care of the individual.</i></td> <td data-bbox="1793 1227 1892 1305">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%			

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		<p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 56% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="993 414 1892 716"> <tr> <td data-bbox="993 414 1087 451">1.</td> <td data-bbox="1087 414 1797 451"><i>The team psychiatrist was present.</i></td> <td data-bbox="1797 414 1892 451">97%</td> </tr> <tr> <td data-bbox="993 451 1087 526">2.</td> <td data-bbox="1087 451 1797 526"><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td data-bbox="1797 451 1892 526">100%</td> </tr> <tr> <td data-bbox="993 526 1087 639">3.</td> <td data-bbox="1087 526 1797 639"><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td data-bbox="1797 526 1892 639">100%</td> </tr> <tr> <td data-bbox="993 639 1087 716">4.</td> <td data-bbox="1087 639 1797 716"><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td data-bbox="1797 639 1892 716">99%</td> </tr> </table> <p>Comparative data indicated that maintenance of a compliance rate of at least 90% for items 1-3 and improvement in compliance from 85% in the previous review period for item 4.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present.</i>	97%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%	4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	99%
1.	<i>The team psychiatrist was present.</i>	97%												
2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%												
3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%												
4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	99%												
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual</p>												

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		<p>WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 305 1887 342"> <tr> <td data-bbox="993 305 1087 342">2.</td> <td data-bbox="1087 305 1793 342"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1793 305 1887 342">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	100%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	100%			
C.1.d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1157 1887 1308"> <tr> <td data-bbox="993 1157 1087 1308">1.</td> <td data-bbox="1087 1157 1793 1308"><i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1793 1157 1887 1308">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 65% in the previous review period.</p>	1.	<i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	99%
1.	<i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	99%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 857 1887 1045"> <tr> <td data-bbox="993 857 1087 1045">3.</td> <td data-bbox="1087 857 1793 1045"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitation services.</i></td> <td data-bbox="1793 857 1887 1045">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitation services.</i>	100%
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<p>C.1.f</p>	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate for the review period was 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
<p>C.1.g</p>	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1227 1887 1412"> <tr> <td data-bbox="991 1227 1087 1412"> <p>5.</p> </td> <td data-bbox="1087 1227 1793 1412"> <p><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p> </td> <td data-bbox="1793 1227 1887 1412"> <p>100%</p> </td> </tr> </table>	<p>5.</p>	<p><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p>	<p>100%</p>
<p>5.</p>	<p><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p>	<p>100%</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue efforts to increase attendance of WRPT members at WRPCs.</p> <p>Findings: ASH presented core WRPT member attendance data based on an average sample of 22% of quarterly and annual WRPCs held during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 932 1755 1276"> <thead> <tr> <th></th> <th>review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>93%</td> <td>94%</td> </tr> <tr> <td>Psychiatrist</td> <td>94%</td> <td>97%</td> </tr> <tr> <td>Psychologist</td> <td>65%</td> <td>83%</td> </tr> <tr> <td>Social Worker</td> <td>70%</td> <td>78%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>75%</td> <td>82%</td> </tr> <tr> <td>Registered Nurse</td> <td>97%</td> <td>98%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>81%</td> <td>91%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>		review period	Current review period	Individual	93%	94%	Psychiatrist	94%	97%	Psychologist	65%	83%	Social Worker	70%	78%	Rehabilitation Therapist	75%	82%	Registered Nurse	97%	98%	Psychiatric Technician	81%	91%
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		<p>Current recommendation: Continue to monitor this requirement.</p>																																													
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Ensure compliance with the required ratios on the admission and long-term units. • Provide data regarding case loads on both the admission and long-term units. <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="993 711 1682 1321"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:12</td> <td>1:12</td> </tr> <tr> <td>PhDs</td> <td>1:18</td> <td>1:16</td> </tr> <tr> <td>SWs</td> <td>1:14</td> <td>1:14</td> </tr> <tr> <td>RTs</td> <td>1:13</td> <td>1:13</td> </tr> <tr> <td>RNs</td> <td>1:6</td> <td>1:6</td> </tr> <tr> <td>PTs</td> <td>1:4</td> <td>1:3</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:21</td> <td>1:19</td> </tr> <tr> <td>PhDs</td> <td>1:42</td> <td>1:30</td> </tr> <tr> <td>SWs</td> <td>1:36</td> <td>1:27</td> </tr> <tr> <td>RTs</td> <td>1:37</td> <td>1:30</td> </tr> <tr> <td>RNs</td> <td>1:10</td> <td>1:10</td> </tr> <tr> <td>PTs</td> <td>1:5</td> <td>1:5</td> </tr> </tbody> </table>		Previous review period	Current review period	Admission Units			MDs	1:12	1:12	PhDs	1:18	1:16	SWs	1:14	1:14	RTs	1:13	1:13	RNs	1:6	1:6	PTs	1:4	1:3	Long-Term Units			MDs	1:21	1:19	PhDs	1:42	1:30	SWs	1:36	1:27	RTs	1:37	1:30	RNs	1:10	1:10	PTs	1:5	1:5
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as C.1.a through C.1.f.</p> <p>Findings: Same as C.1.a through C.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as C.1.a through C.1.f.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brooke Hatcher, RT, Supplemental Activities Coordinator 2. Charlie Joslin, Clinical Administrator 3. Christine Mathiesen, PhD, C-PAS Director 4. Dawn Hartman, Assistant Director of Dietetics 5. Deborah Hewitt, PhD, PBS Team Member 6. Debra Crawford, LCSW, Senior Supervising Social Worker 7. Donna Nelson, Director, Standards Compliance Department 8. Erin Dengate, Assistant Director of Dietetics 9. Gene Courter, Social Worker 10. Glenn Potts, PhD 11. Jan Alarcon, PhD, WRP Master Trainer 12. Jean Adams, Unit Supervisor 13. Jon DeMorales, Executive Director 14. Joshua Goible, RT 15. Karen Dubiel, Assistant to the Clinical Administrator 16. Katherine Bailey, PT 17. Killorin Riddell, PhD, Coordinator of Psychology Specialty Services 18. Ladonna Decou, Chief of Rehabilitation 19. Mary Marble, PT, Assistant to By Choice Coordinator 20. Matthew Hennessy, PhD, Mall Director 21. Michael Robin, M.D 22. Michael Tandy, PhD, PBS Team Member 23. Peggy Hoshino, PT, By Choice Representative 24. Rachelle Rianda, Acting Senior Rehabilitation Therapist 25. Rafael Romero, U.S, By Choice Coordinator 26. Wendi Stivers, PT <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 101 individuals: ACR, AED, AF, AFC, AJS,

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		<p>AM, AMM, ARC, AW, AY, BHR, CE, CJB, CJF, CK, CMD, CN, CP, DB, DEW, DH, DJW, DLA, DLM, DS, DSH, DST, DY, EA, EME, ES, FAT, FB, FKB, GE, GP, GTM, HLC, HTV, JAJ, JB, JCA, JF, JG, JGA, JHG, JJC, JJJ, JM, JMP, JNA, JR, JRF, JSB, JSR, JZR, KB, KEP, KH, KJR, LC, LJR, MAE, MD, MDM, MER, MH, MJ, MJG, MK, MR, NB, NL, PC, PRG, RA-1, RA-2, RAB, RAL, RDB, RDD, RLJ, RM, RMM, RP, RR, RRV, RS, RSC, RSP, RWG, SB, SDH, SJG, SS, TAQ, TC, TH, TMH, WCB and WS</p> <ol style="list-style-type: none"> 2. One WRP per unit for the following 30 individuals: AJ, COH, DS, EAG, GHF, JAF, JFW, JRW, JWW, JJN, JM, JV, KNG, MJG, MP, MPS, ODM, PC, QRB, PJC, PMR, RA, RB, RDT, RJH, SAG, TAS, TE, TW, and WJP 3. CPAS Neuropsychology Section - Brain Fitness Groups Quick Reference Guide 4. Lesson plans for the following: <ul style="list-style-type: none"> • Sport Stacking Challenge: Building Mind-Body Connections PSR Mall Group • Brain Fitness: Basics • Brain Fitness: Attention • Memory Rehabilitation Brain Fitness: Memory • Brain Fitness: Reasoning • Brain Fitness Get With It 5. Objective Checklists for the following groups: <ul style="list-style-type: none"> • Brain Fitness: Memory Group • Brain Fitness: Basic Group • Brain Fitness: Attention Group • Brain Fitness: Reasoning Group 6. ASH WRP Observation Monitoring summary data (September 2009-February 2010) 7. ASH Clinical Chart Auditing Form summary data (September 2009-February 2010) 8. ASH Chart Auditing Form summary data (September 2009-February 2010)
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		<ol style="list-style-type: none"> 9. ASH Substance Abuse Auditing Form summary data (September 2009-February 2010) 10. Medication Education Assessment pre-/post-test on the following four individuals: AN, JC, JO, and JS 11. Medication Education attendance issues 12. AD#415, Individual and Family Education Operating Manual 13. AD#422, Morning Motivational Meetings Operational Manual 14. ASH Chart Auditing Form summary data (September 2009-February 2010) 15. ASH WRP Observation Monitoring summary data (September 2009-February 2010) 16. Course outline and description for Language and Cognitive Services PSR Mall Group 17. Family Therapy Needs Assessment Survey 18. Gymnasium Orientation and Policy and Procedure Manual 19. List of individuals assessed to need family therapy 20. List of individuals in groups for non-English speakers 21. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 22. List of individuals with civil commitment 23. List of scheduled exercise groups 24. List of scheduled supplemental activities 25. List of scheduled vs canceled appointments 26. List showing Physical Wellness Groups 27. Mall Curriculum Committee minutes 28. Mall Facilitator Observation Data 29. Mall non-adherence trigger list 30. New Mall Group titles during this review period 31. PSR Mall Facilitator Consultation Checklists 32. PSR Mall Notes compliance report 33. Psychosocial Enrichment Activity List
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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 1A) for monthly review of JJC 2. WRPC (Program I, unit 1A) for quarterly review of HLC 3. WRPC (Program I, unit 12B) for monthly review of LCC 4. WRPC (Program I, unit 12B) for monthly review of REN 5. WRPC (Program I, unit 17) for quarterly review of MJE 6. WRPC (Program III, unit 14) for Quarterly review of AG 7. WRPC (Program III, unit 21B) for monthly review of FT 8. WRPC (Program IV, unit 2A) for quarterly review of DRM 9. WRPC (Program IV, unit 16A) for 7-Day review of ES 10. WRPC (Program IV, unit 16A) for annual review of AED 11. WRPC (Program VI, unit 7A) for quarterly review of KVK 12. WRPC (Program VI, unit 18A) for quarterly review of SDH 13. WRPC (Program VII, unit 23A) for monthly review of WCB 14. WRPC (Program VII, unit 26A) for annual review of RLH 15. PSR Mall group: Wellness and Recovery Action Planning (WRAP) 16. PSR Mall group: Problem Solving 17. PSR Mall group: Anger Management 18. PSR Mall group: Stress Management 19. PSR Mall group: Chi Gong 20. PSR Mall group: Emotion Management
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Provide a summary outline of changes in WRPT training and mentoring regarding engagement of individuals during the reporting period. • Provide comparative data from previous to current review period related to percentage of staff who have successfully completed TMET training. <p>Findings: Same as in C.1.a.</p>

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		<p>Recommendation 3, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 21% of the WRPCs held each month during the review period (September 2009-February 2010). The following table summarizes the data:</p> <table border="1" data-bbox="993 638 1885 786"> <tr> <td data-bbox="993 638 1087 786">6.</td> <td data-bbox="1087 638 1793 786"><i>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.</i></td> <td data-bbox="1793 638 1885 786">99%</td> </tr> </table> <p>Comparative data indicated improvement from 88% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>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.</i>	99%
6.	<i>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.</i>	99%			
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	Current findings on previous recommendation:			

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	<p>admission;</p>	<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (September 2009-February 2010). Based on an average sample of 20% of the A-WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 20% of the 7-day WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>Other findings: A review of the charts of ten individuals admitted during the review period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 894 1650 1125"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>20%</td> <td>98%</td> </tr> <tr> <td>Monthly</td> <td>20%</td> <td>99%</td> </tr> <tr> <td>Quarterly</td> <td>21%</td> <td>100%</td> </tr> <tr> <td>Annual</td> <td>22%</td> <td>95%</td> </tr> </tbody> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all review frequencies.</p> <p>Other findings: A review of the charts of ten individuals admitted during the review period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH) found substantial compliance in all cases.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	20%	98%	Monthly	20%	99%	Quarterly	21%	100%	Annual	22%	95%
WRP Review	Mean sample size	Mean compliance rate															
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Monthly	20%	99%															
Quarterly	21%	100%															
Annual	22%	95%															

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: ASH assessed compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 24% to 100% of the relevant population for each sub-indicator during the review period (September 2009-February 2010).</p> <table border="1" data-bbox="991 933 1885 1118"> <tr> <td data-bbox="991 933 1087 1118">2.</td> <td data-bbox="1087 933 1791 1118"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 933 1885 1118">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 74% in the previous review period.</p> <p>Recommendation 2, October 2009: Address the process deficiencies outlined by this monitor regarding the care of individuals diagnosed with seizure disorders as part of EP requirements in Section F.7.a.</p>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	98%
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	98%			

		<p>Findings: See F.7.a.</p> <p>Other findings: A review of the charts of 15 individuals who were diagnosed with a variety of cognitive (DST, GP, JR, MH, MJG, RR, RRV and RS) and seizure disorders (DLM, KJR, MR, PRG, RAB, RRV, SW and TAQ) [RRV was in both categories] found evidence of further and significant progress in the following areas:</p> <ol style="list-style-type: none"> 1. Learning-based objectives and interventions to address the needs of individuals diagnosed with dementing illnesses and seizure disorders; 2. Review of the present status of individuals diagnosed with cognitive impairments or seizure disorders; 3. Formal cognitive remediation interventions for individuals diagnosed with cognitive disorders, including but not limited to the following examples: <ol style="list-style-type: none"> a. Dementia Due to General Medical Condition with Behavioral Disturbances (GP and MH); b. Mild Mental Retardation (MJG and RRV); and c. Cognitive Disorder NOS (JR and RS); 4. Informal cognitive strategies for individuals diagnosed with cognitive impairments who did not receive formal interventions (e.g. DST, GP and RR); 5. Timely neuropsychological assessments that met generally accepted standards (e.g. RRV); and 6. Use of long-term high-risk medications (anticholinergics and benzodiazepines) for individuals diagnosed with cognitive impairments (none of the individuals reviewed had concomitant diagnosis of cognitive impairment). <p>The review found a few process deficiencies as follows:</p>
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		<ol style="list-style-type: none">1. Individuals diagnosed with cognitive impairments:<ol style="list-style-type: none">a. The WRP did not include objectives to address a diagnosis of Cognitive Disorder NOS in one individual (JR). However, this individual was assigned to groups that were appropriate to his cognitive limitations.b. The psychiatric progress notes did not provide adequate rationale to justify the long-term treatment with an anticholinergic medication (trihexyphenidyl) for an individual diagnosed with Dementia Due to General Medical Condition with Behavioral Disturbances (MH). In this case, the documented rationale included the medication's presumed benefits in lowering the blood pressure of the individual. This rationale appeared to be medically inappropriate. However, there was documentation of adequate tracking of the individual's cognitive status while receiving this treatment and no evidence of worsening of this status as a result of this treatment.2. Individuals diagnosed with seizure disorders:<ol style="list-style-type: none">a. The WRPs of some individuals (DLM, KJR, PRG and RAB) included an objective statement of learning ways to manage seizure disorder. The statement was vague and not based on appropriate learning outcomes. However, the interventions listed were appropriate to the individuals' needs.b. In general, the WRPs did not include objectives/interventions to assess the risks of treatment with older anticonvulsant medication (phenytoin) and to minimize its impact on the individual's behavioral and/or cognitive status (DLM, KJR, MR and TAQ).c. The neurological consultation for an individual who reportedly suffered from recurrence of seizure or seizure-like activity did not address this issue (KJR). <p>Based on these reviews there was evidence of substantial compliance in 10 charts (DST, GP, MH, MJG, PRG, RAB, RR, RRV, RS and SW) and, partial</p>
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		<p>compliance in five (DLM, JR, KJR, MR and TAQ).</p> <p>The facility presented data showing that the PSR Mall has added seven additional hours of Mall Courses targeted at cognitive rehabilitation. These courses included two hours of Sports Tracking, two hours of Language and Cognitive services, two hours of Brain Fitness-Reasoning and one hour of Brain Fitness-Basics. The total hours of courses offered was increased from 27 during the last reporting period to 34 hours during this review period. In addition, the following process and qualitative improvements were made:</p> <ol style="list-style-type: none">1. New topics were added to the memory and Basics lesson plans;2. More materials were acquired to increase the number of activities within all lesson plans;3. The process of referral was streamlined to improve accountability and tracking through the use of the Task Tracker; and4. The names of courses were modified based on staff and individuals' feedback. <p>In addition, this monitor interviewed the facility's neuropsychologist, Christine Mathiesen, PhD to discuss the changes in cognitive remediation interventions during this review period. This review confirmed that ASH has made further and significant improvements in the number, range and content of cognitive remediation interventions as well as in streamlining the referral process for these interventions since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	Compliance: Substantial.			
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 971 1885 1117"> <tr> <td data-bbox="991 971 1087 1117">3.</td> <td data-bbox="1087 971 1789 1117"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1789 971 1885 1117">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p>The 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.</p>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	100%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	100%			

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		<p>Other findings: This monitor reviewed one WRP per unit for the following 30 individuals: AJ, COH, DS, EAG, GHF, JAF, JFW, JRW, JWW, JJN, JM, JV, KNG, MJG, MP, MPS, ODM, PC, QRB, PJC, PMR, RA, RB, RDT, RJH, SAG, TAS, TE, TW and WJP. The review found that the facility has maintained progress in the overall structure and content of the case formulation. Furthermore, the facility has made adequate correction of the previously mentioned deficiency in ensuring that the Present Status section documents planned modifications of treatment in response to the use of restrictive interventions.</p> <p>As mentioned in Section C.1.a, the facility has developed adequate guidelines to streamline the review and presentation of data in the case formulation in order to avoid unnecessary duplication of information.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Continue efforts to streamline the review and presentation of data in the case formulation. 			
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1" data-bbox="991 971 1887 1118"> <tr> <td data-bbox="991 971 1087 1118">4.</td> <td data-bbox="1087 971 1793 1118"><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td data-bbox="1793 971 1887 1118">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 69% in the previous review period.</p>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	99%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	99%			
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<table border="1" data-bbox="991 1310 1887 1416"> <tr> <td data-bbox="991 1310 1087 1416">5.</td> <td data-bbox="1087 1310 1793 1416"><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td data-bbox="1793 1310 1887 1416">100%</td> </tr> </table>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	100%
5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	100%			

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		Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.			
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	<table border="1"> <tr> <td>6.</td> <td><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	100%
6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	100%			
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<table border="1"> <tr> <td>7.</td> <td><i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 69% in the previous review period.</p>	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	96%
7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>	96%			
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	<table border="1"> <tr> <td>8.</td> <td><i>The case formulation enables 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.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% in the previous review period.</p>	8.	<i>The case formulation enables 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.</i>	99%
8.	<i>The case formulation enables 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.</i>	99%			

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<p>C.2.e</p>	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, ASH assessed compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 560 1883 747"> <tr> <td data-bbox="991 560 1087 747">4.</td> <td data-bbox="1087 560 1789 747"><i>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).</i></td> <td data-bbox="1789 560 1883 747">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the records of 20 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational, physical and speech therapy treatment) to assess compliance with the requirements of C.2.e. Nineteen records were in substantial compliance (ACR, AFC, ARC, CE, DB, FAT, JAJ, JB, JRF, JSB, JZR, KH, LJR, MER, MJ, RA, RS, RWG and SDH) and one record was in partial compliance (TC).</p> <p>This monitor also reviewed the records of 16 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. Fifteen records were in substantial compliance (AY, EA, GE, HTV, JJJ, JM, JNA, JSR, MDM, MJ, RDB, RDD, RP, RSP and</p>	4.	<i>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).</i>	100%
4.	<i>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).</i>	100%			

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		<p>SJG) and one record was in partial compliance (DS).</p> <p>Finally, this monitor reviewed the records of 13 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, ASH assessed compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 20% of the quarterly and annual WRPs due each month during the review</p>

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		<p>period (September 2009-February 2010):</p> <table border="1" data-bbox="993 266 1887 526"> <tr> <td data-bbox="993 266 1087 526">5.</td> <td data-bbox="1087 266 1793 526"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that builds on the individual's strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1793 266 1887 526">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 80% in the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (AJS, AM, BHR, DLM, SS and WCB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that builds on the individual's strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	97%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that builds on the individual's strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	97%			
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, ASH assessed compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p>			

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		<table border="1" data-bbox="991 191 1885 342"> <tr> <td data-bbox="991 191 1094 342">6.</td> <td data-bbox="1094 191 1791 342"><i>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.)</i></td> <td data-bbox="1791 191 1885 342">100%</td> </tr> </table> <p data-bbox="991 386 1925 451">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 500 1925 597">Other findings: A review of the charts of six individuals found substantial compliance in all cases (AJS, AM, BHR, DLM, SS and WCB).</p> <p data-bbox="991 646 1925 711">Compliance: Substantial.</p> <p data-bbox="991 760 1925 824">Current recommendation: Continue to monitor this requirement.</p>	6.	<i>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.)</i>	100%
6.	<i>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.)</i>	100%			
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p data-bbox="991 868 1925 901">Current findings on previous recommendation:</p> <p data-bbox="991 941 1925 1006">Recommendation, October 2009: Continue to monitor this requirement.</p> <p data-bbox="991 1047 1925 1193">Findings: The facility reported a mean compliance rate of 100%. Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p data-bbox="991 1234 1925 1339">Other findings: Chart reviews found substantial compliance in three cases (AJS, BHR and SS) and partial compliance in three (AM, DLM and WCB).</p>			

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		<p>Compliance: Partial.</p> <p>Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (AJS, AM, BHR, DLM, SS and WCB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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		<p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (AJS, AM, BHR, DLM, SS and WCB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2009:</p> <ul style="list-style-type: none"> • Monitor hours of active treatment (scheduled and attended). • Present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period). • Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals. <p>Findings: ASH presented the following data for the review period (September 2009-February 2010):</p>

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		<table border="1"> <thead> <tr> <th colspan="3">Number of individuals by category</th> </tr> <tr> <th></th> <th>Mean scheduled hours</th> <th>Mean attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>992</td> <td>992</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>44</td> <td>635</td> </tr> <tr> <td>6-10</td> <td>169</td> <td>209</td> </tr> <tr> <td>11-15</td> <td>464</td> <td>124</td> </tr> <tr> <td>16-20</td> <td>315</td> <td>25</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="3">Mall Attendance</th> </tr> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>652</td> <td>635</td> </tr> <tr> <td>6-10 hours</td> <td>223</td> <td>209</td> </tr> <tr> <td>11-15 hours</td> <td>114</td> <td>124</td> </tr> <tr> <td>16-20+ hours</td> <td>93</td> <td>25</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Hours in last month of period</td> </tr> <tr> <td>Mean scheduled</td> <td>12</td> <td>15</td> </tr> <tr> <td>Mean attended</td> <td>3</td> <td>6</td> </tr> </tbody> </table> <p>As the table above shows, both the mean hours scheduled (15 vs 12) and mean hours attended (6 vs 3) improved over the previous review period.</p> <p>As the data indicates, attendance drops off in the higher-hour categories of both scheduling and attendance. The Mall Director and the Mall Services staff have done an impressive job of analyzing the attendance data in every way possible (for example, attendance by focus of</p>	Number of individuals by category				Mean scheduled hours	Mean attended hours	N	992	992	Hours:			0-5	44	635	6-10	169	209	11-15	464	124	16-20	315	25	Mall Attendance				period	Current period	Mean number of individuals			0-5 hours	652	635	6-10 hours	223	209	11-15 hours	114	124	16-20+ hours	93	25		Previous period	Current period	Hours in last month of period			Mean scheduled	12	15	Mean attended	3	6
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		<p>hospitalization, attendance by group, attendance by providers, attendance by length of stay, attendance by group cognitive level, and attendance by primary commitment) to assess non-adherence to Mall groups. Non-adherence is being addressed through a variety of therapies and activities including Narrative Restructuring Therapy, Motivational Interviewing, individual counseling, morning motivational meetings, announcements through the PA system ("Mall infomercials"), increased incentives, presentation of attendance certificates, home unit treatment planning and goal-setting groups.</p> <p>Other findings: This monitor reviewed the charts of six individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:</p> <table border="1" data-bbox="991 781 1831 1088"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>BB</td> <td>20</td> <td>17</td> <td>10</td> </tr> <tr> <td>DH</td> <td></td> <td>20</td> <td>14</td> </tr> <tr> <td>EB</td> <td>19</td> <td>19</td> <td>7</td> </tr> <tr> <td>GC</td> <td>12</td> <td>12</td> <td>8</td> </tr> <tr> <td>HC</td> <td>18</td> <td>20</td> <td>18</td> </tr> <tr> <td>MA</td> <td>10</td> <td>15</td> <td>8</td> </tr> </tbody> </table> <p>20</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor hours of active treatment (scheduled and attended). 2. Continue to present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period 	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	BB	20	17	10	DH		20	14	EB	19	19	7	GC	12	12	8	HC	18	20	18	MA	10	15	8
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours																											
BB	20	17	10																											
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HC	18	20	18																											
MA	10	15	8																											

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		<p>compared to current period and last month of current period).</p> <p>3. Continue to address factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.</p>			
C.2.f.vii	<p>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</p>	<p>This requirement is not applicable to ASH at this time.</p>			
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on a mean sample of 19% of the census each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1044 1885 1344"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"> <p><i>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.</i></p> </td> <td style="width: 15%; text-align: center;">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	1.	<p><i>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.</i></p>	99%
1.	<p><i>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.</i></p>	99%			

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		<p>least 90% from the previous review period.</p> <p>A review of the charts of ten individuals found substantial compliance in all ten (DB, DH, DJW, EAA, FB, JG, NB, PC, RLJ and RM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.g.i	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in five cases (AJS, AM, BHR, DLM and SS) and partial compliance in one</p>

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		<p>WCB).</p> <p>Additionally, this monitor reviewed the records of 14 individuals receiving direct occupational, speech and physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 91% of individuals placed in seclusion and/or restraints each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1149 1885 1341"> <tr> <td data-bbox="991 1149 1087 1341">12.</td> <td data-bbox="1087 1149 1791 1341"><i>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).</i></td> <td data-bbox="1791 1149 1885 1341">90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 47% in the</p>	12.	<i>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).</i>	90%
12.	<i>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).</i>	90%			

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		<p>previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during the current review period. This review focused on the documentation in the Present Status section of the circumstances leading to the use of restrictive interventions, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The following table lists the initials of these individuals and the dates of the use of restrictive interventions:</p> <table border="1" data-bbox="991 634 1541 902"> <thead> <tr> <th>Initials</th> <th>Dates</th> </tr> </thead> <tbody> <tr> <td>BHR</td> <td>2/25/10</td> </tr> <tr> <td>CJF</td> <td>2/25/10</td> </tr> <tr> <td>CK</td> <td>3/18/10</td> </tr> <tr> <td>GTM</td> <td>2/12/10</td> </tr> <tr> <td>MAE</td> <td>3/17/10</td> </tr> <tr> <td>MD</td> <td>3/2/10</td> </tr> </tbody> </table> <p>The review found substantial compliance in five charts (BHR, CJF, CK, GTM and MAE) and partial compliance in one (MD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Initials	Dates	BHR	2/25/10	CJF	2/25/10	CK	3/18/10	GTM	2/12/10	MAE	3/17/10	MD	3/2/10
Initials	Dates															
BHR	2/25/10															
CJF	2/25/10															
CK	3/18/10															
GTM	2/12/10															
MAE	3/17/10															
MD	3/2/10															
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>														

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	<p>consistent with his/her legal status; and</p>	<p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 451 1887 599"> <tr> <td data-bbox="993 451 1087 599">7.</td> <td data-bbox="1087 451 1793 599"><i>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.</i></td> <td data-bbox="1793 451 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals to assess 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 found substantial compliance in four charts (AJS, BHR, SS and WCB) and partial compliance in two (AM and DLM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>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.</i>	100%
7.	<i>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.</i>	100%			
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 414 1887 527"> <tr> <td data-bbox="993 414 1087 527">8.</td> <td data-bbox="1087 414 1793 527"><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td data-bbox="1793 414 1887 527">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in five cases (AJS, AM, DLM, SS and WCB) and partial compliance in one (BHR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	100%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	100%			
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.			
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Substantial.			

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<p>C.2.i.i</p>	<p>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 19% of WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 561 1887 672"> <tr> <td data-bbox="991 561 1087 672">2.</td> <td data-bbox="1087 561 1793 672"><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</i></td> <td data-bbox="1793 561 1887 672">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of ten individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in all ten WRPs (DB, DH, DJW, EAA, FB, JG, NB, PC, RLJ and RM).</p> <p>Other findings: This monitor reviewed the records of 20 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<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</i>	100%
2.	<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</i>	100%			

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C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. • Ensure that each objective is directly linked to a relevant focus of hospitalization. <p>Findings: Using the DMH WRP Chart Audit Form, ASH assessed its compliance based on an average sample of 20% of WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 672 1887 784"> <tr> <td data-bbox="993 672 1087 784">7.</td> <td data-bbox="1087 672 1793 784"><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 672 1887 784">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs contained objectives written in a measurable/ observable manner (DB, DJW, FB, JG and NB).</p> <p>A review of the records of ten individuals found that the objectives in all ten of the WRPs in the charts were directly linked to a relevant focus of hospitalization (DB, DH, DJW, EAA, FB, JG, NB, PC, RLJ and RM).</p> <p>Current recommendation: Continue to monitor this requirement</p>	7.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%
7.	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and	<p>Current findings on previous recommendation:</p>			

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	<p>Recovery Plan</p>	<p>Recommendation, October 2009: Provide data indicating that therapies and rehabilitation services provided in the Malls are aligned with individuals' assessed needs.</p> <p>Findings: See C.2.f.viii.</p> <p>Current recommendation: See C.2.f.viii.</p>			
<p>C.2.i.iv</p>	<p>utilizes the individual's strengths, preferences, and interests;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 1% of Mall group facilitators each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 933 1890 1008"> <tr> <td data-bbox="993 933 1087 1008">15.</td> <td data-bbox="1087 933 1793 1008"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 933 1890 1008">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of five individuals found that all five WRPs specified the strengths of the individual in all active interventions reviewed (DB, DJW, FB, JG and NB). The stated strengths were appropriate to the listed interventions.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%			

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<p>C.2.i.v</p>	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of an average random sample of 19% WRPs each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 638 1887 748"> <tr> <td data-bbox="993 638 1087 748">3.</td> <td data-bbox="1087 638 1793 748"><i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i></td> <td data-bbox="1793 638 1887 748">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of five individuals found that the individual's vulnerabilities were documented in the case formulation section in all five WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (DB, DJW, FB, JG and NB).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	98%
3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	98%			
<p>C.2.i.vi</p>	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH WRP Mall Observation Monitoring Form, ASH assessed its compliance based on an average sample of less than 1% of the Mall group facilitators each month during the review period (September 2009-February 2010). The following table summarizes the data:</p> <table border="1" data-bbox="993 414 1887 490"> <tr> <td data-bbox="993 414 1087 490">16.</td> <td data-bbox="1087 414 1793 490"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 414 1887 490">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all seven cases (CK, CN, DSH, JGA, KB, RAL and WS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	100%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	100%			
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;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • 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. • Use the data from monthly Mall Progress Notes in the WRP review process. <p>Findings: The table below showing the number of progress notes due per month (N), the number of progress notes received by the WRPTs (n), and the compliance percentage (%C) is a summary of the facility's data:</p>			

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		<table border="1" data-bbox="991 228 1913 383"> <thead> <tr> <th></th> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>8687</td> <td>9393</td> <td>9385</td> <td>9716</td> <td>9886</td> <td>9351</td> <td>9403</td> </tr> <tr> <td>n</td> <td>6593</td> <td>7525</td> <td>7793</td> <td>8609</td> <td>9442</td> <td>8782</td> <td>8124</td> </tr> <tr> <td>%C Sep</td> <td>76</td> <td>80</td> <td>83</td> <td>89</td> <td>96</td> <td>94</td> <td>86</td> </tr> </tbody> </table> <p data-bbox="991 423 1913 638">A review of the charts of eight individuals found that all eight contained most of the required progress notes (AED, CK, CN, ES, HLC, JCA, JJC and RAL). Observation of the WRPCs of four of the eight individuals (AED, ES, HLC and JJC) found that the WRPTs discussed the information from the progress notes and incorporated the information in the individuals' WRPs.</p> <p data-bbox="991 683 1913 898">Other findings: This monitor reviewed the records of 20 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. All records were in substantial compliance.</p> <p data-bbox="991 943 1913 1008">Current recommendation: Continue to monitor this requirement.</p>			Oct	Nov	Dec	Jan	Feb	Mean	N	8687	9393	9385	9716	9886	9351	9403	n	6593	7525	7793	8609	9442	8782	8124	%C Sep	76	80	83	89	96	94	86
		Oct	Nov	Dec	Jan	Feb	Mean																											
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%C Sep	76	80	83	89	96	94	86																											
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;	<p data-bbox="991 1057 1913 1089">Current findings on previous recommendation:</p> <p data-bbox="991 1130 1913 1195">Recommendation, October 2009: Continue current practice.</p> <p data-bbox="991 1235 1913 1416">Findings: ASH continued to meet the requirement to provide rehabilitation services five days a week for at least four hours a day. ASH also continues to address issues related to facilitator participation and individuals' attendance through education, training, and monitoring.</p>																																

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The tables below showing the census for the review month (N), categories of hours, and the numbers of hours provided and attended by individuals in each category are summaries of the facility's data on individual enrollment in and attendance at Mall groups:

Mall Group Enrollment by Hours							
		Oct	Nov	Dec	Jan	Feb	Mean
N	910	1011	1027	1008	994	998	991
0 - 5	93	57	55	44	45	35	55
6 - 10	304	261	243	272	165	146	232
11-15	412	467	504	519	458	452	469
16-20+	101	226	225	173	326	323	229

Mall Group Attendance by Hours							
	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	910	1011	1027	1008	994	998	991
0 - 5	654	649	651	677	592	585	635
6 - 10	174	211	228	216	217	207	209
11-15	76	130	127	108	137	163	124
16-20+	6	21	21	7	48	44	25

As the tables above indicate, ASH has not enrolled all individuals in the required 20 hours/week of Mall groups (top table). In addition, attendance in the 11-20 hour range is low (bottom table). ASH is taking steps to ensure that non-adherence is classified appropriately (for example, segmenting those who are unable to attend due to physical and/or mental health issues from those who are able but unwilling and lack the motivation to attend). The WRPs will take such factors into consideration when assigning individuals to their Mall groups. The WRP should ensure that proper justification and rationale are documented in the individual's Present Status section when individuals are assigned to

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		<p>fewer than 20 hours/week of Mall hours.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.ix	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: If the facility has bed-bound individuals, ensure that these individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations.</p> <p>Findings: ASH did not have any bed-bound individuals during this review period. In the past, ASH has provided PSR Mall-related activities within the individual's capacity and health status. The facility has a standing policy (Nursing Procedure 303.1) to provide appropriate service to bed-bound individuals.</p> <p>Current recommendation: If the facility has bed-bound individuals, ensure that these individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status, medical health and physical limitations.</p>
C.2.i.x	<p>routinely takes place as scheduled;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH presented the following data regarding cancellation of Mall groups:</p>

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Rehab Therapy ACUTE (7)	3.97	4.53
Rehab Therapy L-T (15)	7.10	8.72

The following table presents scheduled and provided hours by discipline for January and February 2010:

Discipline	Hours Scheduled/ Week	Hours Provided/ Week	Percentage of Scheduled Hours Fulfilled
Psychiatry- Acute (4)	2.43	1.77	73%
Psychiatry L-T (8)	3.20	2.58	81%
Psychology-Acute (5)	6.37	5.10	80%
Psychology L-T (10)	6.37	5.10	80%
Social Work - Acute (5)	4.29	3.51	82%
Social Work L-T (10)	6.83	5.38	79%
Rehab Therapy - Acute (7)	5.16	4.53	88%
Rehab Therapy L-T (15)	10.27	8.72	85%
Nursing- Acute (6)	3.33	3.21	96%
Nursing L-T (12)	3.11	2.62	73%
Administration/Other	3.11	2.45	79%

According to the Mall director, the hours of PSR Mall services provided by the various disciplines are for the most part near maximum, given the other duties performed by the providers (for example, emergency and/or medical services). The provider participation data are shared with each discipline chief for review and action.

Current recommendation:
Continue to monitor this requirement.

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C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 483 1879 727"> <thead> <tr> <th></th> <th>9/09</th> <th>10/09</th> <th>11/09</th> <th>12/09</th> <th>1/10</th> <th>2/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>2209</td> <td>2099</td> <td>2291</td> <td>2376</td> <td>2148</td> <td>1844</td> <td>2152</td> </tr> <tr> <td>Hours offered</td> <td>2209</td> <td>2099</td> <td>2291</td> <td>2376</td> <td>2148</td> <td>1844</td> <td>2152</td> </tr> <tr> <td>Compliance rate</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>Documentation review, observation, and staff interview found that ASH has made significant improvement in a number of areas in providing supplemental activities to individuals in the facility. Improvements were evidenced in the number of activities offered, the hours of activities offered, and in the organization and uniform methodology of conducting the activities. Attendance is being taken with the intent to encourage and motivate individuals who fail to participate regularly. The staff encourages and motivates the individuals during the morning meetings (this monitor observed the morning meeting boards and activities). Unit visits found activity schedules (updated and current) posted. The activity planner was full of evening and weekend activities.</p> <p>Current recommendation: Continue to improve on current practice and monitor this requirement.</p>		9/09	10/09	11/09	12/09	1/10	2/10	Mean	Hours scheduled	2209	2099	2291	2376	2148	1844	2152	Hours offered	2209	2099	2291	2376	2148	1844	2152	Compliance rate	100%	100%	100%	100%	100%	100%	100%
	9/09	10/09	11/09	12/09	1/10	2/10	Mean																											
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Compliance rate	100%	100%	100%	100%	100%	100%	100%																											
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendation:</p>																																

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		<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, ASH assessed its compliance based on observations of an average sample of 95% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 483 1887 1386"> <tr> <td>1.</td> <td><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>There is evidence of a unit recognition program.</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>The posted unit rules reflect recovery language and principles.</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Staff is observed actively engaged with the individuals.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Staff interacts with individuals in a respectful manner.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Situations involving privacy occurred and they were properly handled.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.</i></td> <td>100%</td> </tr> </table>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	98%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	99%	3.	<i>There is evidence of a unit recognition program.</i>	96%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	98%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	100%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	100%	7.	<i>Staff is observed actively engaged with the individuals.</i>	100%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	99%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	100%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	100%	12.	<i>Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.</i>	100%
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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for items 2-10. The compliance rate for item 1 improved from 75% in the previous review period. Item 12 was not tracked in the previous review period.</p> <p>A review of the charts of seven individuals found that all seven contained milieu interventions appropriate to the active intervention (DB, DJW, FB, JG, NB, RLJ and RM).</p> <p>Current recommendation: Continue to monitor this requirement</p>																																			
C.2.j	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 3 and 4, October 2009:</p> <ul style="list-style-type: none"> • Ensure that there is sufficient exercise and recreational programming. • Track and review participation of individuals in scheduled group exercise and recreational activities. • Provide training to Mall facilitators to conduct the activities appropriately. <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="991 1117 1906 1421"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>96</td> <td>102</td> <td>98</td> <td>97</td> <td>98</td> <td>102</td> </tr> <tr> <td>Number of groups needed</td> <td>56</td> <td>61</td> <td>64</td> <td>69</td> <td>74</td> <td>76</td> </tr> <tr> <td>Offered/needed</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> </tr> </tbody> </table>	Exercise Groups Offered vs. Needed								Sep	Oct	Nov	Dec	Jan	Feb	Number of groups offered	96	102	98	97	98	102	Number of groups needed	56	61	64	69	74	76	Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%
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		<p>Recommendation 2, October 2009: Ensure that individuals with weight issues are enrolled in exercise groups.</p> <p>Findings: The facility also presented the following data:</p> <table border="1" data-bbox="991 451 1885 678"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>393</td> <td>373</td> <td>95%</td> </tr> <tr> <td>31 - 35</td> <td>231</td> <td>226</td> <td>98%</td> </tr> <tr> <td>36 - 40</td> <td>84</td> <td>82</td> <td>98%</td> </tr> <tr> <td>>40</td> <td>53</td> <td>53</td> <td>100%</td> </tr> </tbody> </table> <p>According to the Mall Director, ten individuals are scheduled for each exercise group.</p> <p>A review of the charts of five individuals (DB, DJW, FB, JG and NB) found that four individuals had high BMIs; these four individuals were enrolled in exercise groups (DJW, FB, JG and NB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	393	373	95%	31 - 35	231	226	98%	36 - 40	84	82	98%	>40	53	53	100%
BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned																			
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31 - 35	231	226	98%																			
36 - 40	84	82	98%																			
>40	53	53	100%																			
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>																				

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	<p>comprehensively documented in each individual's chart.</p>	<p>Findings: Using the DMH C2k Family Therapy Auditing Form, ASH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:</p> <table border="1" data-bbox="991 414 1892 1010"> <tr> <td data-bbox="991 414 1087 565">1.</td> <td data-bbox="1087 414 1795 565"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1795 414 1892 565">100%</td> </tr> <tr> <td data-bbox="991 565 1087 784">2.</td> <td data-bbox="1087 565 1795 784"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1795 565 1892 784">90%</td> </tr> <tr> <td data-bbox="991 784 1087 1010">3.</td> <td data-bbox="1087 784 1795 1010"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1795 784 1892 1010">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1156 1892 1388"> <thead> <tr> <th data-bbox="991 1156 1522 1234"></th> <th data-bbox="1522 1156 1713 1234">period</th> <th data-bbox="1713 1156 1892 1234">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="991 1234 1892 1274">Mean compliance rate</td> </tr> <tr> <td data-bbox="991 1274 1522 1312">1.</td> <td data-bbox="1522 1274 1713 1312">100%</td> <td data-bbox="1713 1274 1892 1312">100%</td> </tr> <tr> <td data-bbox="991 1312 1522 1349">2.</td> <td data-bbox="1522 1312 1713 1349">51%</td> <td data-bbox="1713 1312 1892 1349">90%</td> </tr> <tr> <td data-bbox="991 1349 1522 1388">3.</td> <td data-bbox="1522 1349 1713 1388">88%</td> <td data-bbox="1713 1349 1892 1388">100%</td> </tr> </tbody> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	90%	3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100%		period	Current period	Mean compliance rate			1.	100%	100%	2.	51%	90%	3.	88%	100%
1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%																								
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		<p>ASH continues to provide family therapy education and/or services to individuals who consent to have such services rendered.</p> <p>A review of six charts of individuals identified as in need of family therapy found that all six individuals were receiving the services (CP, EA, JF, MK, RM and SB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, ASH assessed its compliance based on a 22% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 1079 1887 1416"> <tr> <td>1.</td> <td><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate interventions for each</i></td> <td>99%</td> </tr> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	100%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	100%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	99%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	99%	5.	<i>There are appropriate interventions for each</i>	99%
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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;"><i>objective.</i></td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin: 10px 0;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">period</th> <th style="width: 15%; text-align: center;">Current period</th> </tr> </thead> <tbody> <tr style="background-color: #e0e0e0;"> <td colspan="3" style="text-align: center;">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td style="text-align: center;">89%</td> <td style="text-align: center;">100%</td> </tr> <tr> <td>2.</td> <td style="text-align: center;">92%</td> <td style="text-align: center;">100%</td> </tr> <tr> <td>3.</td> <td style="text-align: center;">77%</td> <td style="text-align: center;">99%</td> </tr> <tr> <td>4.</td> <td style="text-align: center;">88%</td> <td style="text-align: center;">99%</td> </tr> <tr> <td>5.</td> <td style="text-align: center;">78%</td> <td style="text-align: center;">99%</td> </tr> </tbody> </table> <p>A review of the WRPs of 40 individuals (AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that ASH has continued to make significant improvements regarding adequate and appropriate nursing objectives and interventions for Focus 6. The reviews ^{reviews} of the WRPs reviewed for Focus 6 included appropriate objectives and interventions.</p> <p>ASH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 63% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin: 10px 0;"> <tr> <td style="width: 5%; text-align: center;">6.</td> <td style="width: 80%;"><i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></td> <td style="width: 15%; text-align: center;">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 34% in the</p>		<i>objective.</i>		period	Current period	Mean compliance rate			1.	89%	100%	2.	92%	100%	3.	77%	99%	4.	88%	99%	5.	78%	99%	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	98%
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		<p>previous review period.</p> <p>See F.8.a.i and F.9.e for reviewer's findings related to individual-specific goals and objectives addressing refusals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because ASH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in C.2.o.</p> <p>Findings: Same as in C.2.o.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Same as in C.2.o.</p>																																																												
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue to provide summary of process and clinical outcome data regarding delivery of substance use services.</p> <p>Findings: The following is a summary of ASH's process outcome data:</p> <table border="1" data-bbox="991 672 1850 1391"> <thead> <tr> <th>Process Outcomes</th> <th>July-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td>Individuals with Substance Abuse Dx</td> <td>849</td> <td>823</td> <td>786</td> </tr> <tr> <td>Individuals referred for:</td> <td></td> <td></td> <td></td> </tr> <tr> <td> o SAS treatment</td> <td>277</td> <td>315</td> <td>242</td> </tr> <tr> <td> o AA groups</td> <td>141</td> <td>116</td> <td>148</td> </tr> <tr> <td> o NA groups</td> <td>122</td> <td>124</td> <td>144</td> </tr> <tr> <td>Individuals screened by SAS</td> <td>277</td> <td>255</td> <td>228</td> </tr> <tr> <td>Hours of SAS treatment offered per week</td> <td>90.5</td> <td>90.5</td> <td>101.5</td> </tr> <tr> <td>SAS sessions scheduled</td> <td>822</td> <td>737</td> <td>814</td> </tr> <tr> <td>%SAS sessions held</td> <td>99%</td> <td>98%</td> <td>99%</td> </tr> <tr> <td>Individuals enrolled in SAS treatment</td> <td>696</td> <td>572</td> <td>725</td> </tr> <tr> <td>Individuals enrolled in AA</td> <td>636</td> <td>685</td> <td>673</td> </tr> <tr> <td>Individuals enrolled in NA</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>Individuals on wait list</td> <td>20</td> <td>8</td> <td>814</td> </tr> <tr> <td>Hours of staff training</td> <td>9</td> <td>0</td> <td>4</td> </tr> </tbody> </table>	Process Outcomes	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Individuals with Substance Abuse Dx	849	823	786	Individuals referred for:				o SAS treatment	277	315	242	o AA groups	141	116	148	o NA groups	122	124	144	Individuals screened by SAS	277	255	228	Hours of SAS treatment offered per week	90.5	90.5	101.5	SAS sessions scheduled	822	737	814	%SAS sessions held	99%	98%	99%	Individuals enrolled in SAS treatment	696	572	725	Individuals enrolled in AA	636	685	673	Individuals enrolled in NA	-	-	-	Individuals on wait list	20	8	814	Hours of staff training	9	0	4
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	provided			
	Number of staff trained	16	0	7
	Number of staff monitored for fidelity (re implementation of SAS curriculum)	8	7	7
	<p>ASH also evaluated the outcome of the SAR services provided this review period. The table below shows the summary of the data:</p>			
	Clinical Outcomes	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010
	N=Number enrolled 1st day of quarter	696	497	609
	Advanced at least one stage of change or sustained in maintenance.	39%	52%	42%
	Refused treatment or regressed at least one stage of change.	12%	6%	10%
	Did not advance in stage of change	33%	29%	32%
	Out to Court/Other/ Discharged	16%	13%	16%
	Pre/Post Test-Increase Mean	16%	19%	17%
	<p>The facility's consumer satisfaction surveys summary data is as follows:</p>			
	Consumer Satisfaction Survey	July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010
	Learned New Skills			
	• Agree	95%	91%	91%
	• Disagree	5%	9%	9%

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		Group was helpful				
		• Agree	94%	91%	91%	
		• Disagree	6%	9%	9%	
		Understood Information				
		• Agree	97%	94%	94%	
		• Disagree	3%	6%	6%	
		Group Leader Respectful				
		• Agree	98%	96%	94%	
		• Disagree	2%	4%	6%	
		Recommendation 2, October 2009:				
		Continue to monitor this requirement.				
		Findings:				
		Using the DMH Substance Abuse Auditing Form, ASH assessed its compliance with this requirement based on an average sample of 24% of individuals with a current diagnosis of substance abuse (September 2009-February 2010):				
		1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	100%		
2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	100%				
3.	<i>There is at least one objective related to the individual's stage of change.</i>	99%				
4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	99%				
5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	100%				
6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable</i>	98%				

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;"><i>and/or measurable terms.</i></td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for items 1-5. The compliance rate for item 6 improved from 39% in the previous review period.</p> <p>Other findings: A review of the charts of six individuals (AJS, AM, BHR, DLM, SS and WCB) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide summary of process and clinical outcome data regarding delivery of substance use services. 2. Continue to monitor this requirement. 		<i>and/or measurable terms.</i>						
	<i>and/or measurable terms.</i>									
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form. ASH assessed its compliance based on an average sample of 1% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (September 2009-February 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 65%;"></th> <th style="width: 15%;">Previous review period</th> <th style="width: 15%;">Current review period</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1.</td> <td style="text-align: center;"><i>Instructional skills</i></td> <td style="text-align: center;">100%</td> <td style="text-align: center;">100%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	100%	100%
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1.	<i>Instructional skills</i>	100%	100%							

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		2.	<i>Course structure</i>	98%	96%
		3.	<i>Instructional techniques</i>	100%	100%
		4.	<i>Learning process</i>	100%	100%
		<p>Using the DMH Mall Facilitator Observation Monitoring Form ASH assessed compliance from observation of a 1% sample of all facilitators during the review months (September 2009-February 2010):</p>			
		1.	<i>Session starts and ends within 5 minutes of the designated starting and ending time.</i>	93%	
		2.	<i>Facilitator greets participants to begin the session.</i>	99%	
		3.	<i>There is a brief review of work from prior session.</i>	99%	
		4.	<i>Facilitator introduces the day's topic and goals.</i>	95%	
		5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	99%	
		6.	<i>Facilitator attempts to engage each participant in the session.</i>	100%	
		7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	100%	
		8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	100%	
		9.	<i>Facilitator attempts to test the participants understanding.</i>	100%	
		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	96%	
		11.	<i>The facilitator summarizes the work done in the session.</i>	95%	
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role</i>	100%	

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		<table border="1"> <tr> <td data-bbox="989 190 1085 228"></td> <td data-bbox="1085 190 1793 228"><i>play, homework, or multimedia instruction.</i></td> <td data-bbox="1793 190 1896 228"></td> </tr> <tr> <td data-bbox="989 228 1085 305">13.</td> <td data-bbox="1085 228 1793 305"><i>The room is arranged in a way that is as conducive to learning as possible.</i></td> <td data-bbox="1793 228 1896 305">100%</td> </tr> <tr> <td data-bbox="989 305 1085 345">14.</td> <td data-bbox="1085 305 1793 345"><i>Lesson plan is available and followed.</i></td> <td data-bbox="1793 305 1896 345">99%</td> </tr> </table>		<i>play, homework, or multimedia instruction.</i>		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	100%	14.	<i>Lesson plan is available and followed.</i>	99%	
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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor observed six Mall groups (Problem Solving, Anger Management, Stress Management, Chi Gong, WRAP, and Emotion Management). Providers in all six groups were well-prepared, utilized appropriate instructional strategies and techniques and presentations were varied and appropriate.</p> <p>Recommendations for continued progress during the maintenance phase include the following:</p> <ol style="list-style-type: none"> 1. Consider rearranging the room and seating (where appropriate and possible) to suit the number of individuals in the group, the topic discussed, the methodology utilized, and so forth. 2. Acknowledge and give opportunities for individuals to participate as often as possible. 3. Reinforce attendance and participation when handing out By Choice point cards at the end of the session. Include this aspect as an item in the Mall Facilitator Observation Form and include it in the staff By Choice training. 4. Respective discipline Chiefs and Seniors should actively work with the Mall providers on curriculum development, lesson plan development, competency in course content and the delivery methodology. 										

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
C.2.q	<p>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in C.2.o.</p> <p>Findings: As of the previous tour, ASH had the following numbers of Substance Abuse facilitators:</p> <table border="1" data-bbox="991 748 1873 899"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>10</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>7</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>70%</td> </tr> </table> <p>At that time, ASH reported that an additional 42 staff were certified to serve individuals in the pre-contemplative stage.</p> <p>As described in C.2.o, seven staff members were provided four hours of substance abuse training in the past six months.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide data regarding the number of SAR providers/co-providers and the number of certified providers/co-providers.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	10	Number of certified SAR providers/co-providers	7	Percentage of SAR providers/co-providers who are certified	70%
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C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to ensure that all medical appointments of individuals are completed as scheduled.</p> <p>Findings: The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="991 561 1835 945"> <thead> <tr> <th colspan="4">Missed Appointments Monitoring - Outside Medical Services</th> </tr> <tr> <th rowspan="2">Month</th> <th colspan="2">Appointments</th> <th rowspan="2">Reasons for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> </tr> </thead> <tbody> <tr> <td>Sep 09</td> <td>76</td> <td>0</td> <td></td> </tr> <tr> <td>Oct 09</td> <td>84</td> <td>0</td> <td></td> </tr> <tr> <td>Nov 09</td> <td>42</td> <td>0</td> <td></td> </tr> <tr> <td>Scheduled</td> <td>159</td> <td>1</td> <td>1 refusal</td> </tr> <tr> <td>Jan 10</td> <td>169</td> <td>1</td> <td>1 refusal</td> </tr> <tr> <td>Feb 10</td> <td>128</td> <td>2</td> <td>2 refusals</td> </tr> <tr> <td>Total</td> <td>658</td> <td>4</td> <td></td> </tr> </tbody> </table> <table border="1" data-bbox="991 1019 1835 1395"> <thead> <tr> <th colspan="4">Missed Appointments Monitoring - Internal Medical Services</th> </tr> <tr> <th rowspan="2">Month</th> <th colspan="2">Appointments</th> <th rowspan="2">Reasons for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> </tr> </thead> <tbody> <tr> <td>Sep 09</td> <td>1062</td> <td>187</td> <td>1 staffing 186 refusal/no show</td> </tr> <tr> <td>Oct 09</td> <td>1040</td> <td>147</td> <td>147 refusal/no show</td> </tr> <tr> <td>Scheduled Nov 09</td> <td>741</td> <td>128</td> <td>1 staffing 127 refusal/no show</td> </tr> <tr> <td>Dec 09</td> <td>371</td> <td>73</td> <td>1 staffing 72 refusal/no show</td> </tr> </tbody> </table>	Missed Appointments Monitoring - Outside Medical Services				Month	Appointments		Reasons for Cancellation	Scheduled	Cancelled	Sep 09	76	0		Oct 09	84	0		Nov 09	42	0		Scheduled	159	1	1 refusal	Jan 10	169	1	1 refusal	Feb 10	128	2	2 refusals	Total	658	4		Missed Appointments Monitoring - Internal Medical Services				Month	Appointments		Reasons for Cancellation	Scheduled	Cancelled	Sep 09	1062	187	1 staffing 186 refusal/no show	Oct 09	1040	147	147 refusal/no show	Scheduled Nov 09	741	128	1 staffing 127 refusal/no show	Dec 09	371	73	1 staffing 72 refusal/no show
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Feb 10	663	128	1 staffing 127 refusal/no show												
Total	4506	791													
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Information from the Mall Director indicated that ASH is developing a system for tracking refusals and having Psychology Services assess and determine interventions for individuals who refuse to keep medical appointments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.</p> <p>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1"> <tr> <td>10.</td> <td><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate</i></td> <td>100%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate</i>	100%										
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>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.</i></p>	
		<p>Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p>A review of the WRPs of ten individuals found that all ten WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (DB, DH, DJW, EAA, FB, JG, NB, PC, RLJ and RM).</p> <p>Recommendation 2, October 2009: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.</p> <p>Findings: This monitor observed seven Mall groups. The providers in all seven groups were knowledgeable as to the course content and were motivated as evidenced by their preparation and use of language in both oral presentation and in the printed material used.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	

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<p>C.2.t</p>	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 636 1887 824"> <tr> <td data-bbox="991 636 1087 824">11.</td> <td data-bbox="1087 636 1793 824"><i>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.</i></td> <td data-bbox="1793 636 1887 824">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 65% in the previous review period.</p> <p>A review of the WRPs of five individuals found that four of the WRPs were in substantial compliance with the elements of this requirement (DB, FN, JG and NB) and one was in partial compliance (DJW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	11.	<i>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.</i>	94%
11.	<i>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.</i>	94%			
<p>C.2.u</p>	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment</p>	<p>Current findings on previous recommendations:</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups). • Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period. <p>Findings: According to the Mall Director, ASH no longer offers the Sponsor Groups. The facility replaced the Sponsor Groups with the WRP education classes. The tables below summarize the facility's data on WRP education groups:</p> <table border="1" data-bbox="991 636 1881 787"> <tr> <th colspan="4">Number of the Introduction to Wellness and Recovery groups offered during the current and previous three Mall terms</th> </tr> <tr> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> <tr> <td>11</td> <td>11</td> <td>12</td> <td>10</td> </tr> </table> <table border="1" data-bbox="991 837 1887 1213"> <tr> <th colspan="5">Individuals Needing and Provided WRP Education Groups During the Current and Prior Three Mall Terms</th> </tr> <tr> <th></th> <th>Apr-Jun 2009</th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> <tr> <td>Individuals with identified need</td> <td>1340</td> <td>407</td> <td>505</td> <td>501</td> </tr> <tr> <td>Individuals receiving service</td> <td>1231</td> <td>250</td> <td>249</td> <td>298</td> </tr> </table>	Number of the Introduction to Wellness and Recovery groups offered during the current and previous three Mall terms				Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	11	11	12	10	Individuals Needing and Provided WRP Education Groups During the Current and Prior Three Mall Terms						Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Individuals with identified need	1340	407	505	501	Individuals receiving service	1231	250	249	298
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		<table border="1" data-bbox="991 191 1873 535"> <thead> <tr> <th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (September 2009-February 2010, mean)</th> </tr> </thead> <tbody> <tr> <td>Sessions scheduled</td> <td>116</td> </tr> <tr> <td>Sessions held</td> <td>92</td> </tr> <tr> <td>% held</td> <td>79%</td> </tr> <tr> <td>Individuals scheduled</td> <td>386</td> </tr> <tr> <td>Individuals attended at least one group per month</td> <td>140</td> </tr> <tr> <td>% attended</td> <td>36%</td> </tr> </tbody> </table> <p data-bbox="991 576 1900 678">ASH offers the "Introduction to Wellness and Recovery Planning groups" to all new admissions during their first two weeks as part of ASH's New Admission Orientation (NAO) series of Mall classes.</p> <p data-bbox="991 727 1144 792">Compliance: Partial.</p> <p data-bbox="991 841 1333 865">Current recommendations:</p> <ol data-bbox="991 873 1921 1015" style="list-style-type: none"> 1. Provide data regarding this requirement (Introduction to Wellness and Recovery for newly admitted individuals). 2. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period. 	Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (September 2009-February 2010, mean)		Sessions scheduled	116	Sessions held	92	% held	79%	Individuals scheduled	386	Individuals attended at least one group per month	140	% attended	36%
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C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p data-bbox="991 1060 1591 1092">Current findings on previous recommendations:</p> <p data-bbox="991 1133 1444 1166">Recommendation 1, October 2009: Provide data regarding the number of groups scheduled and the percentage that was held compared to the previous review period.</p> <p data-bbox="991 1279 1108 1312">Findings: The facility provided the following data on the average number of Medication Education groups scheduled and provided per month:</p>														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

			Previous review period*	Current review period																				
		Sessions scheduled	287	207																				
		Sessions provided		182																				
		% of scheduled sessions held	72%	88%																				
		*Data reliability compromised by errors in the MAPP II database.																						
		Recommendation 2, October 2009:																						
		Based on the implementation of tools designed to assess need for medication education groups, provide data on number of individuals with assessed need, number enrolled in medication education groups and percentage that successfully completed groups compared to the previous review period.																						
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		The facility presented the following data:																						
		<table border="1"> <thead> <tr> <th colspan="4">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>July-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>566</td> <td>606</td> <td>681</td> </tr> <tr> <td># of individuals scheduled for service</td> <td></td> <td>606</td> <td>681</td> </tr> <tr> <td># of individuals receiving service</td> <td>566</td> <td>325</td> <td>454</td> </tr> </tbody> </table>			Individuals Needing and Provided Medication Education Groups					July-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	# of individuals needing service	566	606	681	# of individuals scheduled for service		606	681	# of individuals receiving service	566	325	454
Individuals Needing and Provided Medication Education Groups																								
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		Compliance:																						
		Substantial.																						
		Current recommendations:																						
		1. Provide data regarding the number of groups scheduled and the percentage held compared to the previous review period.																						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>2. Based on the implementation of tools designed to assess the need for medication education groups, provide data on the number of individuals with assessed need, number enrolled in medication education groups and percentage that successfully completed groups compared to the previous review period.</p>												
<p>C.2.w</p>	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals.</p> <p>Findings: ASH has three certified NRT therapists. Each of the three maintained a caseload of five individuals for a total of 15 individuals receiving the therapy during this review period. Nine of the 15 individuals had been receiving NRT therapy since the previous review period, and the remaining six were newly enrolled. Outcome data showed that three of the individuals had made significant improvement and their WRPTs transitioned them to other treatment activities.</p> <p>Recommendation 2, October 2009: Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers.</p> <p>Findings: The facility provided the following information on staff training in Motivational Interviewing:</p> <table border="1" data-bbox="991 1263 1877 1416"> <thead> <tr> <th>MI Training 1st Phase</th> <th># staff to be trained</th> <th>Staff trained as of 2/28/10</th> <th>Remain to be trained</th> </tr> </thead> <tbody> <tr> <td>Day 1</td> <td>1200</td> <td>517/ 43%</td> <td>683/57%</td> </tr> <tr> <td>Day 2</td> <td>1200</td> <td>509/42%</td> <td>691/58%</td> </tr> </tbody> </table>	MI Training 1 st Phase	# staff to be trained	Staff trained as of 2/28/10	Remain to be trained	Day 1	1200	517/ 43%	683/57%	Day 2	1200	509/42%	691/58%
MI Training 1 st Phase	# staff to be trained	Staff trained as of 2/28/10	Remain to be trained											
Day 1	1200	517/ 43%	683/57%											
Day 2	1200	509/42%	691/58%											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Follow-Up 1	1200	385/32%	815/68%									
		Follow-Up 2	1200	308/26%	892/74%									
		<p>In the first phase of the training, ASH trained staff with regular contact with individuals. The first follow-up training was provided two weeks following the two-day training, and the second follow-up training was conducted two weeks following the first follow-up training. The trained staff then provided Motivational Interviewing sessions to individuals.</p>												
		<p>Recommendation 3, October 2009: Develop a system to identify individuals who are not attending Mall groups and differentiate those who are non-adherent due to a lack of motivation, and provide data on these individuals during the review period compared to the last review period</p>												
		<p>Findings: ASH has begun to screen individuals triggering non-adherence. Upon screening, individuals are assigned to MI-trained staff for individual counseling. Currently, ASH has assigned one MI-trained staff per Program. The number of counselors will be increased as the number of trained staff increases.</p>												
		<p>The table below shows the census of the current and previous review periods (N), and the number of individuals triggering non-adherence (n):</p>												
		<table border="1"> <thead> <tr> <th data-bbox="989 1117 1161 1198"></th> <th data-bbox="1161 1117 1459 1198">December 2008 - May 2009</th> <th data-bbox="1459 1117 1770 1198">September 2009- February 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1198 1161 1230">N</td> <td data-bbox="1161 1198 1459 1230">1028</td> <td data-bbox="1459 1198 1770 1230">1017</td> </tr> <tr> <td data-bbox="989 1230 1161 1271">n</td> <td data-bbox="1161 1230 1459 1271">969</td> <td data-bbox="1459 1230 1770 1271">164</td> </tr> </tbody> </table>					December 2008 - May 2009	September 2009- February 2010	N	1028	1017	n	969	164
	December 2008 - May 2009	September 2009- February 2010												
N	1028	1017												
n	969	164												
		<p>Non-adherence in this case includes individuals who have been in the facility for at least 14 days and have zero hours of Mall attendance. As the table above shows, the number of individuals triggering non-adherence</p>												

Section C: Integrated Therapeutic and Rehabilitation Services Planning

during this review period has decreased significantly.

Recommendation 4, October 2009:

Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.

Findings:

The tables below show NRT therapy services and outcome thereof for 15 individuals:

Individual	Hope Scale Scores	
	Pre-NRT	With NRT
PT	24	30
RS	30	32
DC	32	32
MW	11	9
LW	8	-
HA	25	23
AJ	30	22
BM	19	21
DN	22	-
JS	21	-
MG	27	26
JL	19	20
CH	22	23
EH	23	-
BB	16	-

As seen in the table above, five of the 15 individuals were recent enrollees to NRT and did not have post-test scores. Five of the ten post-test

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scores were higher than the pre-test scores on the Hope Scale, suggesting that these individuals benefited from the therapy.

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
PT	2.3	4.3
RS	2.2	6
DC	4.2	4.7
MW	4	3.7
LW	4.3	-
HA	2.6	3
AJ	4.5	3.9
BM	4.1	4
DN	3.4	-
JS	3.1	-
MG	5.3	5.4
JL	4.1	3.8
CH	2.7	4.3
EH	3.8	-
BB	3.1	-

The table above shows that six of the ten "with NRT" scores are higher than the "pre-NRT" scores on the Mindfulness Attention Awareness Scale, indicating that these six individuals benefited from NRT.

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
PT	8.2	11

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RS	11.7	12
DC	1.2	3.3
MW	6.7	7.9
LW	2.2	-
HA	9.9	9.5
AJ	9.2	9.2
BM	9.4	9.9
DN	13	-
JS	10	-
MG	9.2	11.4
JL	6.8	7.6
CH	8.7	9.5
EH	11	-
BB	6.1	-

The table above shows self-assessment by the individuals on their experience with NRT as measured by the URICA. Eight of ten individuals indicated they benefited from the therapy with regards to their attitude and readiness for change.

Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
PT	9.6	9.5
RS	9.7	10.1
DC	8.4	8.5
MW	6.7	6
LW	5.7	-
HA	6.2	9.9
AJ	9	9.3
BM	8.3	9.8
DN	9.9	-

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		JS	9	-
		MG	10	9.2
		JL	5	3.2
		CH	3.1	8.7
		EH	-	-
		BB	-	-
		<p>The table above shows the Instructor rating of the individuals receiving NRT therapy, as measured through the URICA. The data show that the instructors observed a positive change in six of the ten individuals receiving NRT.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor and provide data on all the elements for this requirement.</p>		

Section D: Integrated Assessments

D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. ASH has achieved substantial compliance with the requirements of Section D.1. However, more work is needed to solidify this level of compliance (see D.1.f and D.1.g). 2. ASH has made further progress in its medical education programs on-site. <p>Summary of Progress on Psychological Assessments:</p> <ol style="list-style-type: none"> 1. ASH has maintained substantial compliance with the requirements of Section D.2. 2. The quality of ASH's Integrated Assessment: Psychology Section has continued to improve; the various sections in the assessments are more comprehensive. 3. ASH has improved the quality of its structural and functional assessments. <p>Summary of Progress on Nursing Assessments:</p> <ol style="list-style-type: none"> 1. ASH has done an exceptional job at maintaining substantial compliance regarding Nursing Admission and Integrated Assessments, and has continued to improve the clinical content of these assessments. 2. ASH has continued to facilitate the collaboration of different disciplines with nursing regarding clinical issues related to the nursing admission process. <p>Summary of Progress on Rehabilitation Therapy Assessments: ASH has attained substantial compliance with all requirements of Section D.4, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: ASH has attained substantial compliance with all requirements of Section</p>

Section D: Integrated Assessments

		<p>D.5. However, the facility should continue to address the timeliness of lower-acuity assessments (D.5.f, D.5.i, D.5.j.i and D.5.j.ii).</p> <p>Summary of Progress on Social History Assessments: ASH has maintained substantial compliance with the requirements of Section D.6.</p> <p>Summary of Progress on Court Assessments:</p> <ol style="list-style-type: none">1. ASH has maintained substantial compliance with the requirements of Section F.7.2. The facility's Chief of Forensic Services, David. Fennell, MD, has continued to provide an excellent oversight system and an effective training program.
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses	
<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christine Mathiesen, PhD, Neuropsychologist 2. Jean Dansereau, MD, Chief of Psychiatry 3. Frank Stass, MD, Assistant to the Chief of Psychiatry 4. Renee Oertel, RN, Psychiatric Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 22 individuals: AC, AW, BHR, CJB, CMD, DLA, DLM, DRM, GC, JCW, JJK, JLN, LJM, LEP, NL, RAB, RMM, RS, RSC, TAS, TE and TH 2. Monthly Psychiatric Progress Note for the following 40 individuals: AF, CB, CJR, CP, DAW, DE, DH, DL, DLA, DT, DW, EA, EO, FT, JB, JC, JF, JF2, JH, JHG, JPM, JS, KA, KLB, LL, LP, MC, MG, MG2, MK, MWM, RDW, RG, RP, SB, SR, ST, TC, TK and WB 3. Inter Unit Transfer Note templates (versions 3.1 and 4.0) 4. Inter Unit Transfer Acceptance note template 5. Copy of the D.1.d.i table with additional explanations for seven continuing medical education activities 6. Outline for Malingering Parts I & II with participant sign-in sheets 7. Outline for Learning Disorder Part I & II 8. Journal Club's preliminary articles on delirium: A Prospective Study of Reversible Dementias; Frequency, Causes, Clinical Profile and Results of Diagnosis and Treatment of Dementia 9. Journal Club's Delirium Part I: Delirium and Long-Term Cognitive Impairment--An Overview 10. Journal Club's Delirium Part II: Unraveling the Pathophysiology of Delirium--A Focus on the Role of Aberrant Stress Responses 11. NOS Diagnosis Tracking; sample report and email 12. Report of NOS 4/16/10 Authorized Greater than 60 days 13. Report ASH Physician Profile prescribing rates for the following:

Section D: Integrated Assessments

		<p>benztropine mesylate, clonazepam, hydroxyzine, lorazepam, diphenhydramine, and trihexyphenidyl</p> <ol style="list-style-type: none"> 14. Policy on Biannual Psychiatric Physician Quality Performance Profile (PPQPP) and form template 15. DMH Medication Comparison: Anticholinergics and Benzodiazepines Trend Chart November 2008 - September 2009 16. Aggregate data on High Risk Medication Usage <ul style="list-style-type: none"> • For Benztropine; per psychiatrist, by caseload • For Clonazepam; per psychiatrist, by caseload • Intra Class Polypharmacy; number of individuals per psychiatrist, average number of individuals divided by caseload • Inter Class Polypharmacy; number of individuals per psychiatrist, number of individuals divided by caseload 17. Sample of PLATO report: Psychiatric Physician Quality Performance Profile - Psychiatry Admission Assessment Audit 309 18. ASH Admission Psychiatric Assessment Audit summary data (September 2009-February 2010) 19. ASH Integrated Psychiatric Assessment Audit summary data (September 2009-February 2010) 20. ASH Monthly PPN Audit summary data (September 2009-February 2010) 21. ASH Weekly Physician Progress Note Audit summary data (September 2009-February 2010) 22. ASH Medical Initial Admission Assessment Audit summary data (September 2009-February 2010) 23. ASH Physician Inter-Unit Transfer Note Audit summary data (September 2009-February 2010)
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

Section D: Integrated Assessments

		<p>Findings:</p> <p>ASH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (September 2009-February 2010). The average samples were 96% of admission assessments, 98% of integrated assessments and 23% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 522 1887 600"> <tr> <th colspan="3">Admission Assessment</th> </tr> <tr> <td>4.</td> <td><i>Admission diagnosis is documented.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 750 1887 1166"> <tr> <th colspan="3">Integrated Assessment</th> </tr> <tr> <td>2.b</td> <td><i>Psychiatric history, including review of present and past history include statements from the individual are included, if available.</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Psychiatric history, including review of present and past history including diagnosis and medications given at previous facility and medications given at previous facility are included.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 1315 1887 1425"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i></td> <td>100%</td> </tr> </table>	Admission Assessment			4.	<i>Admission diagnosis is documented.</i>	100%	Integrated Assessment			2.b	<i>Psychiatric history, including review of present and past history include statements from the individual are included, if available.</i>	100%	2.d	<i>Psychiatric history, including review of present and past history including diagnosis and medications given at previous facility and medications given at previous facility are included.</i>	100%	7.	<i>Diagnostic formulation</i>	100%	8.	<i>Differential diagnosis</i>	100%	9.	<i>Current psychiatric diagnoses</i>	100%	Monthly PPN			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i>	100%
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Integrated Assessment																																
2.b	<i>Psychiatric history, including review of present and past history include statements from the individual are included, if available.</i>	100%																														
2.d	<i>Psychiatric history, including review of present and past history including diagnosis and medications given at previous facility and medications given at previous facility are included.</i>	100%																														
7.	<i>Diagnostic formulation</i>	100%																														
8.	<i>Differential diagnosis</i>	100%																														
9.	<i>Current psychiatric diagnoses</i>	100%																														
Monthly PPN																																
3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i>	100%																														

Section D: Integrated Assessments

		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.															
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility's report on the number and type of psychiatric positions is summarized below:</p> <table border="1" data-bbox="991 1044 1583 1291"> <thead> <tr> <th>Psychiatric positions</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Direct care</td> <td>57</td> <td>54.6</td> </tr> <tr> <td>Supervisory</td> <td>16.35</td> <td>16.4</td> </tr> <tr> <td>Board-certified</td> <td>51</td> <td>46</td> </tr> <tr> <td>Board-eligible</td> <td>28</td> <td>25</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>	Psychiatric positions	Previous period	Current period	Direct care	57	54.6	Supervisory	16.35	16.4	Board-certified	51	46	Board-eligible	28	25
Psychiatric positions	Previous period	Current period															
Direct care	57	54.6															
Supervisory	16.35	16.4															
Board-certified	51	46															
Board-eligible	28	25															

Section D: Integrated Assessments

		<p>Current recommendation: Continue to provide data regarding average number of direct care and supervisory FTE psychiatric positions (filled) and number of board-certified and Board-eligible psychiatrists, with comparisons to the last review period.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide summary of any corrective actions to address group and/or practitioner trends/patterns. <p>Findings: During this review period, ASH has refined the Psychiatric Physician Quality Performance Profile to better identify practitioner performance relative to high-risk medication usage and deficiencies related to Enhancement Plan documentation requirements. The facility reported that psychiatrists who were found to be two standard deviations from the norm on high-risk medications were referred to Peer Review for further consideration of the data and/or practice. The facility indicated that the overall usage of high-risk medications has decreased, which may reflect the effect of this process in identifying practitioner trends/patterns.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide summary of any corrective actions to address group and/or practitioner trends/patterns.

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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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor completeness of the admission medical examination within the specified time frame.</p> <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, ASH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 77% of admissions each month during the review period (September 2009-February 2010). The facility reported 100% compliance with this requirement. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of ten individuals admitted during the review period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH). The review found substantial compliance in nine cases and partial compliance in one (TH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.i.2	medical history;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.3	physical examination;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.5	management of acute medical conditions	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
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:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Ensure that the violence risk assessment upon admission provides specific information regarding the nature and severity of previous aggression and the timeframes for the most recent aggression and that the rating of risk accounts for this information.</p> <p>Findings: Starting Feb. 1, 2010, ASH implemented a new version of the Psychiatric Admission Evaluation. The violence risk assessment now includes specific information regarding the nature, severity and time frames of previous and recent acts of aggression. The rating of violence risk accounts for this information.</p> <p>Recommendation 2, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>

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		<p>Findings: Using the DMH Admission Psychiatric Assessment Audit, ASH assessed compliance based on an average sample of 96% of admissions each month during the review period (September 2009-February 2010). The mean compliance rate was 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>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 comparative data are listed, as appropriate.</p> <p>Other findings: This monitor reviewed the charts of ten individuals admitted during the review period. The review found substantial compliance in eight cases (AW, BHR, DLA, DLM, NL, RMM, RSC and TH) and partial compliance in two (CJB and CMD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.ii.4	completed AIMS;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.6	consultations ordered; and	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Same as D.1.c.ii, Recommendation 1.</p> <p>Findings: See D.1.c.ii.</p> <p>Recommendation 2, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, ASH assessed compliance based on an average sample of 98% of Integrated Assessments due each month during the review period (September 2009-February 2010). The mean compliance rate was 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: This monitor reviewed the charts of ten individuals admitted during the review period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH). The review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 6	diagnostic formulation;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.iii. 7	differential diagnosis;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 9	psychopharmacology treatment plan; and	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue to provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation and provide data regarding the title of each program, the instructors with their academic affiliation, if applicable and the professionals who have received training.</p> <p>Findings: The following tables outline the educational activities that were provided at ASH during this review period. The first table addresses neuropsychological/neuropsychiatric disorders and the second table covers other topics (forensic topics are addressed in section D.7).</p>

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Date	Title	Speaker/ affiliations	MD Attendees
9/3/09	Limb Apraxias	M. Ono, Clinical Psychologist, ASH	5
9/10/09	Diagnosis and Treatment of Dementia	C. Duke, Clinical Psychologist, ASH	1
9/17/09	Neuro Anatomy Coloring	C. Broderick, Clinical Psychologist, ASH	5
9/24/09	Delirium: Part I	M. Ono, Clinical Psychologist, ASH	5
10/1/09	Evaluation of Visual and Constructional Ability	L. Bolin, Clinical Psychologist, ASH	2
10/8/09	Delirium: Part 2	M. Ono, Clinical Psychologist, ASH	1
10/15/09	Neuro Anatomy Coloring	C. Duke, Clinical Psychologist, ASH	2
10/22/09	Cognitive Deficits in Cocaine Use	L. Bolin, Clinical Psychologist, ASH	2
11/5/09	Disorders of Attention	C. Duke, Clinical Psychologist	3
11/19/09	Neuro Anatomy Coloring	M. Ono, Clinical Psychologist	0
12/10/09	Learning Disorders: Assessment, Diagnosis and Intervention	M. Ono and L. Bolin, Clinical Psychologists, ASH	1
12/17/09	Neuro Anatomy Coloring	C. Mathiesen, L. Bolin and C. Duke; C. Broderick; Clinical Psychologists, ASH	0

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		Disorder			
		12/1/09	ADR: Two Depakote Cases: Pancreatitis and Neutropenia	S. Mohaupt, Staff Psychiatrist, ASH	7
		12/8/09	DUE: Abilify	S. Mohaupt, Staff Psychiatrist, ASH	13
		1/5/10	Treatment Refractory Schizophrenia: Pharmacologic Interventions	S. Mohaupt, Staff Psychiatrist, ASH	16
		1/19/10	ADR: Neutropenia: H. pylori medications	S. Mohaupt, Staff Psychiatrist, ASH	7
		1/26/10	Case Presentation: Water Intoxication	S. Gandhi, Staff Psychiatrist, ASH	24
		2/2/10	ADR: Elevated, Asymptomatic CPK: 3 Case Reports	S. Mohaupt, Staff Psychiatrist, ASH	9
		2/9/10	New Atypical Antipsychotics: Sustenna, Replevv, Asenapine and Iloperidone	S. Mohaupt, Staff Psychiatrist, ASH	23
<p>The above programs were comprehensive in range, appropriate in content and well-aligned with the needs of the facility.</p> <p>Recommendation 2, October 2009: Continue to 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.</p>					

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		<p>Findings: ASH reported the comparative number of individuals receiving NOS, Deferred and Rule Out Diagnoses for more than 60 days. The data showed significant decreases in the number of individuals in all categories compared to the previous review period. The following is a summary of the data:</p> <table border="1" data-bbox="991 451 1890 654"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2" style="text-align: center;">Number of individuals in category</td> </tr> <tr> <td>Rule Out</td> <td style="text-align: center;">18</td> <td style="text-align: center;">1</td> </tr> <tr> <td>Deferred</td> <td style="text-align: center;">4</td> <td style="text-align: center;">1</td> </tr> <tr> <td>NOS</td> <td style="text-align: center;">51</td> <td style="text-align: center;">25</td> </tr> </tbody> </table> <p>Other findings: ASH has implemented a process of oversight by the Chief of Psychiatry to ensure that provisional diagnoses listed on Axis I are finalized as clinically appropriate and the diagnosis of record is consistent with DSM IV criteria and with the information in the psychiatric and psychological assessments.</p> <p>This monitor reviewed the facility's database of current (in-house) individuals who received diagnosis of NOS on Axis I for than 60 days. The database identified that a total of only ten individuals receiving NOS diagnosis, nine of whom were diagnosed with Cognitive Disorder NOS. No individual received a diagnosis listed as Deferred or Rule Out.</p> <p>In addition, this monitor reviewed the charts of five individuals who have received diagnoses listed as NOS for more than two months during this review period:</p> <table border="1" data-bbox="991 1321 1879 1396"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>GC</td> <td>Cognitive Disorder NOS and Mild Mental Retardation</td> </tr> </tbody> </table>	Diagnostic category	Previous Period	Current Period		Number of individuals in category		Rule Out	18	1	Deferred	4	1	NOS	51	25	Initials	Diagnosis (NOS)	GC	Cognitive Disorder NOS and Mild Mental Retardation
Diagnostic category	Previous Period	Current Period																			
	Number of individuals in category																				
Rule Out	18	1																			
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NOS	51	25																			
Initials	Diagnosis (NOS)																				
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		<table border="1" data-bbox="991 188 1883 345"> <tr> <td>JJK</td> <td>Dementia NOS</td> </tr> <tr> <td>RAB</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>RS</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>TE</td> <td>Depressive Disorder NOS</td> </tr> </table> <p data-bbox="991 386 1883 456">This review found substantial compliance in three charts (JJK, RS and TE) and partial compliance in two (GC and RAB).</p> <p data-bbox="991 500 1142 565">Compliance: Substantial.</p> <p data-bbox="991 609 1325 638">Current recommendations:</p> <ol data-bbox="991 646 1898 938" style="list-style-type: none"> 1. Continue to provide documentation of continuing medical education to psychiatry staff. Provide data regarding the date and title of each program, the instructors with their academic affiliation, if applicable and the physicians who have received training. 2. Continue to 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. 	JJK	Dementia NOS	RAB	Cognitive Disorder NOS	RS	Cognitive Disorder NOS	TE	Depressive Disorder NOS
JJK	Dementia NOS									
RAB	Cognitive Disorder NOS									
RS	Cognitive Disorder NOS									
TE	Depressive Disorder NOS									
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);	<p data-bbox="991 980 1577 1010">Current findings on previous recommendation:</p> <p data-bbox="991 1053 1415 1083">Recommendation, October 2009: Same as in D.1.a and D.1.d.i.</p> <p data-bbox="991 1166 1331 1230">Findings: Same as in D.1.a and D.1.d.i.</p> <p data-bbox="991 1274 1142 1339">Compliance: Substantial.</p>								

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		<p>Current recommendations: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.</p> <p>Findings: ASH reported that three individuals were diagnosed with "no diagnosis" on Axis I during this review period. The Chief Psychiatrist reviewed all three individuals. Of the three, one was authorized but subsequently revised within four months, and the remaining two were resolved within 60 days. At the time of this review, no individuals in-house received "no diagnosis" on Axis I.</p>

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		<p>Other findings: This monitor reviewed the chart of the only individual (LJM) who received "no diagnosis" on Axis I for more than 60 days during this review period. The review found evidence of appropriate diagnostic updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.</p>			
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, ASH assessed compliance based on an average sample of 100% of individuals with length of stay less than 60 days during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1227 1892 1412"> <tr> <td data-bbox="991 1227 1087 1412">1.</td> <td data-bbox="1087 1227 1793 1412"><i>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 admission units.</i></td> <td data-bbox="1793 1227 1892 1412">96%</td> </tr> </table>	1.	<i>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 admission units.</i>	96%
1.	<i>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 admission units.</i>	96%			

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		<p>Comparative data indicated improvement from 67% in the previous review period.</p> <p>ASH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rate was 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review focusing on the timeliness of the notes in the charts of ten individuals who were admitted during this reporting period (AW, BHR, CJB, CMD, DLA, DLM, NL, RMM, RSC and TH) found substantial compliance in all cases with the requirements regarding the weekly notes (for individuals hospitalized fewer than 60 days) and the monthly notes (for individuals hospitalized for 90 or more days).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: ASH used the DMH Monthly PPN Audit to assess compliance, based on an</p>

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		<p>average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed monthly psychiatric progress notes for the following 40 individuals: AF, CB, CJR, CP, DAW, DE, DH, DL, DLA, DT, DW, EA, EO, FT, JB, JC, JF, JF2, JH, JHG, JPM, JS, KA, KLB, LL, LP, MC, MG, MG2, MK, MWM, RDW, RG, RP, SB, SR, ST, TC, TK, and WB. These individuals were treated by different providers at the facility. In general, the review found that the facility has made sufficient progress in addressing the previously mentioned deficiencies in content, including the documentation of actual side effects of treatment and risks and benefits of treatment relevant to these side effects. However, the facility needs to reevaluate the current format for documentation to ensure that the formats provide for synthesis of information rather than simply accumulating or listing data.</p> <p>This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during the review period (BHR, CJF, CK, GTM, MAE and MD). The review focused on the utilization of PRN/Stat medications (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 general evidence of improved practice in the following areas:</p> <ol style="list-style-type: none"> 1. Documentation by nursing of the circumstances leading to PRN/Stat medication use and of the individual's response, using the PRN/Stat Emergency Medication Note (form); 2. Consideration of behavioral interventions in a timely manner, when indicated (e.g. BHR); 3. Tracking of PRN/Stat medication use (as documented in psychiatric progress notes); and
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		<p>4. Attempts to adjust regular medication regimen in response to PRN/Stat medication use.</p> <p>This review found a few process deficiencies, as follows:</p> <ol style="list-style-type: none"> 1. There was a pattern of over-use of lorazepam as the sole PRN/Stat for generic indication of agitation (e.g. BHR, CJF and GTM);and 2. In general, the documentation following the use of Stat medications (in the context of seclusion/restraint use) was limited to the rationale for the continued use of seclusion/restraints and did not address further implications of Stat medication use to refine diagnosis and regular treatment. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. In order to maintain substantial compliance, the facility needs to improve the practitioners' use of the current format for the monthly psychiatric reassessments to ensure that the reassessments consistently provide clear evaluations of the individuals' progress and that the plans of care are linked to these evaluations. 3. In order to maintain substantial compliance, the facility needs to correct the above-mentioned process deficiencies regarding the PRN/Stat medication use.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	100%. Comparative data indicated improvement in compliance from 89% in the previous review period.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1" data-bbox="991 228 1887 451"> <tr> <td data-bbox="991 228 1087 451">5.</td> <td data-bbox="1087 228 1793 451"><i>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.</i></td> <td data-bbox="1793 228 1887 451">100%</td> </tr> </table> <p data-bbox="991 493 1921 565">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>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.</i>	100%
5.	<i>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.</i>	100%			
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	100%. Comparative data indicated improvement in compliance from 76% in the previous review period.			
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<table border="1" data-bbox="991 824 1887 1084"> <tr> <td data-bbox="991 824 1087 1084">5.d</td> <td data-bbox="1087 824 1793 1084"><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td data-bbox="1793 824 1887 1084">100%</td> </tr> </table> <p data-bbox="991 1127 1921 1198">Comparative data indicated improvement in compliance from 88% in the previous review period.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	100%
5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	100%			
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	100%. Comparative data indicated improvement in compliance from 71% in the previous review period.			

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D.1.f.vii	<p>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.</p>	<p>100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>																		
D.1.g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 25% of the individuals who experienced inter-unit transfer per month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1081 1887 1312"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p>	1.	<i>Psychiatric course of hospitalization,</i>	100%	2.	<i>Medical course of hospitalization,</i>	100%	3.	<i>Current target symptoms,</i>	100%	4.	<i>Psychiatric risk assessment,</i>	100%	5.	<i>Current barriers to discharge,</i>	100%	6.	<i>Anticipated benefits of transfer.</i>	100%
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		<table border="1"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>75%</td> <td>100%</td> </tr> <tr> <td>2.</td> <td>76%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>86%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td>86%</td> <td>100%</td> </tr> <tr> <td>5.</td> <td>75%</td> <td>100%</td> </tr> <tr> <td>6.</td> <td>90%</td> <td>100%</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this review period. The following table identifies these reviews.</p> <table border="1"> <thead> <tr> <th>Individuals</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>AC</td> <td>12/24/09</td> </tr> <tr> <td>DRM</td> <td>12/29/09</td> </tr> <tr> <td>JCW</td> <td>1/6/10</td> </tr> <tr> <td>JLN</td> <td>1/13/10</td> </tr> <tr> <td>LEP</td> <td>1/4/10</td> </tr> <tr> <td>TAS</td> <td>1/19/10</td> </tr> </tbody> </table> <p>This review found substantial compliance in four charts (AC, JLN, LEP and TAS) and partial compliance in two (DRM and JCW).</p> <p>Compliance: Substantial.</p> <p>Current recommendations: 1. Continue to monitor this requirement.</p>		period	Current period	Mean compliance rate			1.	75%	100%	2.	76%	100%	3.	86%	100%	4.	86%	100%	5.	75%	100%	6.	90%	100%	Individuals	Date of transfer	AC	12/24/09	DRM	12/29/09	JCW	1/6/10	JLN	1/13/10	LEP	1/4/10	TAS	1/19/10
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		2. In order to maintain substantial compliance, ensure that the course of hospitalization section consistently provides clear review and synthesis of significant events during hospitalization.
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2. Psychological Assessments	
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Bettina Odel, PhD, Senior Psychologist Specialist 2. Deborah Hewitt, PhD, Senior Psychologist Specialist 3. Diane Imrem, PsyD, Chief of Psychology 4. Ed Bischof, PhD, Psychologist 5. Killorin Riddell, PhD, Coordinator of Psychology Specialist Services 6. Michael Tandy, PhD, Psychologist 7. Teresa George, PhD, Senior Psychologist Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 46 individuals: AB, AC, AJ, AV, CB, CK, CN, DG, DSH, DW, EC, EG, EM, GH, GJ, GM, GR, JA, JC, JGA, JH, JR, JSC, KB-1, KB-2, KB-3, LL, MC, MD, MJ, MJP, MM, MV, PG, PKB, RAL, RD, RJS, SEM, SFS, SM, SS, TB, TC, WHG and WS 2. Focused Psychological Assessments 3. Functional Assessments completed in the last six months 4. Integrated Assessments: Psychology Section 5. List of individuals 23 years and under 6. List of individuals whose preferred/primary language is other than English 7. List of individuals with diagnostic uncertainties (No Diagnosis, NOS, Rule-out, and Deferred) 8. List of neuropsychological referrals 9. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 10. Neuropsychological Assessments completed in the last six months 11. PBS Plans developed and implemented in the last six months 12. Structural Assessments completed in the last six months

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<p>D.2.a</p>	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: ASH continues to use the DMH approved assessment tools. No new tools were implemented during this review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
<p>D.2.b</p>	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: This monitor's documentation review found that ASH cared for a total of nine individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1302 1890 1409"> <tr> <td data-bbox="991 1302 1081 1409">1.</td> <td data-bbox="1081 1302 1795 1409"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e.,</i></td> <td data-bbox="1795 1302 1890 1409">100%</td> </tr> </table>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e.,</i>	100%
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		<table border="1" data-bbox="991 191 1906 342"> <tr> <td data-bbox="991 191 1094 342"></td> <td data-bbox="1094 191 1793 342"> <p><i>22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></p> </td> <td data-bbox="1793 191 1906 342"></td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of six individuals under 23 years of age admitted to ASH during this review period (GM, GR, JC, MC, SM and SS) found that the individuals were assessed in a timely fashion or the individuals had refused to participate (documented in the progress notes). According to Dr. Teresa George, the psychologists will continue to meet with the individuals who refused and seek their consent and participation in the assessments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></p>				
	<p><i>22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></p>							
D.2.c	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure that all psychologist positions are filled.</p> <p>Findings: The following table describes ASH's psychology staffing pattern as of March 2010:</p> <table border="1" data-bbox="991 1341 1852 1421"> <thead> <tr> <th data-bbox="991 1341 1278 1382"></th> <th data-bbox="1278 1341 1566 1382">Filled positions</th> <th data-bbox="1566 1341 1852 1382">Vacant positions</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1382 1278 1421">Unit psychologist</td> <td data-bbox="1278 1382 1566 1421">23</td> <td data-bbox="1566 1382 1852 1421">3</td> </tr> </tbody> </table>		Filled positions	Vacant positions	Unit psychologist	23	3
	Filled positions	Vacant positions						
Unit psychologist	23	3						

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		<table border="1"> <tr> <td>Senior psychologist</td> <td>3</td> <td>0</td> </tr> <tr> <td>Neuropsychologist</td> <td>5</td> <td>0</td> </tr> </table> <p>Other findings: The following table shows 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:</p> <table border="1"> <tr> <td>1.a</td> <td><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td>74</td> </tr> <tr> <td>1.b</td> <td><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td>74</td> </tr> <tr> <td>2.a</td> <td><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td>17</td> </tr> <tr> <td>2.b</td> <td><i>Number observed to be verifiably competent in assessment procedures</i></td> <td>17</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Senior psychologist	3	0	Neuropsychologist	5	0	1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	74	1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	74	2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	17	2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	17
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D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	Compliance: Substantial.																		
D.2.d.i	expressly state the clinical question(s) for the assessment;	Current findings on previous recommendation:																		

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		<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 524 1887 602"> <tr> <td data-bbox="993 524 1087 602">3.</td> <td data-bbox="1087 524 1793 602"><i>Expressly state the clinical question(s) for the assessment.</i></td> <td data-bbox="1793 524 1887 602">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven contained clear and concise statements with a rationale for the referral (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%
3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%			
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p>			

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">4.</td> <td style="width: 80%; padding: 5px;"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td style="width: 15%; text-align: center; vertical-align: top;">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%
4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%			
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">5.</td> <td style="width: 80%; padding: 5px;"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td style="width: 15%; text-align: center; vertical-align: top;">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%
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		<p>least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven indicated if the individual would benefit from individual and/or group therapy (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 933 1892 971"> <tr> <td data-bbox="991 933 1087 971">6.</td> <td data-bbox="1087 933 1795 971"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1795 933 1892 971">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>Be based on current, accurate, and complete data.</i>	99%
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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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 597 1887 748"> <tr> <td data-bbox="991 597 1087 748">7.</td> <td data-bbox="1087 597 1793 748"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 597 1887 748">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%
7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%			
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 414 1887 492"> <tr> <td data-bbox="993 414 1087 492">8.</td> <td data-bbox="1087 414 1793 492"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 414 1887 492">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven contained documentation of the implications of the findings for PSR and other interventions (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Include the implications of the findings for interventions</i>	100%
8.	<i>Include the implications of the findings for interventions</i>	100%			
D.2.d.vii	<p>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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1343 1887 1414"> <tr> <td data-bbox="993 1343 1087 1414">9.</td> <td data-bbox="1087 1343 1793 1414"><i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further</i></td> <td data-bbox="1793 1343 1887 1414">100%</td> </tr> </table>	9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further</i>	100%
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		<table border="1" data-bbox="991 191 1906 305"> <tr> <td data-bbox="991 191 1087 305"></td> <td data-bbox="1087 191 1795 305"><i>observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i></td> <td data-bbox="1795 191 1906 305"></td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for seven individuals found that all seven contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	
	<i>observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>				
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1156 1906 1307"> <tr> <td data-bbox="991 1156 1087 1307">10.</td> <td data-bbox="1087 1156 1795 1307"><i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></td> <td data-bbox="1795 1156 1906 1307">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	100%
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		<p>A review of the Focused Psychology Assessments for seven individuals found that all seven had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (GM, GR, MJP, MM, SEM, SFS and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>ASH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments.</p> <p>Compliance: Substantial.</p>
D.2.f	<p>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</p>	<p>Compliance: Substantial.</p>

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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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 597 1885 711"> <tr> <td data-bbox="991 597 1087 711">12.</td> <td data-bbox="1087 597 1793 711"><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td data-bbox="1793 597 1885 711">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <p>A review of the IAPs for 14 individuals found that all 14 were conducted in a timely manner (AV, CK, CN, DSH, GM, JGA, JSC, KB-1, MC, MM, MV, RAL, SS and WS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	99%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	99%			
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated</p>			

Section D: Integrated Assessments

		<p>Assessments: Psychology Section (IAPs) completed each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 305 1887 380"> <tr> <td data-bbox="993 305 1087 380">13.</td> <td data-bbox="1087 305 1793 380"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 305 1887 380">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for seven individuals found that all seven had documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AV, GM, JSC, MC, MM, MV and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	99%
13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	99%			
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendations:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1230 1887 1344"> <tr> <td data-bbox="993 1230 1087 1344">14.</td> <td data-bbox="1087 1230 1793 1344"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1793 1230 1887 1344">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	99%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	99%			

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		<p>least 90% from the previous review period.</p> <p>A review of the IAPs for seven individuals found that all seven provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (AV, GM, JSC, MC, MM, MV and SS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.f.ii	<p>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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: A review of structural assessments, functional assessments, behavioral guidelines and Positive Behavior Support plans confirmed that ASH continues to ensure that all behavioral interventions are developed following structural and functional assessments.</p> <p>Current recommendation: Continue current practice</p>
D.2.f.iii	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated</p>

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		<p>Assessments: Psychology Section (IAPs) due each month during the review period (September 2009-February 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 414 1885 605"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed the charts of 23 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all 23 Integrated Assessments in the charts contained documentation of requests for and/or conduct of additional psychological assessments (AB, AC, AJ, CB, DG, DW, EC, EG, EM, GH, GJ, JA, JH, KB-1, KB-2, KB-3, LL, MJ, PKB, RJS, TB, TC, and WHG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>Differential diagnosis</i>	100%	17.	<i>Rule-out</i>	100%	18.	<i>Deferred</i>	100%	19.	<i>No diagnosis</i>	100%	20.	<i>NOS diagnosis</i>	100%
16.	<i>Differential diagnosis</i>	100%															
17.	<i>Rule-out</i>	100%															
18.	<i>Deferred</i>	100%															
19.	<i>No diagnosis</i>	100%															
20.	<i>NOS diagnosis</i>	100%															
D.2.g	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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, ASH assessed</p>															

Section D: Integrated Assessments

	<p>language and dialect, if feasible.</p>	<p>its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 341 1890 828"> <tr> <td data-bbox="991 341 1087 451">21.a</td> <td data-bbox="1087 341 1795 451"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1795 341 1890 451">23</td> </tr> <tr> <td data-bbox="991 451 1087 527">21.b</td> <td data-bbox="1087 451 1795 527"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1795 451 1890 527">16</td> </tr> <tr> <td data-bbox="991 527 1087 604">22.a</td> <td data-bbox="1087 527 1795 604"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1795 527 1890 604">0</td> </tr> <tr> <td data-bbox="991 604 1087 714">22.b</td> <td data-bbox="1087 604 1795 714"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1795 604 1890 714">0</td> </tr> <tr> <td data-bbox="991 714 1087 828">23.</td> <td data-bbox="1087 714 1795 828"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1795 714 1890 828">0</td> </tr> </table> <p>Documentation review (progress notes) and staff interview found that 23 individual were identified as in need of language support. Sixteen of the 23 were assessed in their primary/preferred languages, and the remaining seven were discharged before 30 days and thus were not available for testing or refused to participate in the assessment despite repeated attempts by the psychological examiners.</p> <p>A review of the charts of five individuals found that all five assessments in the charts were completed in the individual's primary language by bilingual examiners or with the use of interpreters (EC, JR, MD, PG and RD).</p> <p>Compliance: Substantial.</p>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	23	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	16	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	0	22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	0	23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	0
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	23															
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	16															
22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	0															
22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	0															
23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	0															

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		Current recommendation: Continue to monitor this requirement.
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3. Nursing Assessments					
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cynthia Davis, RN, MSN, Nurse Administrator 2. Donna Hunt, RN, HSS 3. Rosemary Morrison, HSS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. ASH's training rosters 3. Admission and integrated assessments and WRPs for the following 40 individuals: AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG 			
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>			
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 94% mean sample of admissions each month during the review period (September 2009-February 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;">A description of presenting conditions</td> <td style="width: 10%; text-align: center;">99%</td> </tr> </table>	1.	A description of presenting conditions	99%
1.	A description of presenting conditions	99%			

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		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that ASH has maintained the quality of the assessments and has continued to make improvements in the narrative content of the admission assessments. The overall content of the assessments includes clinical information gathered from the admission interviews, and the narrative sections addressing the presenting conditions were outstanding regarding the summary of the findings from the assessment process. There was noted to be additional clinically relevant information contained in many of the sections throughout the nursing assessments. All of the efforts and collaboration with other disciplines that ASH has put into the nursing admission assessment process has culminated in thorough and comprehensive nursing admission assessments. These findings comport with ASH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 97% mean sample of admissions each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1117 1890 1266"> <tr> <td data-bbox="991 1117 1087 1266">1.</td> <td data-bbox="1087 1117 1793 1266"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 1117 1890 1266">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 82% in the previous review period.</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	98%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	98%			

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		<p>A review of Integrated Nursing Assessments for 40 individuals (AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that ASH has also maintained the significant improvement in the quality and content of the Integrated Nursing Assessments since the last review. The information contained in the Integrated Assessments included updated information since the individual was admitted rather than just repeating information that was contained in the Nursing Assessment. The training that ASH has implemented addressing nursing admission/integrated assessments has resulted in exceptional clinical nursing assessments/integrated assessments. These findings comport with ASH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 896 1887 1193"> <tr> <td data-bbox="991 896 1087 1193">2.</td> <td data-bbox="1087 896 1793 1193"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 896 1887 1193">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%			

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 264 1885 451"> <tr> <td data-bbox="991 264 1087 451">2.</td> <td data-bbox="1087 264 1793 451"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 264 1885 451">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%			
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 673 1885 714"> <tr> <td data-bbox="991 673 1087 714">3.</td> <td data-bbox="1087 673 1793 714"><i>Vital signs</i></td> <td data-bbox="1793 673 1885 714">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 938 1885 979"> <tr> <td data-bbox="991 938 1087 979">3.</td> <td data-bbox="1087 938 1793 979"><i>Vital signs</i></td> <td data-bbox="1793 938 1885 979">99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	3.	<i>Vital signs</i>	100%	3.	<i>Vital signs</i>	99%
3.	<i>Vital signs</i>	100%						
3.	<i>Vital signs</i>	99%						
D.3.a.iv	allergies;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1198 1885 1239"> <tr> <td data-bbox="991 1198 1087 1239">4.</td> <td data-bbox="1087 1198 1793 1239"><i>Allergies</i></td> <td data-bbox="1793 1198 1885 1239">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	4.	<i>Allergies</i>	100%			
4.	<i>Allergies</i>	100%						

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		<p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>4.</td> <td><i>Allergies</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	4.	<i>Allergies</i>	100%			
4.	<i>Allergies</i>	100%						
D.3.a.v	pain;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Pain</i>	99%	5.	<i>Pain</i>	100%
5.	<i>Pain</i>	99%						
5.	<i>Pain</i>	100%						
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>The update assistive devices use or need section is</i></td> <td>100%</td> </tr> </table>	6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	100%	6.	<i>The update assistive devices use or need section is</i>	100%
6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	100%						
6.	<i>The update assistive devices use or need section is</i>	100%						

Section D: Integrated Assessments

		<table border="1"> <tr> <td></td> <td><i>complete, or the "no problems noted" box is checked.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>		<i>complete, or the "no problems noted" box is checked.</i>				
	<i>complete, or the "no problems noted" box is checked.</i>							
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	7.	<i>Activities of daily living</i>	100%	7.	<i>Activities of daily living</i>	100%
7.	<i>Activities of daily living</i>	100%						
7.	<i>Activities of daily living</i>	100%						
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>100%</td> </tr> </table>	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%						
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%						

Section D: Integrated Assessments

		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>						
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	100%	9.	<i>Conditions needing immediate nursing interventions</i>	99%
9.	<i>Conditions needing immediate nursing interventions</i>	100%						
9.	<i>Conditions needing immediate nursing interventions</i>	99%						
D.3.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: ASH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>						

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D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Atascadero State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH's training rosters indicated that 42 existing RNs and 15 newly hired RNs received and passed the Psychiatric Nursing training during the current review period. Sixty-eight PTs have also received the training since this class began in February 2010. In addition, all nurses at ASH are currently licensed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.3.d	<p>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</p>	<p>Compliance: Substantial.</p>			
D.3.d.i	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practices.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 94% mean sample of admissions each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1377 1885 1416"> <tr> <td data-bbox="993 1377 1087 1416">10.</td> <td data-bbox="1096 1377 1791 1416"><i>Initial nursing assessments are completed within 24</i></td> <td data-bbox="1799 1377 1885 1416">100%</td> </tr> </table>	10.	<i>Initial nursing assessments are completed within 24</i>	100%
10.	<i>Initial nursing assessments are completed within 24</i>	100%			

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		<table border="1" data-bbox="991 188 1890 230"> <tr> <td data-bbox="991 188 1087 230"></td> <td data-bbox="1087 188 1793 230"><i>hours of the individual's admission.</i></td> <td data-bbox="1793 188 1890 230"></td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>hours of the individual's admission.</i>	
	<i>hours of the individual's admission.</i>				
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practices.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 97% mean sample of admissions each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1084 1890 1230"> <tr> <td data-bbox="991 1084 1087 1230">10.</td> <td data-bbox="1087 1084 1793 1230"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1793 1084 1890 1230">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 88% in the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AHS,</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	93%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	93%			

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		<p>ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on a mean sample of 22% of WRPCs observed each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 857 1915 1011"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>97%</td> <td></td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>81%</td> <td></td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (AHS, ARC, BNT, CED, CJB, CJR, DAW, DEW, DMG, DSH, DSJ, DWP, DWW, ELB, FAB, FM, JAE, JAS, JR, JRR, JSV, JWS, LJR, LRP, MDF, MJC, MJC, MSA, OWW, PCM, REA, RJB, RK, SDH, SWW, TC, TMH, TTN, TW and WLG) found that all had an RN and PT in attendance at the WRP.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	97%		<i>Psychiatric Technician attendance at WRPC</i>	81%	
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	97%										
<i>Psychiatric Technician attendance at WRPC</i>	81%										

4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ladonna Decou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA-RTS assessments from September 2009-February 2010 2. Records of the following 14 individuals who had IA-RTS assessments from September 2009-February 2010: ASV, BLB, CSS, EDR, EJ, GEA, JJJ, JNA, JSR, KTC, LJM, MDM, RF and RT 3. List of individuals who had Occupational Therapy assessments from September 2009-February 2010 4. Records of the following five individuals who had Occupational Therapy assessments from September 2009-February 2010: AY, GE, JM, NGZ and ROS 5. List of individuals who had Physical Therapy assessments from September 2009-February 2010 6. Records of the following three individuals who had Physical Therapy assessments from September 2009-February 2010: DMS, JM and RDD 7. List of individuals who had Speech Therapy assessments from September 2009-February 2010 8. Records of the following four individuals who had Speech Therapy assessments from September 2009-February 2010: DS, HTV, LMR and NS 9. List of individuals who had Vocational Rehabilitation assessments from September 2009-February 2010 10. Records of the following nine individuals who had Vocational Rehabilitation assessments from September 2009-February 2010: AT, ATB, FSV, JPW, RDB, REOM, RP, RSP and SLS

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		<p>11. List of individuals who had CIPRTA assessments from September 2009-February 2010</p> <p>12. Records of the following three individuals who had CIPRTA assessments from September 2009-February 2010: MJ, NCY and SJG</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Revise and update current protocols as needed according to systemic changes and evolving standards of practice.</p>
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness based on an</p>

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		<p>average sample of 90% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2009-February 2010 (total of 537 out of 596):</p> <table border="1" data-bbox="991 337 1887 561"> <tr> <td data-bbox="991 337 1087 561">1.</td> <td data-bbox="1087 337 1793 561"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i></td> <td data-bbox="1793 337 1887 561">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 15):</p> <table border="1" data-bbox="991 1042 1887 1234"> <tr> <td data-bbox="991 1042 1087 1234">1.</td> <td data-bbox="1087 1042 1793 1234"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 1042 1887 1234">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i>	98%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
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		<p>Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 76 out of 79):</p> <table border="1" data-bbox="991 487 1890 673"> <tr> <td data-bbox="991 487 1087 673">1.</td> <td data-bbox="1087 487 1795 673"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1795 487 1890 673">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 72% in the previous review period.</p> <p>A review of the records of three individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 36):</p> <table border="1" data-bbox="991 1153 1890 1339"> <tr> <td data-bbox="991 1153 1087 1339">1.</td> <td data-bbox="1087 1153 1795 1339"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1795 1153 1890 1339">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	97%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
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		<p>least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found three records in compliance (DS, LMR and NS) and one record not in compliance (HTV).</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 42% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2009-February 2010 (total of 121 out of 291):</p> <table border="1" data-bbox="991 672 1887 859"> <tr> <td data-bbox="991 672 1087 859">1.</td> <td data-bbox="1087 672 1793 859"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 672 1887 859">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% in the previous review period.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found six records in compliance (AT, FSV, REOM, RP, RSP and SLS) and three records not in compliance (ATB, JPW and RDB).</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period September 2009-February 2010 (total of nine):</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>	93%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>	93%			

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		<table border="1"> <tr> <td data-bbox="989 188 1087 378">1.</td> <td data-bbox="1087 188 1793 378"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 188 1892 378">100%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%	
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%				
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>				
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 90% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2009-February 2010 (total of 537 out of 596):</p> <table border="1" data-bbox="989 1305 1892 1382"> <tr> <td data-bbox="989 1305 1087 1382">2.</td> <td data-bbox="1087 1305 1793 1382"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1305 1892 1382">99%</td> </tr> </table>		2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	99%
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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 15):</p> <table border="1" data-bbox="991 672 1890 748"> <tr> <td data-bbox="991 672 1087 748">2.</td> <td data-bbox="1087 672 1793 748"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 672 1890 748">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 76 out of 79):</p> <table border="1" data-bbox="991 1268 1890 1344"> <tr> <td data-bbox="991 1268 1087 1344">2.</td> <td data-bbox="1087 1268 1793 1344"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1268 1890 1344">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	99%
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		<p>least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 36):</p> <table border="1" data-bbox="991 597 1890 673"> <tr> <td data-bbox="991 597 1087 673">2.</td> <td data-bbox="1087 597 1793 673"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 597 1890 673">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 42% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2009-February 2010 (total of 121 out of 291):</p> <table border="1" data-bbox="991 1193 1890 1269"> <tr> <td data-bbox="991 1193 1087 1269">2.</td> <td data-bbox="1087 1193 1793 1269"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1193 1890 1269">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	99%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
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		<p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period September 2009-February 2010 (total of nine):</p> <table border="1" data-bbox="991 561 1887 638"> <tr> <td data-bbox="991 561 1087 638">2.</td> <td data-bbox="1087 561 1793 638"><i>Is accurate and comprehensive as to the individual's functional abilities:</i></td> <td data-bbox="1793 561 1887 638">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities:</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities:</i>	100%			
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section</p>			

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		<p>Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 90% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2009-February 2010 (total of 537 out of 596):</p> <table border="1" data-bbox="991 376 1890 527"> <tr> <td data-bbox="991 376 1087 451">3.</td> <td data-bbox="1087 376 1795 451"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1795 376 1890 451">99%</td> </tr> <tr> <td data-bbox="991 451 1087 527">4.</td> <td data-bbox="1087 451 1795 527"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1795 451 1890 527">99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals to assess compliance of IA-RTS assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 15):</p> <table border="1" data-bbox="991 1047 1890 1198"> <tr> <td data-bbox="991 1047 1087 1122">3.</td> <td data-bbox="1087 1047 1795 1122"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1795 1047 1890 1122">100%</td> </tr> <tr> <td data-bbox="991 1122 1087 1198">4.</td> <td data-bbox="1087 1122 1795 1198"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1795 1122 1890 1198">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found</p>	3.	<i>Identifies the individual's current functional status, and</i>	99%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	99%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%												

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		<p>all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 76 out of 79):</p> <table border="1" data-bbox="991 483 1887 638"> <tr> <td data-bbox="991 483 1087 560">3.</td> <td data-bbox="1087 483 1793 560"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 483 1887 560">100%</td> </tr> <tr> <td data-bbox="991 560 1087 638">4.</td> <td data-bbox="1087 560 1793 638"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 560 1887 638">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 36):</p> <table border="1" data-bbox="991 1117 1887 1271"> <tr> <td data-bbox="991 1117 1087 1193">3.</td> <td data-bbox="1087 1117 1793 1193"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1117 1887 1193">100%</td> </tr> <tr> <td data-bbox="991 1193 1087 1271">4.</td> <td data-bbox="1087 1193 1793 1271"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1193 1887 1271">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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Section D: Integrated Assessments

		<p>A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 42% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2009-February 2010 (total of 121 out of 291):</p> <table border="1" data-bbox="991 561 1887 712"> <tr> <td data-bbox="991 561 1087 638">3.</td> <td data-bbox="1087 561 1793 638"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 561 1887 638">97%</td> </tr> <tr> <td data-bbox="991 638 1087 712">4.</td> <td data-bbox="1087 638 1793 712"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 638 1887 712">94%</td> </tr> </table> <p>Comparative data indicated maintenance of a compliance rate of at least 90% for item 3 and improvement in compliance from 79% in the previous review period for item 4.</p> <p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period September 2009-February 2010 (total of nine):</p> <table border="1" data-bbox="991 1268 1887 1417"> <tr> <td data-bbox="991 1268 1087 1344">3.</td> <td data-bbox="1087 1268 1793 1344"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1268 1887 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1417">4.</td> <td data-bbox="1087 1344 1793 1417"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1344 1887 1417">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	97%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	94%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>									
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 90% of Integrated Rehabilitation Therapy Assessments due each month for the review period September 2009-February 2010 (total of 537 out of 596):</p> <table border="1" data-bbox="991 1154 1887 1271"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	99%
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6.	<i>Strengths, and</i>	100%									
7.	<i>Motivation for engaging in wellness activities.</i>	99%									

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		<p>A review of the records of 14 individuals to assess compliance of IA-RTS assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 15):</p> <table border="1" data-bbox="991 561 1890 677"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 96% of Physical Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 76 out of 79):</p> <table border="1" data-bbox="991 1195 1890 1310"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	97%	7.	<i>Motivation for engaging in wellness activities.</i>	99%
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Section D: Integrated Assessments

		<p>A review of the records of three individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2009-February 2010 (total of 36):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 42% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2009-February 2010 (total of 121 out of 291):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Identifies the individual's life goals,</i>	96%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	99%	7.	<i>Motivation for engaging in wellness activities.</i>	97%
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		<p>A review of the records of nine individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period September 2009-February 2010 (total of nine):</p> <table border="1" data-bbox="991 597 1887 712"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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6.	<i>Strengths, and</i>	100%									
7.	<i>Motivation for engaging in wellness activities.</i>	100%									
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p>									

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		<p>Findings: The facility reported that eight out of eight Rehabilitation Therapists requiring training were trained on the IA-RTS assessment on 9/29/09, 10/30/09, and 1/6/10. Nine out of nine Rehabilitation Therapists requiring training on the V-RAT were trained on 10/6/09, 10/7/09, 1/7/10, and 2/8/10. Four out of four Rehabilitation Therapists requiring IA-RTS follow-up training were trained on 9/2/09, 9/11/09, 9/16/09, and 11/9/09.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>
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 D.4.b and sub-cells above.	All conversion assessments were completed as of the April 2009 tour. <p>Compliance: Substantial.</p>

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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dawn Hartman, Assistant Director of Dietetics 2. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for September 2009-February 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from September 2009-February 2010 for each assessment type 3. Records of the following three individuals with type D.5.a assessments from September 2009-February 2010: BNT, DLB and EME 4. Records of the following two individuals with type D.5.b assessments from September 2009-February 2010: JHG and MR 5. Records of the following eight individuals with type D.5.d assessments from September 2009-February 2010: DEW, FKB, GD, LCP, RA, TAR, TMH and WSW 6. Records of the following four individuals with type D.5.e assessments from September 2009-February 2010: DRR, HP, LJR and RB 7. Records of the following five individuals with type D.5.f assessments from September 2009-February 2010: CM, JJC, JN, MN and TJP 8. Records of the following seven individuals with type D.5.g assessments from September 2009-February 2010: ARC, CD, JJF, JNA, JRR, MJG and TC 9. Records of the following six individuals with type D.5.i assessments from September 2009-February 2010: AG, AM, AMM, CSS, DY and RA 10. Records of the following six individuals with type D.5.j.i assessments from September 2009-February 2010: ADS, AF, DAB, KEP, MAR and TAQ

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		<p>11. Records of the following seven individuals with type D.5.j.ii assessments from September 2009-February 2010: JDC, JPM, LC, MF, PMM, RR-1 and RR-2</p>																																	
<p>D.5.a</p>	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period September 2009-February 2010 (total of 10):</p> <table border="1" data-bbox="991 748 1892 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 188 1087 266">12.</td> <td data-bbox="1087 188 1793 266"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1793 188 1896 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 344">13.</td> <td data-bbox="1087 266 1793 344"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1793 266 1896 344">100%</td> </tr> <tr> <td data-bbox="989 344 1087 422">14.</td> <td data-bbox="1087 344 1793 422"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 344 1896 422">N/A</td> </tr> <tr> <td data-bbox="989 422 1087 461">15.</td> <td data-bbox="1087 422 1793 461"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 422 1896 461">100%</td> </tr> <tr> <td data-bbox="989 461 1087 500">16.</td> <td data-bbox="1087 461 1793 500"><i>Assessment is concise</i></td> <td data-bbox="1793 461 1896 500">100%</td> </tr> <tr> <td data-bbox="989 500 1087 539">17.</td> <td data-bbox="1087 500 1793 539"><i>Assessment is legible</i></td> <td data-bbox="1793 500 1896 539">100%</td> </tr> <tr> <td data-bbox="989 539 1087 578">18.</td> <td data-bbox="1087 539 1793 578"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 539 1896 578">100%</td> </tr> </table> <p data-bbox="989 613 1896 685">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all applicable items.</p> <p data-bbox="989 724 1896 795">A review of the records of three individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.</p> <p data-bbox="989 834 1142 906">Compliance: Substantial.</p> <p data-bbox="989 945 1461 1016">Current recommendation: Continue to enhance current practice.</p>	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%																					
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.	<p data-bbox="989 1058 1579 1091">Current findings on previous recommendation:</p> <p data-bbox="989 1130 1461 1201">Recommendation, October 2009: Continue to monitor this requirement.</p> <p data-bbox="989 1240 1896 1421">Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b assessments due each month for the review period September 2009-February 2010 (total of three):</p>																					

Section D: Integrated Assessments

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		<p>A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>												
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. ASH does not have a skilled nursing facility unit.												
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period September 2009-February 2010 (total of 127):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	95%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%
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4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%												

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	5.	<i>Assessment utilizes findings from subjective and objective data</i>	99%													
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	<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all applicable items except items 5 and 10. Compliance rates for items 5 and 10 improved as follows:</p> <table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>5.</td> <td>87%</td> <td>99%</td> </tr> <tr> <td>10.</td> <td>81%</td> <td>99%</td> </tr> </tbody> </table>					Previous period	Current period	Mean compliance rate			5.	87%	99%	10.	81%	99%
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		<p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>																								
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period September 2009-February 2010 (total of eight):</p> <table border="1" data-bbox="991 971 1890 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention</i>	100%
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D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive	Current findings on previous recommendation:																																	

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	<p>Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period September 2009-February 2010 (total of 25):</p> <table border="1" data-bbox="991 524 1890 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>84%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	84%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	96%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A
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		<p>The facility reported that although four out of 25 assessments were completed late due to high caseloads and RD vacancies, all assessments were completed within 30 days of admission.</p>																
		<p>A review of the records of five individuals to assess compliance with Nutrition type D.5.f criteria found four records in substantial compliance (CM, JN, MN and TJP) and one record in partial compliance (JJC) due to timeliness.</p>																
		<p>Previous</p>																
		<p>Compliance: Substantial.</p>																
		<p>Current recommendation: Continue to improve and enhance current practice.</p>																

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D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 24% of Nutrition Type D.5.g assessments due each month for the review period September 2009-February 2010 (total of 90 out of 381):</p> <table border="1" data-bbox="991 597 1885 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>94%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>99%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>99%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	94%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	99%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	99%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	99%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A
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Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1900 423"> <tr> <td data-bbox="993 191 1087 269">14.</td> <td data-bbox="1087 191 1793 269"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 191 1900 269">N/A</td> </tr> <tr> <td data-bbox="993 269 1087 310">15.</td> <td data-bbox="1087 269 1793 310"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 269 1900 310">99%</td> </tr> <tr> <td data-bbox="993 310 1087 350">16.</td> <td data-bbox="1087 310 1793 350"><i>Assessment is concise</i></td> <td data-bbox="1793 310 1900 350">100%</td> </tr> <tr> <td data-bbox="993 350 1087 391">17.</td> <td data-bbox="1087 350 1793 391"><i>Assessment is legible</i></td> <td data-bbox="1793 350 1900 391">100%</td> </tr> <tr> <td data-bbox="993 391 1087 423">18.</td> <td data-bbox="1087 391 1793 423"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 391 1900 423">100%</td> </tr> </table> <p data-bbox="993 464 1900 605">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all applicable items except items 1 and 10, the rates for which were 89% and 88% respectively in the previous review period.</p> <p data-bbox="993 651 1900 716">A review of the records of seven individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p data-bbox="993 761 1140 826">Compliance: Substantial.</p> <p data-bbox="993 872 1457 937">Current recommendation: Continue to enhance current practice.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	99%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%															
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.	<p data-bbox="993 984 1577 1016">Current findings on previous recommendation:</p> <p data-bbox="993 1062 1457 1127">Recommendation, October 2009: Continue to monitor this requirement.</p> <p data-bbox="993 1172 1900 1414">Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 31% of Nutrition assessments (all types) due each month of the review period September 2009-February 2010 (496 out of 1618). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p>															

Section D: Integrated Assessments

		<p>A review of the records of 48 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with the requirement of D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																					
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 20% of Nutrition Type D.5.i assessments due each month for the review period September 2009-February 2010 (total of 115 out of 559):</p> <table border="1" data-bbox="991 1003 1890 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>58%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>99%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	58%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	97%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	99%
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Section D: Integrated Assessments

		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	99%
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	96%
		11.	<i>Recommendations are appropriate and complete</i>	100%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all applicable items except item 1, the rate for which was 57% in the previous review period. The facility reported that less than substantial timeliness is due to high caseloads and RD vacancies as well as the prioritization of higher-acuity assessments. The department continues vigorous recruitment efforts.</p>		
		<p>A review of the records of six individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p>		
		<p>Compliance: Substantial.</p>		
		<p>Current recommendation: Continue to improve and enhance current practice.</p>		

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D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.j.i assessments due each month for the review period September 2009-February 2010 (total of 64 out of 277):</p> <table border="1" data-bbox="989 597 1885 1427"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>83%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>98%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	83%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	97%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	98%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

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18.	<i>Each page of the assessment is signed</i>	100%															
D.5.j.ii	Every individual will be assessed annually.	<p data-bbox="993 1159 1577 1200">Current findings on previous recommendation:</p> <p data-bbox="993 1240 1583 1313">Recommendation, October 2009: Continue current efforts to achieve compliance.</p> <p data-bbox="993 1354 1803 1421">Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its</p>															

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		<p>compliance based on an average sample of 24% of Nutrition Type D.5.j.ii assessments due each month for the review period September 2009-February 2010 (total of 54 out of 228):</p>
1.	<i>Assessment is completed on time per policy</i>	22%
2.	<i>All required subjective concerns are addressed</i>	100%
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
7.	<i>Nutrition education is documented</i>	100%
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
9.	<i>Progress is monitored, measured, and evaluated</i>	100%
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
11.	<i>Recommendations are appropriate and complete</i>	100%
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
15.	<i>Assessment utilizes approved abbreviations</i>	100%
16.	<i>Assessment is concise</i>	100%
17.	<i>Assessment is legible</i>	100%
18.	<i>Each page of the assessment is signed</i>	100%

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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all applicable items except item 1, the rate for which was 18% in the previous review period. The facility reported that less than substantial timeliness is due to high caseloads and RD vacancies as well as the prioritization of higher-acuity assessments. The department continues vigorous recruitment efforts.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.j.ii criteria found five records in substantial compliance (JDC, JPM, LC, MF and RR-1) and two records in partial compliance (PMM and RR-2) due to timeliness.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to improve and enhance current practice.</p>
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6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Heidi Metz, LCSW 2. Janet Bouffard, LCSW, Chief of Social Work 3. Katherine Goodwin, MSW 4. Michael Ostash, LCSW, Acting Supervising Social Worker <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 19 individuals: AJY, CHM, CK, CN, DSH, JA, JD, JGA, KB, MC, MP, NL, RAL, RB, RC, SS, TC, TG and WS 2. ASH's Social History Progress Report (September 2009 to February 2010) 3. 30-Day Social History Assessments 4. Integrated Assessments: Social Work Section 5. Summary data on SW Progress Notes for individuals in the facility during this review period (January to March 2010) 									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 62% of the Integrated Assessments: Social Work Sections due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1304 1892 1416"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at</i></td> <td>98%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at</i>	98%
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3.	<i>Comprehensive: All sections are completed with at</i>	98%									

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		<table border="1" data-bbox="993 191 1902 305"> <tr> <td data-bbox="993 191 1094 305"></td> <td data-bbox="1094 191 1797 305"><i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1797 191 1902 305"></td> </tr> </table> <p data-bbox="993 347 1902 415">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 457 1902 600">This monitor reviewed the charts of ten individuals to evaluate the Integrated Assessments: Social Work Sections. Nine assessments were current and comprehensive (CK, JA, MC, NL, RB, RC, SS, TC and TG) and one was not comprehensive (MP).</p> <p data-bbox="993 643 1902 786">Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of the 30-Day Psychosocial Assessments due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 821 1902 1049"> <tr> <td data-bbox="993 821 1094 862">1.</td> <td data-bbox="1094 821 1797 862"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1797 821 1902 862">99%</td> </tr> <tr> <td data-bbox="993 862 1094 902">2.</td> <td data-bbox="1094 862 1797 902"><i>Current, and</i></td> <td data-bbox="1797 862 1902 902">100%</td> </tr> <tr> <td data-bbox="993 902 1094 1049">3.</td> <td data-bbox="1094 902 1797 1049"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1797 902 1902 1049">99%</td> </tr> </table> <p data-bbox="993 1091 1902 1159">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 1201 1902 1344">This monitor reviewed the charts of 19 individuals to evaluate the 30-Day Psychosocial Assessments. All 19 assessments were timely and comprehensive (AJY, CHM, CK, CN, DSH, JA, JD, JGA, KB, MC, MP, NL, RAL, RB, RC, SS, TC, TG, and WS).</p>		<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>		1.	<i>Is, to the extent reasonably possible, accurate</i>	99%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	99%
	<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>													
1.	<i>Is, to the extent reasonably possible, accurate</i>	99%												
2.	<i>Current, and</i>	100%												
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	99%												

Section D: Integrated Assessments

		<p>Other findings: A review of ASH's Social Work staffing pattern found that as of January 2010, ASH had 36 enduring team members (requirement is 50). Among the 14 vacancies, four are on long-term leave of absence, three are working outside their category, and seven positions are not filled.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of the 30-Day Psychosocial Assessments due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1044 1892 1196"> <tr> <td data-bbox="993 1044 1087 1117">4.</td> <td data-bbox="1087 1044 1795 1117"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1795 1044 1892 1117">100%</td> </tr> <tr> <td data-bbox="993 1117 1087 1157">5.</td> <td data-bbox="1087 1117 1795 1157"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1795 1117 1892 1157">99%</td> </tr> <tr> <td data-bbox="993 1157 1087 1196">6.</td> <td data-bbox="1087 1157 1795 1196"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1795 1157 1892 1196">99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed the charts of ten individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	99%	6.	<i>Explains the rationale for the resolution offered.</i>	99%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	99%									
6.	<i>Explains the rationale for the resolution offered.</i>	99%									

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		<p>inconsistencies (CK, JA, MC, MP, NL, RB, RC, SS, TC and TG). All ten assessments addressed this requirement by resolving the factual inconsistencies when they were identified or stating what was being done to resolve them (for example, waiting for more information or continuing to contact the family for clarification).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 62% of Integrated Assessments: Social Work Sections due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1044 1887 1081"> <tr> <td data-bbox="991 1044 1087 1081">7.</td> <td data-bbox="1087 1044 1793 1081"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 1044 1887 1081">94%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed 19 charts to evaluate timeliness of the Social Work Integrated Assessments. All 19 assessments were timely (AJY, CHM, CK, CN, DSH, JA, JD, JGA, KB, MC, MP, NL, RAL, RB, RC, SS, TC, TG, and WS).</p>	7.	<i>Is included in the 7-day integrated assessment</i>	94%
7.	<i>Is included in the 7-day integrated assessment</i>	94%			

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		<p>Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 341 1892 415"> <tr> <td data-bbox="993 341 1087 415">8.</td> <td data-bbox="1087 341 1795 415"><i>Fully documented by the 30th day of the individual's admission.</i></td> <td data-bbox="1795 341 1892 415">96%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed ten charts to evaluate timeliness of the 30-Day Psychosocial Assessments. All ten assessments were timely (CK, JA, MC, MP, NL, RB, RC, SS, TC and TG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Fully documented by the 30th day of the individual's admission.</i>	96%
8.	<i>Fully documented by the 30th day of the individual's admission.</i>	96%			
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1304 1892 1344"> <tr> <td data-bbox="993 1304 1087 1344">10.</td> <td data-bbox="1087 1304 1795 1344"><i>Educational status</i></td> <td data-bbox="1795 1304 1892 1344">99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</p>	10.	<i>Educational status</i>	99%
10.	<i>Educational status</i>	99%			

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		<p>at least 90% from the previous review period.</p> <p>This monitor reviewed ten charts to evaluate documentation of the individual's social factors and educational status in the 30-day Psychosocial Assessments. All ten assessments included this information (CK, JA, MC, MP, NL, RB, RC, SS, TC and TG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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Section D: Integrated Assessments

7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. David Fennell, MD, Chief of Forensic Psychiatry 2. Jennifer Brush, Forensic Services Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals who were admitted under PC 1026 (AJT, GG, GP, JW, LRM and RNG) 2. Charts of six individuals who were admitted under PC 1370 (CK, CS, ELC, JAA, JRW and MJG) 3. ASH PC 1026 Report auditing summary data (September 2009-February 2010) 4. ASH PC 1370 Report auditing summary data (September 2009-February 2010) 5. Minutes of the Forensic Review Panel meetings during the review period
D.7.a	<p>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:</p>	<p>Compliance: Substantial.</p>
D.7.a.i	<p>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);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p>

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		<p>Findings: ASH used the DMH Court Report PC 1026 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (September 2009-February 2010). The mean compliance rate was 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (AJT, GG, GP, JW, LRM and RNG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.7.a.iii	<p>understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in five cases (GG, GP, JW, LRM and RNG) and partial compliance in one (AJT).</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.7.a.iv	<p>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1"> <tr> <td>14.</td> <td><i>Individual's acceptance of mental illness</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's understanding of the need for treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Individual's adherence to treatment</i></td> <td>100%</td> </tr> </table>	14.	<i>Individual's acceptance of mental illness</i>	100%	15.	<i>Individual's understanding of the need for treatment</i>	100%	16.	<i>Individual's adherence to treatment</i>	100%
14.	<i>Individual's acceptance of mental illness</i>	100%									
15.	<i>Individual's understanding of the need for treatment</i>	100%									
16.	<i>Individual's adherence to treatment</i>	100%									

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		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.7.a.v	<p>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;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: The facility reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="991 932 1885 1083"> <tr> <td data-bbox="991 932 1087 1005">17.</td> <td data-bbox="1087 932 1793 1005"><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td data-bbox="1793 932 1885 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1083">18.</td> <td data-bbox="1087 1005 1793 1083"><i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i></td> <td data-bbox="1793 1005 1885 1083">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p>	17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%	18.	<i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i>	100%
17.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	100%						
18.	<i>Individual's recognition of precursors and warning signs and symptoms for future dangerous acts</i>	100%						

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		<p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.vi	<p>willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.vii	<p>previous community releases, if the individual has had previous CONREP revocations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases to which this requirement was</p>

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		<p>applicable (AJT, GG and RNG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.viii	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.a.ix	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1026 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.b	<p>Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:</p>	<p>Compliance: Substantial.</p>
D.7.b.i	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 92% of the court reports written during the review period (September 2009-February 2010). The mean compliance rate was 100%. Comparative data indicated that ASH has</p>

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		<p>maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (CK, CS, ELC, JAA, JRW and MJG).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue to monitor this requirement.</p> <p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1370 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Same as above.</p> <p>Findings: ASH reported the following mean compliance rates for each indicator regarding this requirement:</p> <table border="1" data-bbox="991 524 1885 824"> <tr> <td>14.</td> <td><i>Description of any progress or lack of progress</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Individual's response to treatment</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Current relevant mental status</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all four items.</p> <p>Other findings: A review of the charts of six individuals admitted under PC 1370 found substantial compliance in five cases (CK, CS, JAA, JRW and MJG) and noncompliance in one (ELC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Description of any progress or lack of progress</i>	100%	15.	<i>Individual's response to treatment</i>	100%	16.	<i>Current relevant mental status</i>	100%	17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	100%
14.	<i>Description of any progress or lack of progress</i>	100%												
15.	<i>Individual's response to treatment</i>	100%												
16.	<i>Current relevant mental status</i>	100%												
17.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	100%												
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Same as above.</p>												

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		<p>Findings: ASH reported a mean compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the above-identified charts of six individuals admitted under PC 1370 found substantial compliance in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																
D.7.c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Provide information regarding changes in relevant training to FRP members and WRPTs.</p> <p>Findings: The facility has maintained an effective training program since the last review. During this review period, the following forensic educational seminars were held:</p> <table border="1" data-bbox="989 1078 1883 1416"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/affiliations</th> <th>MD Attendees</th> </tr> </thead> <tbody> <tr> <td>9/9/09</td> <td>Involuntary Treatment: Keyhea, Qawi and Probate 3200</td> <td>G. Gaines, Staff Psychiatrist, ASH</td> <td>21</td> </tr> <tr> <td>9/16/09</td> <td>Introduction to Forensics</td> <td>G. Gaines, Staff Psychiatrist, ASH</td> <td>15</td> </tr> <tr> <td>9/23/09</td> <td>The Bullet Train to Competency</td> <td>G. Gaines, Staff Psychiatrist, ASH</td> <td>12</td> </tr> </tbody> </table>	Date	Title	Speaker/affiliations	MD Attendees	9/9/09	Involuntary Treatment: Keyhea, Qawi and Probate 3200	G. Gaines, Staff Psychiatrist, ASH	21	9/16/09	Introduction to Forensics	G. Gaines, Staff Psychiatrist, ASH	15	9/23/09	The Bullet Train to Competency	G. Gaines, Staff Psychiatrist, ASH	12
Date	Title	Speaker/affiliations	MD Attendees															
9/9/09	Involuntary Treatment: Keyhea, Qawi and Probate 3200	G. Gaines, Staff Psychiatrist, ASH	21															
9/16/09	Introduction to Forensics	G. Gaines, Staff Psychiatrist, ASH	15															
9/23/09	The Bullet Train to Competency	G. Gaines, Staff Psychiatrist, ASH	12															

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		10/2/09	Forensic, Clinical, and Ethical Issues in a Corrections Setting	J. Youngren, Clinical and Forensic Psychology; Clinical Professor; UCLA David Geffen School of Medicine	1
		10/7/09	MDO Law and Practice	G. Gaines, Staff Psychiatrist, ASH	27
		10/14/09	PC1026: Legal Insanity and Post Acquittal Release	G. Gaines, Staff Psychiatrist, ASH	16
		10/28/09	Twenty Testimony Tips	G. Gaines, Staff Psychiatrist, ASH	15
		11/4/09	Question and Answer Session	G. Gaines, Staff Psychiatrist, ASH	21
		11/25/09	Question and Answer Session	G. Gaines, Staff Psychiatrist, ASH	5
		12/2/09	The Coleman Court and PC 2684	D. Fennell, Chief of Forensic Psychiatry, ASH	21
		12/16/09	Question and Answer Session	G. Gaines, Staff Psychiatrist, ASH	10
		12/30/09	Question and Answer Session	G. Gaines, Staff Psychiatrist, ASH	10
		1/6/10	MDO Case Presentation	W. Knowlton, Clinical Psychologist, ASH	15
		1/13/10	Case Presentation: Incompetent to Stand Trial, is Martyrdom Irrational	G. Gaines, Staff Psychiatrist, ASH	22
		1/27/10	CDC-R and DMH	G. Gaines, Staff Psychiatrist, ASH	22

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		2/3/10	Violence Risk Assessment	B. Yakush, Clinical Psychologist	40
		2/10/10	Malingering Assessment Part I	A. MacKinnon, Clinical Psychologist	40
		2/17/10	Malingering Assessment Part II	A. MacKinnon, Clinical Psychologist	36
		2/23/10	MDO Law	M. Mihordin, MD, JD, MSP; Chief Clinical Coordinator MDO Evaluations, Forensic Services, DMH	46
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009:: Continue current practice.</p> <p>Findings: ASH has maintained the required membership of the panel.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. ASH has attained substantial compliance with all requirements of Section E. 2. ASH has reduced the numbers of individuals referred for discharge but still hospitalized.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Heidi Metz, LCSW, 2. Janet Bouffard, LCSW, Chief of Social Work 3. Katherine Goodwin, MSW 4. Michael Ostash, LCSW, Acting Supervising Social Worker <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 33 individuals: AED, CK, DB, DH, DJW, DT, EAA, ES, FB, HLC, JA, JC, JG, JJC, JL, JP, MC, MP, NB, NL, PC, PN, RB, RC, RD, RLJ, RH, RM, RS, SD, SS, TC, and TG 2. List of individuals who have met discharge criteria in the last six months 3. List of individuals who have met discharge criteria in the last six months and are still hospitalized 6. Summary data on SW Progress notes for individuals in the facility during this review period (January to March 2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 1) for monthly review of JJC 2. WRPC (Program I, unit 1) for quarterly review of HLC 3. WRPC (Program III, unit 21) for 7-day review of ES 4. WRPC (Program IV, unit 16) for annual review AED

Section E: Discharge Planning and Community Integration

E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings:			
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 821 1890 935"> <tr> <td data-bbox="991 821 1087 935">1.</td> <td data-bbox="1087 821 1793 935"><i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i></td> <td data-bbox="1793 821 1890 935">96%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%			

Section E: Discharge Planning and Community Integration

		<p>Current recommendation: Continue to monitor this requirement.</p>			
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 711 1892 751"> <tr> <td>2.</td> <td><i>The individual's level of psychosocial functioning</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs included the individual's psychosocial functioning in the Present Status section (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>The individual's level of psychosocial functioning</i>	100%
2.	<i>The individual's level of psychosocial functioning</i>	100%			
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Ensure that discharge barriers, especially difficulties in previously 			

Section E: Discharge Planning and Community Integration

		<p>unsuccessful placements, are discussed with the individual at scheduled WRPCs.</p> <ul style="list-style-type: none"> • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. <p>Findings: A review of the Social Work Operations Manual found that the requirements for this cell had been incorporated into the Manual. Furthermore, the WRPT Master Trainer had worked with the WRPTs during WRPCs on engaging individuals during the WRPCs and providing pertinent discharge and community integration information to the individual.</p> <p>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 857 1887 971"> <tr> <td data-bbox="991 857 1087 971">3.</td> <td data-bbox="1087 857 1793 971"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 857 1887 971">99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that eight WRPs contained documentation that discharge barriers were discussed with the individual (DT, JC, JP, PN, RD, RH, RS and SD) and one (JL) did not.</p> <p>Compliance: Substantial.</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	99%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	99%			

Section E: Discharge Planning and Community Integration

		<p>Current recommendation: Continue to monitor this requirement.</p>			
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 711 1890 787"> <tr> <td>4.</td> <td><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	100%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	100%			
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout	<p>Current findings on previous recommendations:</p>			

Section E: Discharge Planning and Community Integration

	<p>the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Recommendations 1-3, October 2009:</p> <ul style="list-style-type: none"> • Ensure that the individual is an active participant in the discharge planning process. • Ensure that the individual understands all of the discharge requirements before leaving the WRPC. • Prioritize objectives and interventions related to the discharge processes. <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 711 1890 1008"> <tr> <td data-bbox="991 711 1087 1008">9.</td> <td data-bbox="1087 711 1793 1008"><i>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. The WRPT engages the individual, if possible, in a discussion concerning their progress toward discharge.</i></td> <td data-bbox="1793 711 1890 1008">100%</td> </tr> </table> <p>ASH changed the monitoring tool during the review period, adding an additional element to this item (<i>The WRPT engages the individual, if possible, in a discussion concerning their progress towards discharge</i>) and renumbering it from item 12 to item 9. The compliance rate for this review period is higher than that obtained during the previous period; however, a direct comparison is not entirely valid given the change.</p> <p>A review of the records of nine individuals found that all nine WRPs contained documentation indicating that the individual was an active participant in the discharge process (AED, DB, DJW, ES, FB, HLC, JG,</p>	9.	<i>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. The WRPT engages the individual, if possible, in a discussion concerning their progress toward discharge.</i>	100%
9.	<i>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. The WRPT engages the individual, if possible, in a discussion concerning their progress toward discharge.</i>	100%			

Section E: Discharge Planning and Community Integration

		<p>JJC and NB).</p> <p>This monitor observed four WRPCs (AED, ES, HLC and JJC). In all four cases, the WRPTs discussed the individual's progress and current barriers to discharge.</p> <p>A review of the records of ten individuals found that all ten WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (DB, DH, DJW, EAA, FB, JG, NB, PC, RLJ and RM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3	<p>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:</p>	<p>Please see sub-cells for compliance findings.</p>
E.3.a	<p>measurable interventions regarding these discharge considerations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period</p>

Section E: Discharge Planning and Community Integration

		<p>(September 2009-February 2010):</p> <table border="1" data-bbox="991 266 1887 602"> <tr> <td data-bbox="991 266 1087 526"></td> <td data-bbox="1087 266 1793 526"> <p><i>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:</i></p> </td> <td data-bbox="1793 266 1887 526"></td> </tr> <tr> <td data-bbox="991 526 1087 602">6.</td> <td data-bbox="1087 526 1793 602"> <p><i>Measurable interventions regarding these discharge considerations</i></p> </td> <td data-bbox="1793 526 1887 602">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of nine individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all nine (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>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:</i></p>		6.	<p><i>Measurable interventions regarding these discharge considerations</i></p>	100%
	<p><i>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:</i></p>							
6.	<p><i>Measurable interventions regarding these discharge considerations</i></p>	100%						
E.3.b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of</p>						

Section E: Discharge Planning and Community Integration

		<p>quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 305 1887 378"> <tr> <td data-bbox="993 305 1087 378">7.</td> <td data-bbox="1087 305 1793 378"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1793 305 1887 378">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs identified the staff member responsible for the interventions (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%			
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1307 1887 1416"> <tr> <td data-bbox="993 1307 1087 1416"></td> <td data-bbox="1087 1307 1793 1416"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i></td> <td data-bbox="1793 1307 1887 1416"></td> </tr> </table>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i>	
	<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed</i>				

Section E: Discharge Planning and Community Integration

		<p><i>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:</i></p> <table border="1"> <tr> <td>8.</td> <td><i>The time frames for completion of interventions</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that all nine WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (DT, JC, JL, JP, PN, RD, RH, RS and SD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>The time frames for completion of interventions</i>	100%
8.	<i>The time frames for completion of interventions</i>	100%			
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:	<p>Compliance: Substantial.</p>			
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The table below showing the list of individuals who have met discharge criteria and still are hospitalized (as of March 26, 2010), along with their status and the reasons for their continued hospitalization is a summary</p>			

Section E: Discharge Planning and Community Integration

		of the facility's data:	
Initials	Discharge Readiness	Placement Availability	Barriers to placement
DH	3/17/09	CONREP accepted 2/20/10	Waiting 1604 from Court
DB	11/23/09	CONREP accepted 1/7/10	Waiting 1604 from court
AH	12/15/09		1026 - Difference of Opinion re: COT conference scheduled 4/6/10
DT	12/17/09	CONREP accepted 3/23/10	Waiting for acceptance letter
JM	12/31/09	CONREP accepted 2/23/10	Waiting 1604 from Court
RR	1/14/10	CONREP accepted 2/24/10	Waiting 1604 from Court
MA	2/12/10	CONREP accepted 3/5/10	Waiting 1604 due to stability
DS	2/16/10	CONREP accepted 2/23/10	
RP	2/23/10		Waiting for placement interview
RH	2/26/10		Waiting for placement interview
DN	3/11/10		Waiting for placement interview
RS	3/16/10		Waiting for placement interview
As the table above indicates, 12 individuals who had been referred for			

Section E: Discharge Planning and Community Integration

		<p>discharge are still hospitalized for a variety of reasons, with most of the delays due to non-availability of placement.</p> <p>Other findings: Document review found that ASH has discharged 126 individuals to all locations since January 1, 2010. At the time of this review, ASH has five individuals (2684 PC Commitment) for pick-up by CDC-R within 72 hours. An additional 24 individuals are waiting to be discharged upon expiration of their term, and according to the Chief of Social Work, the recommendation is not to extend their term.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1117 1890 1414"> <tr> <td data-bbox="991 1117 1087 1268"></td> <td data-bbox="1087 1117 1793 1268"><i>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:</i></td> <td data-bbox="1793 1117 1890 1268"></td> </tr> <tr> <td data-bbox="991 1268 1087 1344">10.</td> <td data-bbox="1087 1268 1793 1344"><i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i></td> <td data-bbox="1793 1268 1890 1344">89%</td> </tr> <tr> <td data-bbox="991 1344 1087 1414">10.a</td> <td data-bbox="1087 1344 1793 1414"><i>The Present Status section of the individual's WRP describes the assistance needed to</i></td> <td data-bbox="1793 1344 1890 1414">91%</td> </tr> </table>		<i>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:</i>		10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	89%	10.a	<i>The Present Status section of the individual's WRP describes the assistance needed to</i>	91%
	<i>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:</i>										
10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	89%									
10.a	<i>The Present Status section of the individual's WRP describes the assistance needed to</i>	91%									

Section E: Discharge Planning and Community Integration

		<table border="1"> <tr> <td></td> <td><i>transition to the discharge setting; and</i></td> <td></td> </tr> <tr> <td>10.b</td> <td><i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i></td> <td>86%</td> </tr> </table> <p>Comparative data indicated a decline in compliance since the previous review period:</p> <table border="1"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>10.</td> <td>100%</td> <td>89%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>10.</td> <td>-%</td> <td>67%</td> </tr> <tr> <td>10.a</td> <td>-%</td> <td>67%</td> </tr> <tr> <td>10.b</td> <td>-%</td> <td>67%</td> </tr> </tbody> </table> <p>A review of the records of ten individuals found that nine of the WRPs contained documentation of the assistance needed by the individual in the new setting (CK, MC, MP, NL, RB, RC, SS, TC and TG). The remaining one WRP did not (JA).</p> <p>Current recommendation: Conduct Review to monitor this requirement.</p>		<i>transition to the discharge setting; and</i>		10.b	<i>Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.</i>	86%		period	Current period	Mean compliance rate			10.	100%	89%	Compliance rate in last month of period			10.	-%	67%	10.a	-%	67%	10.b	-%	67%
	<i>transition to the discharge setting; and</i>																												
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Compliance rate in last month of period																													
10.	-%	67%																											
10.a	-%	67%																											
10.b	-%	67%																											
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to ASH as it does not serve children and adolescents.</p>																											
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and																												
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an																												

Section E: Discharge Planning and Community Integration

	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.	
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F. Specific Therapeutic and Rehabilitation Services	
	<p data-bbox="989 266 1913 370">Summary of Progress on Psychiatric Services: ASH has attained substantial compliance with all but one of the requirements of Section F.1.</p> <p data-bbox="989 415 1913 444">Summary of Progress on Psychological Services:</p> <ol data-bbox="989 451 1913 1075" style="list-style-type: none">1. ASH has attained substantial compliance with all requirements of Section F.2.2. The Psychology staff is actively collaborating with the Mall Director in many areas including the development of Mall groups, curricula, and lesson plans; the DCAT is also involved in assisting the Mall Director.3. Psychology staff participation in Mall hours provided has improved.4. The quality of the assessments and the plans has improved. The outcome data showed a reduction in the number of restrictive interventions (seclusion and restraint) in individuals with PBS plans.5. There has been significant improvement in By Choice incentive system process and procedures. ASH has expanded the Incentive Store operation hours, increased the number of stores including one in the main courtyard, and the main incentive store is set up to provide a relaxing and therapeutic environment for individuals during their time there.6. The Neuropsychology staff has increased the number of cognitive remediation groups. <p data-bbox="989 1117 1913 1146">Summary of Progress on Nursing Services:</p> <ol data-bbox="989 1153 1913 1399" style="list-style-type: none">1. ASH has put significant efforts into the documentation of PRN and Stat medications and has achieved substantial compliance with this area of Section F.3.2. With continued efforts, ASH should be able to achieved substantial compliance with all requirements of this section by the next review. However, significant efforts need to be directed at the nursing documentation addressing change of status.

	<p>Summary of Progress on Rehabilitation Therapy Services: ASH has attained substantial compliance with the requirements of Section F.4 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Services: ASH has maintained substantial compliance with all requirements of Section F.5.</p> <p>Summary of Progress on Pharmacy Services:</p> <ol style="list-style-type: none">1. ASH has maintained substantial compliance with the requirements in this section.2. The Chief of Pharmacy at ASH, Ronald O'Brien, PharmD, has continued to provide an excellent oversight system. <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. ASH has attained substantial compliance with the requirements of Section F.7.2. The Chief of Medical Services, Douglas Shelton, MD, has continued to provide an effective oversight system as well as active and competent participation in the care of individuals at the facility.3. The Chief of the Medical Unit at ASH, Willard Towle, MD, should be commended for his dedicated and competent management of the individuals under his care. <p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. ASH's Infection Control Department has maintained substantial compliance with all requirements of Section F.8 and has continued to collaborate with Nursing to ensure that clinically sound and appropriate objectives and interventions regarding diseases are contained in the WRPs.2. ASH's Infection Control Department continues to review its practices and update its policies and procedures in alignment with current
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>standards of practice.</p> <p>Summary of Progress on Dental Services</p> <ol style="list-style-type: none">1. ASH's Dental Department has attained substantial compliance with all requirements of Section F.9 except for the requirement pertaining to refusals. With ASH's current efforts directed at individualizing the WRPs, this area should come into substantial compliance by the next review period.2. ASH's Dental Department has implemented tours of the Dental Clinic to increase individual's comfort level with the dental staff, answer questions, and provide information about dental services.
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Frank Stass, MD, Assistant to the Chief of Psychiatry 2. Jean Dansereau, MD, Chief of Psychiatry 3. Robert Knapp, MD, Medical Director 4. Rosemary Morrison, RN, Assistant Nurse Administrator 5. Stephanie Chavez, Associate Mental Health Specialist 6. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 39 individuals: AB, AFG, AH, AM, BG, CDB, DAA, DJM, DKM, DWH, EAMW, EGM, GD, GOG, GP, GTM, HLW, HSH, JCW, JG, JHG, JJC, JJL, JJN, JLA, JLR, JPW, KLW, KTC, MH, MM, PRI, RA, RAB, RB, RCD, RJH, RW, and SB 2. ASH Admission Psychiatric Assessment Audit summary data (September 2009-February 2010) 3. ASH Integrated Assessment: Psychiatry Section Audit summary data (September 2009-February 2010) 4. ASH Monthly PPN Audit summary data (September 2009-February 2010) 5. ASH PRN and Stat monitoring summary data (September 2009-February 2010) 6. ASH Tardive Dyskinesia Database: Current Diagnosis of TD, Positive AIMS score, and History of TD 7. ASH TD Monitoring summary data (September 2009-February 2010) 8. Last ten ADRs for this reporting period 9. ASH aggregated data regarding ADRs (September 2009-February 2010) 10. Intensive case analyses (ICAs) completed during this review period 11. Last ten MVRs for this reporting period

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 12. Performance Improvement project Medication Room: Do Not Disturb Vest 13. Summary Report - Med Pass Time Study 2/11/10 and 2/12/10 14. Nursing Procedure 309.0 Control Drugs 15. Pharmacy Policy Manual 107 Controlled Medications 16. Controlled Drug Count Signature Record Form 17. Controlled Drug issues 18. ASH aggregated data regarding medication variances (September 2009-February 2010) 19. Pharmacy and Therapeutics Committee Minutes during the review period 20. Drug utilization evaluations (DUEs) completed by ASH during this review period
F.1.a	<p>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:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and provide specific summary outline of these updates.</p> <p>Findings: During this review period, ASH has adopted all new protocols and revisions in existing protocols that were developed by DMH's Psychopharmacology Advisory Committee (PAC). The following is a summary of these updates:</p> <ul style="list-style-type: none"> • Protocols for asenapine, iloperidone, non-SSRI antidepressants and Invega Sustenna (added to the Consta protocol) were developed. • The protocol regarding new generation antipsychotics was revised to add the warning of leukocytosis and agranulocytosis as a class effect as mandated by the US Food and Drug Administration. • The lamotrigine protocol was revised to include the possible adverse

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		<p>reaction of suicidal ideation.</p> <ul style="list-style-type: none"> • The Valproic Acid Protocol was revised regarding gastrointestinal side effects and bioavailability of this compound. • The Geriatric Prescribing Guidelines were revised to include the class warning of new generation antipsychotics regarding the increased risk of cerebrovascular accidents and death. Also added was a warning that SSRI treatment in middle age increases the risk of fracture in old age. <p>Recommendation 2, October 2009: Implement corrective actions to ensure timely communications between the PAC and all facilities.</p> <p>Findings: The DMH has established a process that adequately addresses this recommendation.</p> <p>Recommendation 3, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 99%, 99% and 23%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary
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		and provide specific summary outline of these updates. 2. Continue to monitor this requirement.																								
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td><i>Plan of care includes [regular psychotropic medications, with rationale; PRN and/or Stat medications, as applicable, with specific behavioral indicators; and special precautions to address risk factors, as indicated].</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <table border="1"> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan includes:</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.b</td> <td><i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p>	Admission Psychiatric Assessment			8.	<i>Plan of care includes [regular psychotropic medications, with rationale; PRN and/or Stat medications, as applicable, with specific behavioral indicators; and special precautions to address risk factors, as indicated].</i>	100%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation is documented</i>	100%	10.	<i>Psychopharmacology treatment plan includes:</i>	100%	Monthly PPN			2.b	<i>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i>	100%	3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	100%
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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;																									

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		<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 84% in the previous review period.</p>	Monthly PPN			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i>	100%			
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F.1.a.iii	tailored to each individual's symptoms;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i>	100%			
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F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.c</td> <td><i>Monitored for effectiveness against clearly identified target variables</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.c	<i>Monitored for effectiveness against clearly identified target variables</i>	100%			
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F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>100%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines,</i></td> <td>100%</td> </tr> </table>	Monthly PPN			2.g	<i>Current AIMS</i>	100%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines,</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for item 2.g. The compliance rate for item 5.d improved from 88% in the previous review period.</p>		<i>anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>							
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F.1.a.vi	modified based on clinical rationales;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>100%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for item 5.a. The compliance rate for item 5.d improved from 88% in the previous review period.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	100%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	100%
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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric</i></td> <td>100%</td> </tr> </table>	Monthly PPN			5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric</i>	100%			
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F.1.a.viii	Properly documented.	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">Admission Psychiatric Assessment</td> <td style="width: 30%;">8.a, 8.b and 8.c</td> <td style="width: 20%; text-align: center;">100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td style="text-align: center;">100%</td> </tr> <tr> <td>Monthly PPN</td> <td>2.b, 2.g, 3 and 5.a-5.d</td> <td style="text-align: center;">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" style="width: 100%; margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">period</th> <th style="width: 15%; text-align: center;">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Mean compliance rate</td> </tr> <tr> <td>Admission Psychiatric Assessment</td> <td style="text-align: center;">89%</td> <td style="text-align: center;">100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td style="text-align: center;">97%</td> <td style="text-align: center;">100%</td> </tr> <tr> <td>Monthly PPN</td> <td style="text-align: center;">88%</td> <td style="text-align: center;">100%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2.b, 2.g, 3 and 5.a-5.d	100%		period	Current period	Mean compliance rate			Admission Psychiatric Assessment	89%	100%	Integrated Assessment (Psychiatry)	97%	100%	Monthly PPN	88%	100%
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: As revised the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (September 2009-February 2010). The facility also used the DMH Nursing Services</p>																								

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Monitoring Forms for PRN and Stat medication uses, based on average samples of 58% and 49% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

Monthly PPN		
6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	100%

Comparative data indicated improvement in compliance from 71% in the previous review period.

Nursing Services PRN		
1.	<i>Safe administration of PRN medication.</i>	98%
2.	<i>Documentation of the circumstances requiring PRN medication.</i>	96%
3.	<i>Documentation of the individual's response to PRN medication.</i>	95%

Comparative data indicated improvement in compliance since the previous review period:

	period	Current period
Mean compliance rate		
1.	91%	98%
2.	86%	96%
3.	87%	95%

Nursing Services Stat		
1.	<i>Safe administration of Stat medication.</i>	96%

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		<table border="1" data-bbox="993 190 1887 342"> <tr> <td data-bbox="993 190 1087 266">2.</td> <td data-bbox="1087 190 1793 266"><i>Documentation of the circumstances requiring Stat medication.</i></td> <td data-bbox="1793 190 1887 266">96%</td> </tr> <tr> <td data-bbox="993 266 1087 342">3.</td> <td data-bbox="1087 266 1793 342"><i>Documentation of the individual's response to Stat medication.</i></td> <td data-bbox="1793 266 1887 342">95%</td> </tr> </table> <p data-bbox="993 386 1898 451">Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 492 1887 719"> <thead> <tr> <th data-bbox="993 492 1522 568"></th> <th data-bbox="1522 492 1713 568">period</th> <th data-bbox="1713 492 1887 568">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="993 568 1887 605">Mean compliance rate</td> </tr> <tr> <td data-bbox="993 605 1522 643">1.</td> <td data-bbox="1522 605 1713 643">79%</td> <td data-bbox="1713 605 1887 643">96%</td> </tr> <tr> <td data-bbox="993 643 1522 680">2.</td> <td data-bbox="1522 643 1713 680">81%</td> <td data-bbox="1713 643 1887 680">96%</td> </tr> <tr> <td data-bbox="993 680 1522 719">3.</td> <td data-bbox="1522 680 1713 719">85%</td> <td data-bbox="1713 680 1887 719">95%</td> </tr> </tbody> </table> <p data-bbox="993 764 1192 829">Other findings: Same as in D.1.f.</p> <p data-bbox="993 875 1142 940">Compliance: Substantial.</p> <p data-bbox="993 985 1507 1089">Current recommendations: 1. Continue to monitor this requirement. 2. Same as Recommendation 3 in D.1.f.</p>	2.	<i>Documentation of the circumstances requiring Stat medication.</i>	96%	3.	<i>Documentation of the individual's response to Stat medication.</i>	95%		period	Current period	Mean compliance rate			1.	79%	96%	2.	81%	96%	3.	85%	95%
2.	<i>Documentation of the circumstances requiring Stat medication.</i>	96%																					
3.	<i>Documentation of the individual's response to Stat medication.</i>	95%																					
	period	Current period																					
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2.	81%	96%																					
3.	85%	95%																					
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.	<p data-bbox="993 1138 1591 1170">Current findings on previous recommendations:</p> <p data-bbox="993 1211 1457 1276">Recommendation 1, October 2009: Continue to monitor this requirement.</p> <p data-bbox="993 1320 1898 1422">Findings: ASH used the standardized DMH Monthly PPN Audit Form to assess compliance (September 2009-February 2010). Sample size was based on</p>																					

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the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:

PPN - Revised		
5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>	
5.d.i	<i>Benzodiazepines</i>	100%
5.d.ii	<i>Anticholinergics</i>	100%
5.d.iii	<i>Polypharmacy</i>	100%

Comparative data indicated improvement in compliance since the previous review period:

	period	Current period
Mean compliance rate		
5.d.i	88%	100%
5.d.ii	88%	100%
5.d.iii	82%	100%

Recommendation 2, October 2009:

Continue to provide aggregated data (and data comparisons across review periods) regarding the mean total number of individuals receiving the following:

- a. Benzodiazepines for 60 days or more;
- b. Benzodiazepines in the presence of any diagnosis of substance use disorder;
- c. Benzodiazepines in the presence of any diagnosis of cognitive impairment;
- d. Anticholinergics for 60 days or more;

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- e. Anticholinergics in the presence of any diagnosis of cognitive impairments and/or tardive dyskinesia;
- f. Anticholinergics for individuals age 65 or above;
- g. Intra-class polypharmacy; and
- h. Inter-class polypharmacy.

Findings:

Additionally, ASH reported the following comparative data:

		Previous Period	Current Period
1.	Total number of individuals receiving benzodiazepines for 60 days or more	119	98
2.	Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more	108	91
3.	Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more	95	79
4.	Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)	22	18
5.	Total number receiving anticholinergics for 60 days or more	155	95
6.	Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above	30	16
7.	Total number with intra-class	405	378

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		<table border="1"> <tr> <td data-bbox="989 188 1050 228"></td> <td data-bbox="1050 188 1610 228"><i>polypharmacy</i></td> <td data-bbox="1610 188 1753 228"></td> <td data-bbox="1753 188 1892 228"></td> </tr> <tr> <td data-bbox="989 228 1050 305">8.</td> <td data-bbox="1050 228 1610 305"><i>Total number with inter-class polypharmacy</i></td> <td data-bbox="1610 228 1753 305">240</td> <td data-bbox="1753 228 1892 305">207</td> </tr> </table>		<i>polypharmacy</i>			8.	<i>Total number with inter-class polypharmacy</i>	240	207								
	<i>polypharmacy</i>																	
8.	<i>Total number with inter-class polypharmacy</i>	240	207															
		<p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>The reviews found a significant decrease in the number of individuals receiving high-risk medications compared to the last review period.</p> <p>This monitor also reviewed the charts of 25 individuals receiving the above types of medication regimens. The following is an outline of these reviews:</p> <p><u>Benzodiazepine use</u></p>																
		<table border="1"> <thead> <tr> <th data-bbox="989 1079 1144 1120">Individual</th> <th data-bbox="1144 1079 1417 1120">Medication(s)</th> <th data-bbox="1417 1079 1892 1120">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1120 1144 1193">AB</td> <td data-bbox="1144 1120 1417 1193">Lorazepam</td> <td data-bbox="1417 1120 1892 1193">Alcohol Abuse, Cannabis Abuse and Borderline Intellectual Functioning</td> </tr> <tr> <td data-bbox="989 1193 1144 1266">BG</td> <td data-bbox="1144 1193 1417 1266">Lorazepam</td> <td data-bbox="1417 1193 1892 1266">Polysubstance Dependence and Cognitive Disorder NOS</td> </tr> <tr> <td data-bbox="989 1266 1144 1307">EAMW</td> <td data-bbox="1144 1266 1417 1307">Clonazepam</td> <td data-bbox="1417 1266 1892 1307">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="989 1307 1144 1383">GP</td> <td data-bbox="1144 1307 1417 1383">Lorazepam</td> <td data-bbox="1417 1307 1892 1383">Dementia Due to Medical Condition with Behavioral Disturbance</td> </tr> </tbody> </table>		Individual	Medication(s)	Diagnosis	AB	Lorazepam	Alcohol Abuse, Cannabis Abuse and Borderline Intellectual Functioning	BG	Lorazepam	Polysubstance Dependence and Cognitive Disorder NOS	EAMW	Clonazepam	Polysubstance Dependence	GP	Lorazepam	Dementia Due to Medical Condition with Behavioral Disturbance
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GP	Lorazepam	Dementia Due to Medical Condition with Behavioral Disturbance																

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		<table border="1"> <tr> <td>GTM</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>HLW</td> <td>Clonazepam (tapering regimen)</td> <td>Alcohol Dependence, Cannabis Abuse and Cocaine Dependence</td> </tr> <tr> <td>JJC</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JLR</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JPW</td> <td>Clonazepam</td> <td>Alcohol Dependence and Amphetamine Abuse</td> </tr> <tr> <td>RAB</td> <td>Lorazepam (tapering regimen)</td> <td>Polysubstance Dependence and Cognitive Disorder NOS</td> </tr> </table> <p>This review found substantial compliance in nine charts (AB, BG, EAMW, GP, GTM, HLW, JJC, JLR and RAB) and partial compliance in one (JPW).</p> <p><u>Anticholinergic use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AM</td> <td>Benztrapine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>DKM</td> <td>Benztrapine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>MH</td> <td>Trihexyphenidyl</td> <td>Dementia Due to General Condition with Behavioral Disturbance</td> </tr> <tr> <td>MM</td> <td>Benztrapine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>RA</td> <td>Benztrapine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>RDC</td> <td>Benztrapine partial</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>RW</td> <td>Benztrapine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>This review found substantial compliance in four charts (AM, DKM, MM and RW) and partial compliance in three (MH, RA and RDC). At the time of this review, no individual age 65 or above received long-term anticholinergic treatment.</p>	GTM	Clonazepam	Polysubstance Dependence	HLW	Clonazepam (tapering regimen)	Alcohol Dependence, Cannabis Abuse and Cocaine Dependence	JJC	Lorazepam	Polysubstance Dependence	JLR	Clonazepam	Polysubstance Dependence	JPW	Clonazepam	Alcohol Dependence and Amphetamine Abuse	RAB	Lorazepam (tapering regimen)	Polysubstance Dependence and Cognitive Disorder NOS	Individual	Medication(s)	Diagnosis	AM	Benztrapine	Cognitive Disorder NOS	DKM	Benztrapine	Borderline Intellectual Functioning	MH	Trihexyphenidyl	Dementia Due to General Condition with Behavioral Disturbance	MM	Benztrapine	Borderline Intellectual Functioning	RA	Benztrapine	Borderline Intellectual Functioning	RDC	Benztrapine partial	Borderline Intellectual Functioning	RW	Benztrapine	Borderline Intellectual Functioning
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<u>Polypharmacy use</u>		
Individual	Medication(s)	Diagnosis
DAA	Mirtazapine, venlafaxine, buspirone, olanzapine and diphenhydramine	
DJM	Olanzapine, loxapine, fluvoxamine, clonazepam and topiramate	Polysubstance Dependence
DWH	Haloperidol decanoate, olanzapine, divalproex, lithium, benztropine and lorazepam	Polysubstance Dependence
GD	Haloperidol, buspirone, sertraline, divalproex, risperidone and benztropine	
GOG	Quetiapine, sertraline, haloperidol and benztropine	
JCW	Chlorpromazine, risperidone, ziprasidone, divalproex and benztropine	Borderline intellectual Functioning
JJL	Chlorpromazine, risperidone, lithium, zonisamide and trihexyphenidyl	
PRI	Aripiprazole, duloxetine, buspirone, oxcarbazepine, benztropine and propranolol	

The review found substantial compliance in four charts (DJM, GD, GOG and JJL) and partial compliance in four (DAA, DWH, JCW and PRI).

Compliance:
Partial, improved compared to the last review.

Current recommendation:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

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		compared to the last period.												
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Monthly PPN Auditing Form, ASH assessed its compliance based on an average sample of 23% of individuals receiving these medications during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 711 1887 824"> <tr> <td data-bbox="993 711 1087 824">5.d.v</td> <td data-bbox="1087 711 1793 824"><i>Atypical antipsychotic with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical, except for aripiprazole and ziprasidone</i></td> <td data-bbox="1793 711 1887 824">100</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 55% in the previous review period.</p> <p>Other findings: This monitor reviewed the charts of nine individuals who were receiving new generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="993 1193 1871 1421"> <thead> <tr> <th data-bbox="993 1193 1144 1230">Individual</th> <th data-bbox="1144 1193 1381 1230">Medication(s)</th> <th data-bbox="1381 1193 1871 1230">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 1230 1144 1308">AFG</td> <td data-bbox="1144 1230 1381 1308">Olanzapine and aripiprazole</td> <td data-bbox="1381 1230 1871 1308">Diabetes Mellitus</td> </tr> <tr> <td data-bbox="993 1308 1144 1421">AH</td> <td data-bbox="1144 1308 1381 1421">Risperidone and haloperidol</td> <td data-bbox="1381 1308 1871 1421">Diabetes Mellitus, Hyperlipidemia, Obesity, Metabolic Syndrome and Hypertension</td> </tr> </tbody> </table>	5.d.v	<i>Atypical antipsychotic with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical, except for aripiprazole and ziprasidone</i>	100	Individual	Medication(s)	Diagnosis	AFG	Olanzapine and aripiprazole	Diabetes Mellitus	AH	Risperidone and haloperidol	Diabetes Mellitus, Hyperlipidemia, Obesity, Metabolic Syndrome and Hypertension
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		CDB	Clozapine and quetiapine	Diabetes Mellitus and Obesity
		EGM	Olanzapine and quetiapine	Diabetes Mellitus and Obesity
		JG	Clozapine	Diabetes Mellitus
		JHG	Risperidone and olanzapine	Diabetes Mellitus and Hypertension
		JJN	Olanzapine	Diabetes Mellitus, Hyperlipidemia, Hypertension and Obesity
		KLW	Quetiapine and haloperidol	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
		RB	Risperidone, olanzapine and aripiprazole	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
		<p>The review found timely and appropriate monitoring in all cases, except for the following:</p> <ol style="list-style-type: none"> 1. The psychiatric progress note did not address the fact that the individual's triglyceride level rose from 212 to 321 during the previous month. There was no mention of this significant change as a possible side effect of treatment. In fact, this note indicated "none" under side effects of treatment and no diagnosis of hypertriglyceridemia was mentioned or addressed in the discussion of side effects/risk benefit analysis of treatment (JHG). 2. In the chart of AH, the psychiatric note addressed two metabolic conditions (diabetes and obesity) and indicated that no other side effects occurred. However, the chart included evidence of other disorders, including hyperlipidemia (this was not mentioned by the psychiatrist as a diagnosis or addressed in the discussion of side effects/risk benefit analysis of treatment). 3. No diagnosis of obesity was mentioned in the psychiatric progress note although the individual's BMI was documented at >41 (AFG). 		

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. In order to maintain compliance, the facility needs to correct the above mentioned process deficiencies. 															
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Movement Disorders Auditing Form, ASH assessed its compliance based on average samples ranging from 23% to 99% of individuals relevant to each indicator during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 932 1887 1421"> <tr> <td data-bbox="991 932 1087 1008">1.</td> <td data-bbox="1087 932 1793 1008"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 932 1887 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1087 1122">2.</td> <td data-bbox="1087 1008 1793 1122"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1008 1887 1122">100%</td> </tr> <tr> <td data-bbox="991 1122 1087 1235">3.</td> <td data-bbox="1087 1122 1793 1235"><i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 1122 1887 1235">100%</td> </tr> <tr> <td data-bbox="991 1235 1087 1312">4.</td> <td data-bbox="1087 1235 1793 1312"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 1235 1887 1312">100%</td> </tr> <tr> <td data-bbox="991 1312 1087 1421">5.</td> <td data-bbox="1087 1312 1793 1421"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1793 1312 1887 1421">100%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	100%	3.	<i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	100%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	100%
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		<table border="1"> <tr> <td>6.</td> <td><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td>100%</td> </tr> </table>	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	100%	7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	100%	8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	100%						
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<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for items 1-4 and 6. Compliance improved as follows for the remaining items:</p>																	
<table border="1"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>5.</td> <td>68%</td> <td>100%</td> </tr> <tr> <td>7.</td> <td>84%</td> <td>100%</td> </tr> <tr> <td>8.</td> <td>84%</td> <td>100%</td> </tr> </tbody> </table>				period	Current period	Mean compliance rate			5.	68%	100%	7.	84%	100%	8.	84%	100%
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<p>Other findings: This monitor reviewed the charts of six individuals who were diagnosed with tardive dyskinesia per the facility's database (HSH, JG, JLA, KTC, RJH and SB). The database identified 35 individuals as currently having this diagnosis, compared to 42 during the last review. In addition, one individual was identified as having history of TD diagnosis and 50 individuals were identified as having abnormal AIMS results but no current TD diagnosis. The review found that ASH has maintained progress in the following areas:</p> <ol style="list-style-type: none"> 1. Adequate system of identifying individuals with diagnosis or history of TD; 2. Completion of admission AIMS tests; 3. Completion of AIMS tests on a quarterly basis; 4. Including TD diagnosis, focus and corresponding objectives and 																	

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		<p>interventions in the individuals' WRPs;</p> <ol style="list-style-type: none"> 5. With few exceptions, using appropriate learning outcomes in the WRP objectives related to TD; 6. Caution in the use of unnecessary long-term treatment with anticholinergic agents; 7. Consideration of safer antipsychotic medication interventions; and 8. With few exceptions, adequate tracking of AIMS score in the psychiatric progress notes. <p>A few deficiencies were identified as follows:</p> <ol style="list-style-type: none"> 1. The objective related to TD was not clinically appropriate (SB) or easily understandable (JLA). 2. The psychiatric progress note did not track a significant change in AIMS score in one individual (JG). However, this individual received appropriate management of TD, including a safer antipsychotic medication. <p>The review found substantial compliance in five charts (HSH, JG, JLA, KTC and RJH) and partial compliance in one (SB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period

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		<p>compared with number reported during the previous period;</p> <p>b. Classification of probability and severity of ADRs;</p> <p>c. Any negative outcomes for individuals who were involved in serious reactions;</p> <p>d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</p> <p>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p> <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 708 1887 1167"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>69</td> <td>73</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>4</td> <td>3</td> </tr> <tr> <td>Possible</td> <td>38</td> <td>39</td> </tr> <tr> <td>Probable</td> <td>24</td> <td>27</td> </tr> <tr> <td>Definite</td> <td>3</td> <td>4</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>15</td> <td>15</td> </tr> <tr> <td>Moderate</td> <td>40</td> <td>49</td> </tr> <tr> <td>Severe</td> <td>14</td> <td>9</td> </tr> </tbody> </table> <p>Of the nine severe ADRs, none reportedly resulted in permanent sequelae to the individual involved.</p> <p>Previous</p> <p>ASH conducted intensive case analyses (ICAs) on all nine severe ADRs. A review of the facility's data regarding these ICAs found that the analyses utilized appropriate methodology and that the recommendations</p>		period	Current period	Total ADRs	69	73	Classification of Probability of ADRs			Doubtful	4	3	Possible	38	39	Probable	24	27	Definite	3	4	Classification of Severity of ADRS			Mild	15	15	Moderate	40	49	Severe	14	9
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		<p>for systemic corrective/educational actions were generally adequate.</p> <p>Recommendation 2, October 2009: Continue to provide analysis of patterns and trends, with corrective/ educational actions related to ADRs.</p> <p>ASH conducted analysis of ADR data during this review period. A summary follows:</p> <ol style="list-style-type: none"> 1. The trending of ADR reactions remained consistent over the last year, with the most common reactions involving hypotension and dizziness. The other common reactions were movement disorders, including rigidity. 2. The four most common medications involved in ADRs were haloperidol, divalproex, olanzapine, and chlorpromazine. 3. Educational events were scheduled monthly to discuss the data from ADR intensive case analysis, review of ASH protocols and discussion of relevant literature (see D.1.d.i). <p>The facility's analysis of ADR data and follow-up actions were adequate.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. In order to maintain substantial compliance, ASH needs to continue to increase reporting of ADRs. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs;
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		<ul style="list-style-type: none"> c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). <p>3. Continue to provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</p>
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: During this review period, ASH conducted DUEs to assess the use of risperidone, aripiprazole and SSRI antidepressants. In addition, the facility reviewed its data regarding the use of new generation antipsychotics for individuals with Axis III diagnoses of dyslipidemia, diabetes mellitus, hypertension or obesity (waist circumference greater than 40). A review of these DUEs found that the facility utilized adequate methodologies and follow-up actions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>

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<p>F.1.h</p>	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Present data to address the following:</p> <ol style="list-style-type: none"> Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; Total number of actual and potential variances during the review period compared with numbers reported during the previous period; Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); Number of critical breakdown points by outcome; Clinical information regarding each variance (category E or above) and the outcome to the individual involved; Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and Outline of ICAs, including description of variance, recommendations and actions taken. <p>Findings: ASH reported the following data regarding MVRs:</p> <table border="1" data-bbox="1003 1003 1789 1386"> <thead> <tr> <th>Number of Medication Variances</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Prescribing</td> <td>50</td> <td>171</td> </tr> <tr> <td>Transcribing</td> <td>263</td> <td>255</td> </tr> <tr> <td>Ordering/procurement</td> <td>14</td> <td>7</td> </tr> <tr> <td>Dispensing</td> <td>29</td> <td>28</td> </tr> <tr> <td>Administration</td> <td>368</td> <td>424</td> </tr> <tr> <td>Drug security</td> <td>204</td> <td>245</td> </tr> <tr> <td>Documentation</td> <td>1391</td> <td>1317</td> </tr> <tr> <td>Total variances</td> <td>2319</td> <td>2381</td> </tr> </tbody> </table>	Number of Medication Variances	Previous Period	Current Period	Prescribing	50	171	Transcribing	263	255	Ordering/procurement	14	7	Dispensing	29	28	Administration	368	424	Drug security	204	245	Documentation	1391	1317	Total variances	2319	2381
Number of Medication Variances	Previous Period	Current Period																											
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		Total Critical Breakdown Points	Previous Period	Current Period
		Total Critical Breakdown Points	2083	2208
		Potential MVRs	1728	1792
		Actual MVRs	355	416
		# Prescribing	30	152
		# Transcribing	222	215
		# Order/Procure	5	5
		# Dispensing	17	18
		# Administration	264	322
		# Drug Security	197	240
		# Document	1348	1256
		Outcome A	125	105
		Outcome B	1603	1689
		Outcome C	338	391
		Outcome D	17	22
		Outcome E	0	1
		Outcome F	0	0
		Outcome G	0	0
		Outcome H	0	0
		Outcome I	0	0
	<p>During this review period, only one MVR involving drug security reached threshold for an ICA. This monitor reviewed this ICA and found that the investigation, analysis and corrective actions were adequate.</p> <p>Recommendation 2, October 2009: Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p> <p>A summary of the facility's analysis of patterns/trends of MVR data and</p>			

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		<p>corresponding corrective actions follows:</p> <ol style="list-style-type: none">1. An education session (by the facility's Chief of the Pharmacy and Therapeutics Committee) was provided to the medical staff to address a pattern of increased prescribing variances (December 2009 to January 2010).2. The facility is in the process of using a chart sticker and corresponding sheet in the order section (providing visual cues to specific allergies) to address a spike in administration variances (September 2009).3. The facility's Health Specialist Services has initiated a daily review of all controlled drug logs to ensure staff compliance with drug security procedures (these procedures were revised during the previous review). This was done to address a pattern of potential drug security variances (missed initials on the controlled drug log at each shift change was the most frequent variance).4. ASH conducted a medication room survey to analyze a pattern of documentation variances (missed initials). The survey concluded that distraction was the primary contributor to these variances. Subsequently, the facility began a pilot of the medication room "DO NOT DISTURB" garment in Programs III and VII beginning in February 2010. In addition to medication variance outcome data, ASH plans to conduct a satisfaction survey on these pilot programs. ASH will then analyze both the quantitative data regarding the volume of documentation variance change and the input from staff regarding their perceptions of the benefits and challenges of the "DO NOT DISTURB" garment. <p>This monitor reviewed the facility's data and found that the facility's analysis and follow-up actions were adequate and that the facility has made sufficient progress in addressing both potential and actual variances.</p>
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		<p>Other findings: Reviews by this monitor found that the facility's data in this section were internally consistent and adequately covered the range of variance categories and critical breakdown points. However, some inconsistencies were noted between the KI indicator data and the data presented in this section regarding the counting of variances during the review period and there was a single math error in the total number of critical breakdown points in the progress report data. [The inconsistencies were explained subsequent to the tour and the facility has taken corrective action; it appears that that the issues contributing to MVR data variability have been resolved.]</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Present data to address the following:<ol style="list-style-type: none">a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period,b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period,c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc),d. Number of critical breakdown points by outcome,e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved,f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above, andg. Outline of ICAs, including description of variance, recommendations and actions taken.2. Provide analysis of patterns and trends, with corrective/educational
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		actions related to MVRs.
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in F.1.b and F.1.i.</p> <p>Findings: Same as in F.1.b and F.1.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.b and F.1.i.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics	<p>Current findings on previous recommendation:</p>

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	Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Recommendation, October 2009: Same as in F.1.b and F.1.i.</p> <p>Findings: Same as in F.1.b and F.1.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.b and F.1.i.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Compliance: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Substantial (in general).</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, October 2009: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p>Current recommendations: Same as in F.1.c, D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive	<p>Current findings on previous recommendation:</p>

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	<p>impairments, regardless of duration of treatment; and</p>	<p>Recommendation, October 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.v	<p>all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	<p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	<p>Each State hospital shall ensure that the medication management of individuals with</p>	<p>Current findings on previous recommendation:</p>

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	<p>substance abuse disorders is provided consistent with generally accepted professional standards of care.</p>	<p>Recommendation, October 2009: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Same as in C.2.o and F.1.c.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
F.1.o	<p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.</p>	<p>This requirement applies exclusively to Metropolitan State Hospital.</p>

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2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brooke Hatcher, RT, Supplemental Activities Coordinator 2. Charlie Joslin, Clinical Administrator 3. Christine Mathiesen, PhD, C-PAS Director 4. Deborah Hewitt, PhD, PBS Team Member 5. Debra Crawford, LCSW, Senior Supervising Social Worker 6. Diane Imrem, PsyD, Chief of Psychology 7. Donna Nelson, Standards Compliance Director 8. Glenn Potts, PhD 9. John De Morales, Executive Director 10. Karen Dubiel, Assistant to the Clinical Administrator 11. Killorin Riddell, PhD, Coordinator of Psychology Specialty Services 12. Mary Marble, PT, Assistant to By Choice Coordinator 13. Matthew Hennessy, PhD, Mall Director 14. Michael Tandy, PhD, PBS Team Member 15. Peggy Hoshino, PT, By Choice Staff 16. Rafael Romero, U.S, By Choice Coordinator 17. Teresa M. George, PhD, Senior Psychologist Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of the following 41 individuals: AA, AB, AED, AF, DP, DR, DS, EB, EE, EF, EME, ES, GP, HA, HLC, JA, JAM, JC, JN, JP, JSC, KN, LRM, MA, MC, MG, MO, NL, OR, RB, RBD, RC, RD, RH, RJ, RR, SAD, SB, SW, WT, and ZS 2. Neuropsychological Reports completed during this review period 3. Structural and Functional Assessments conducted during this review period 4. Behavioral Guidelines conducted during this review period 5. Staff training list and data conducted on PBS plans 6. Integrity checklists on PBS plans

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		<p>7. Outcome data for PBS plans and Behavioral Guideline implemented during this review period</p> <p>8. Trigger list and data for this review period</p> <p>9. PSR Mail services progress notes</p> <p>10. Psychology Progress Notes written as part of the interdisciplinary collaboration for PBS plans.</p> <p>11. PSSC Meeting minutes</p> <p><u>Observed:</u></p> <p>1. WRPC (Program I, unit 1) for monthly review of JJC</p> <p>2. WRPC (Program I, unit 1) for quarterly review of HLC</p> <p>3. WRPC (Program III, unit 21) for 7-day review of ES</p> <p>4. WRPC (Program IV, unit 16) for annual review AED</p> <p>5. By Choice Incentive Store</p>
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Maintain the required number of PBS teams to meet the 1:300 ratio as stated in the EP.</p> <p>Findings: ASH has three PBS teams and one DCAT. Together these four teams meet the 1:300 ratio of one team for each 300 individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring</p>	<p>Current findings on previous recommendation:</p>

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program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and

Recommendation, October 2009:

Continue current practice.

Findings:

The table below showing the number of new staff hired at ASH during the review month (N), the number of new staff trained during the review month (n), and the percentage of new staff trained (%C) is a summary of the facility's data:

New Staff Training							
2009/2010	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	34	0	1	24	37	0	16
n	34	0	1	24	37	0	16
%S	100	NA	100	100	100	NA	100
% C	100	NA	100	100	100	NA	100

The table below showing the number of direct care staff at ASH (N), the number of direct care staff trained (cumulative across months) during the Annual Staff training for each month of this review period (n), and the percent staff trained (%C) is a summary of the facility's data:

Annual Staff Training							
2009/2010	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	1064	1064	1063	1063	1039	1039	1055
n	1222	1225	1225	1232	1242	1245	1232
%S	100	100	100	100	100	NA	100
% C	100	100	100	100	100	NA	100

As indicated in the tables above, ASH trained all new staff (two hours each) and re-trained all staff during the Annual Staff Training (six hours each) on PBS. In addition, documentation review found that all staff responsible for implementing behavior intervention plans (behavior guidelines and Positive Behavior Support Plans) had been trained to

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		<p>competency on implementing the plans.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																																											
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The following table summarizes staff training on By Choice during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 821 1890 1198"> <thead> <tr> <th colspan="8">Staff Training on By Choice</th> </tr> <tr> <th>2008/9</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Number of staff eligible for training</td> <td>34</td> <td>0</td> <td>1</td> <td>24</td> <td>37</td> <td>0</td> <td>16</td> </tr> <tr> <td>Number of staff trained</td> <td>34</td> <td>0</td> <td>1</td> <td>24</td> <td>37</td> <td>0</td> <td>16</td> </tr> <tr> <td>Percentage of eligible staff trained</td> <td>100</td> <td>NA</td> <td>100</td> <td>100</td> <td>100</td> <td>NA</td> <td>100</td> </tr> </tbody> </table> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, ASH assessed its compliance based on a mean sample of 14% of the Level of Care staff:</p> <table border="1" data-bbox="993 1385 1871 1422"> <tr> <td>1.</td> <td><i>Staff understands the goal of the By Choice system.</i></td> <td>100%</td> </tr> </table>	Staff Training on By Choice								2008/9	Sep	Oct	Nov	Dec	Jan	Feb	Mean	Number of staff eligible for training	34	0	1	24	37	0	16	Number of staff trained	34	0	1	24	37	0	16	Percentage of eligible staff trained	100	NA	100	100	100	NA	100	1.	<i>Staff understands the goal of the By Choice system.</i>	100%
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1.	<i>Staff understands the goal of the By Choice system.</i>	100%																																											

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		2.	<i>Staff can state the current point cycle.</i>	100%
		3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	100%
		4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%
		5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice.</i>	98%
		6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	100%
		7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	100%
		8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	100%
		9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	99%
		10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	100%
		11.	<i>Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.</i>	100%
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for item 1-4 and 6-11. The compliance rate for item 5 in the previous review period was 88%.</p> <p>Other findings: Using the Fidelity of Implementation by Individuals Form, ASH also assessed fidelity of By Choice implementation based on a mean sample of 24% of individuals in the facility:</p>		
		1.	<i>The individual understands the goal of the By Choice</i>	100%

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			<i>system.</i>	
		2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	94%
		3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	100%
		4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	100%
		5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	99%
		6.	<i>Individual can indicate how many points he or she may earn each day.</i>	99%
		7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	91%
		8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	93%
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	98%
		10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	96%
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for items 1 and 3-6. Compliance for the remaining items improved as follows:</p>		
			Previous period	Current period
		Mean compliance rate		
		2.	76%	94%
		7.	81%	91%
		8.	73%	93%
		9.	89%	98%

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		10.	74%	96%																																																				
<p>Using the By Choice Monitoring Form: Satisfaction Check, ASH surveyed a mean sample of 24% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>																																																								
<table border="1"> <thead> <tr> <th data-bbox="976 414 1066 492"></th> <th data-bbox="1066 414 1610 492"></th> <th data-bbox="1610 414 1745 492">Previous period</th> <th data-bbox="1745 414 1921 492">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="976 492 1066 565">1.</td> <td data-bbox="1066 492 1610 565"><i>By Choice motivates me to participate in treatment.</i></td> <td data-bbox="1610 492 1745 565">93%</td> <td data-bbox="1745 492 1921 565">98%</td> </tr> <tr> <td data-bbox="976 565 1066 638">2.</td> <td data-bbox="1066 565 1610 638"><i>The point system motivates me to improve my behavior.</i></td> <td data-bbox="1610 565 1745 638">92%</td> <td data-bbox="1745 565 1921 638">99%</td> </tr> <tr> <td data-bbox="976 638 1066 711">3.</td> <td data-bbox="1066 638 1610 711"><i>The point system motivates me to learn new skills.</i></td> <td data-bbox="1610 638 1745 711">87%</td> <td data-bbox="1745 638 1921 711">98%</td> </tr> <tr> <td data-bbox="976 711 1066 829">4.</td> <td data-bbox="1066 711 1610 829"><i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP.</i></td> <td data-bbox="1610 711 1745 829">88%</td> <td data-bbox="1745 711 1921 829">96%</td> </tr> <tr> <td data-bbox="976 829 1066 902">5.</td> <td data-bbox="1066 829 1610 902"><i>My WRPT discusses By Choice with me during my WRPC.</i></td> <td data-bbox="1610 829 1745 902">75%</td> <td data-bbox="1745 829 1921 902">98%</td> </tr> <tr> <td data-bbox="976 902 1066 976">6.</td> <td data-bbox="1066 902 1610 976"><i>During my WRPC I have input into how my points are allocated on my Point Card.</i></td> <td data-bbox="1610 902 1745 976">82%</td> <td data-bbox="1745 902 1921 976">99%</td> </tr> <tr> <td data-bbox="976 976 1066 1049">7.</td> <td data-bbox="1066 976 1610 1049"><i>My WRPT uses By Choice to help me improve my behavior.</i></td> <td data-bbox="1610 976 1745 1049">89%</td> <td data-bbox="1745 976 1921 1049">99%</td> </tr> <tr> <td data-bbox="976 1049 1066 1122">8.</td> <td data-bbox="1066 1049 1610 1122"><i>My WRPT uses By Choice to help me learn new skills.</i></td> <td data-bbox="1610 1049 1745 1122">-%</td> <td data-bbox="1745 1049 1921 1122">98%</td> </tr> <tr> <td data-bbox="976 1122 1066 1195">9.</td> <td data-bbox="1066 1122 1610 1195"><i>My unit staff uses By Choice to help me improve my behavior.</i></td> <td data-bbox="1610 1122 1745 1195">-%</td> <td data-bbox="1745 1122 1921 1195">98%</td> </tr> <tr> <td data-bbox="976 1195 1066 1268">10.</td> <td data-bbox="1066 1195 1610 1268"><i>My unit staff uses By Choice to help me learn new skills.</i></td> <td data-bbox="1610 1195 1745 1268">-%</td> <td data-bbox="1745 1195 1921 1268">98%</td> </tr> <tr> <td data-bbox="976 1268 1066 1341">11.</td> <td data-bbox="1066 1268 1610 1341"><i>I like the selection of ITEMS at the Incentive Store.</i></td> <td data-bbox="1610 1268 1745 1341">-%</td> <td data-bbox="1745 1268 1921 1341">98%</td> </tr> <tr> <td data-bbox="976 1341 1066 1391">12.</td> <td data-bbox="1066 1341 1610 1391"><i>I like the selection of ACTIVITIES at</i></td> <td data-bbox="1610 1341 1745 1391">-%</td> <td data-bbox="1745 1341 1921 1391">100%</td> </tr> </tbody> </table>							Previous period	Current period	1.	<i>By Choice motivates me to participate in treatment.</i>	93%	98%	2.	<i>The point system motivates me to improve my behavior.</i>	92%	99%	3.	<i>The point system motivates me to learn new skills.</i>	87%	98%	4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP.</i>	88%	96%	5.	<i>My WRPT discusses By Choice with me during my WRPC.</i>	75%	98%	6.	<i>During my WRPC I have input into how my points are allocated on my Point Card.</i>	82%	99%	7.	<i>My WRPT uses By Choice to help me improve my behavior.</i>	89%	99%	8.	<i>My WRPT uses By Choice to help me learn new skills.</i>	-%	98%	9.	<i>My unit staff uses By Choice to help me improve my behavior.</i>	-%	98%	10.	<i>My unit staff uses By Choice to help me learn new skills.</i>	-%	98%	11.	<i>I like the selection of ITEMS at the Incentive Store.</i>	-%	98%	12.	<i>I like the selection of ACTIVITIES at</i>	-%	100%
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			<i>the Incentive Store.</i>		
		13.	<i>I like the prices of the ITEMS at the Incentive Store.</i>	-%	97%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store.</i>	-%	99%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system.</i>	-%	99%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, ASH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p>			
		1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>		100%
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>		100%
		3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>		100%
		4.	<i>The incentive store has an inventory control system.</i>		100%
		5.	<i>The incentive store has a system to track and remove outdated food items.</i>		100%
		6.	<i>There is a By Choice Manual located in the incentive store.</i>		100%
		7.	<i>The incentive store staff has completed incentive store training.</i>		100%
		8.	<i>The individuals bring their point cards to the store to make a purchase.</i>		100%
		9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>		100%
		10.	<i>There is an Alert List in the incentive store for staff</i>		100%

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			<i>reference.</i>	
		11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%
<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for items 1, 2 and 7-11. Compliance for the remaining items improved as follows:</p>				
			Previous period	Current period
Mean compliance rate				
		3.	31%	100%
		4.	29%	100%
		5.	52%	100%
		6.	28%	100%
<p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), ASH assessed fidelity of implementation based on average samples of 14% of the Level of Care Staff, 24% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p>				
		Level of Care Staff	100%	
		Individuals	97%	
		By Choice Program Staff	100%	
<p>Recommendations for further improvements during the maintenance stage include:</p>				
<ol style="list-style-type: none"> 1. Include "social attention" when delivering By Choice point cards as part of the By Choice staff training. 2. Include "social attention" when delivering By Choice point cards as an 				

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		<p>item in the By Choice staff monitoring data.</p> <p>3. Introduce a "level system" for the By Choice incentive system.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The Chief of Psychology confirmed that she continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1"> <tr> <td data-bbox="989 415 1087 526">1.</td> <td data-bbox="1087 415 1793 526"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1793 415 1887 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 602">2.</td> <td data-bbox="1087 526 1793 602"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 526 1887 602">100%</td> </tr> <tr> <td data-bbox="989 602 1087 678">3.</td> <td data-bbox="1087 602 1793 678"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms.</i></td> <td data-bbox="1793 602 1887 678">100%</td> </tr> <tr> <td data-bbox="989 678 1087 789">4.</td> <td data-bbox="1087 678 1793 789"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1793 678 1887 789">100%</td> </tr> <tr> <td data-bbox="989 789 1087 899">5.</td> <td data-bbox="1087 789 1793 899"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 789 1887 899">100%</td> </tr> <tr> <td data-bbox="989 899 1087 976">6.</td> <td data-bbox="1087 899 1793 976"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 899 1887 976">100%</td> </tr> <tr> <td data-bbox="989 976 1087 1052">7.</td> <td data-bbox="1087 976 1793 1052"><i>Direct observations of the challenging behavior were undertaken, as applicable.</i></td> <td data-bbox="1793 976 1887 1052">100%</td> </tr> <tr> <td data-bbox="989 1052 1087 1162">8.</td> <td data-bbox="1087 1052 1793 1162"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1052 1887 1162">100%</td> </tr> <tr> <td data-bbox="989 1162 1087 1206">9.</td> <td data-bbox="1087 1162 1793 1206"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 1162 1887 1206">100%</td> </tr> <tr> <td data-bbox="989 1206 1087 1386">10.</td> <td data-bbox="1087 1206 1793 1386"><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1206 1887 1386">100%</td> </tr> <tr> <td data-bbox="989 1386 1087 1424">11.</td> <td data-bbox="1087 1386 1793 1424"><i>Patterns of challenging behavior were recognized</i></td> <td data-bbox="1793 1386 1887 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms.</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable.</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%	11.	<i>Patterns of challenging behavior were recognized</i>	100%
1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%																																	
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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%; text-align: center;"><i>based on the structural and functional assessments.</i></td> <td style="width: 10%;"></td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of eight PBS plans (AF, DP, DWR, EB, HA, JC, JN and MG) found that all eight plans had been developed and implemented based on data derived from structural and functional assessments.</p> <p>Recommendations for continued improvement during the maintenance phase include:</p> <ol style="list-style-type: none"> 1. Collect and analyze baseline data on the cyclical and episodic nature of the target behaviors for better data analysis during the treatment phases. 2. Emphasize the preventive factors in data collection and intervention: including the setting events, antecedents, and precursors. <p>Current recommendation: Continue to monitor this requirement.</p>		<i>based on the structural and functional assessments.</i>	
	<i>based on the structural and functional assessments.</i>				
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">12.</td> <td style="width: 85%; text-align: center;"><i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i></td> <td style="width: 10%; text-align: center;">100%</td> </tr> </table>	12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i>	100%
12.	<i>Hypotheses of the maladaptive behavior are based on structural and functional assessments.</i>	100%			

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		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of eight PBS plans (AF, DP, DWR, EB, HA, JC, JN and MG) found that the hypotheses in all eight plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1008 1892 1118"> <tr> <td data-bbox="993 1008 1087 1118">5.</td> <td data-bbox="1087 1008 1793 1118"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 1008 1892 1118">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of five PBS plans and their related assessments (AB, AF, EE, JC and MG) found that all five plans had documented previous interventions and their results throughout the assessments under different categories (for example, psychiatric history, treatment history, other structural</p>	5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5.	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			

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		<p>assessments, and records review). However, when previous behavioral interventions and their effects were not found in the assessments, it was not obvious to this monitor if it was due to absence of previous behavioral interventions or failure to include the information in the assessments. It will be helpful if the PBS staff would state as such in the assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 894 1887 1008"> <tr> <td data-bbox="993 894 1087 1008">17.</td> <td data-bbox="1087 894 1793 1008"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs;</i></td> <td data-bbox="1793 894 1887 1008">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 14 PBS plans (AA, AB, AF, DP, DR, EE, GP, JC, JN, JP, MA, MG, RD and RH) found that all 14 behavioral interventions were based on a positive behavioral support model without any use of aversive or punishment contingencies.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs;</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs;</i>	100%			

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<p>F.2.c.v</p>	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines implemented during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 565 1890 673"> <tr> <td data-bbox="991 565 1087 673">22.</td> <td data-bbox="1087 565 1795 673"><i>The PSSC ensures that the BG and PBS Plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></td> <td data-bbox="1795 565 1890 673">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity check data for the PBS plans and behavior guidelines of eight individuals (AA, AB, AF, EE, JC, MG, RD and RH) found that ASH had conducted fidelity checks on all eight plans/guidelines.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	22.	<i>The PSSC ensures that the BG and PBS Plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%
22.	<i>The PSSC ensures that the BG and PBS Plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%			
<p>F.2.c.vi</p>	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals who have triggered one</p>			

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or more of the thresholds during this review period (September 2009-February 2010):

10.	<i>Triggers for instituting individualized behavioral interventions are specified and utilized, and these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control.</i>	100%
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The compliance data above indicates that Psychological Services reviewed all individuals who met trigger threshold during this review period. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.

Other findings:

The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:

DMH Psychology Services Monitoring Form							
2009/2010	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Restraint	32	29	31	20	35	8	27
%C	100	100	100	100	100	100	100
Seclusion	25	30	33	26	23	19	26
%C	100	100	100	100	100	100	100
1:1	41	38	51	40	40	19	38
%C	100	100	100	100	100	100	100
Aggression to others	45	34	36	26	40	18	33
%C	100	100	100	100	100	100	100
Aggression to self	7	7	10	7	8	3	7

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		%C	100	100	100	100	100	100	100																								
		<p>As the table above indicates, Psychological Services had reviewed and addressed the service needs of all individuals who had met trigger thresholds during this review period. The PSSC under the current Coordinator and the support psychology staff is functioning very well as evidenced by the data.</p> <p>The table below showing the numbers of triggers during the months in which Behavioral Guidelines were implemented and the numbers of triggers during the last month of this review period is a summary of the facility's data:</p>																															
		<table border="1"> <thead> <tr> <th data-bbox="991 675 1264 716"></th> <th colspan="2" data-bbox="1264 675 1780 716">Number of triggers</th> </tr> <tr> <th data-bbox="991 716 1264 805">Months</th> <th data-bbox="1264 716 1530 805">At time BG was implemented</th> <th data-bbox="1530 716 1780 805">In February 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 805 1264 846">Sept 2009</td> <td data-bbox="1264 805 1530 846">23</td> <td data-bbox="1530 805 1780 846">0</td> </tr> <tr> <td data-bbox="991 846 1264 886">Oct 2009</td> <td data-bbox="1264 846 1530 886">11</td> <td data-bbox="1530 846 1780 886">5</td> </tr> <tr> <td data-bbox="991 886 1264 927">Nov 2009</td> <td data-bbox="1264 886 1530 927">13</td> <td data-bbox="1530 886 1780 927">0</td> </tr> <tr> <td data-bbox="991 927 1264 967">Dec 2009</td> <td data-bbox="1264 927 1530 967">4</td> <td data-bbox="1530 927 1780 967">1</td> </tr> <tr> <td data-bbox="991 967 1264 1008">Jan 2010</td> <td data-bbox="1264 967 1530 1008">11</td> <td data-bbox="1530 967 1780 1008">5</td> </tr> <tr> <td data-bbox="991 1008 1264 1049">Feb 2010</td> <td data-bbox="1264 1008 1530 1049">5</td> <td data-bbox="1530 1008 1780 1049">-</td> </tr> </tbody> </table>									Number of triggers		Months	At time BG was implemented	In February 2010	Sept 2009	23	0	Oct 2009	11	5	Nov 2009	13	0	Dec 2009	4	1	Jan 2010	11	5	Feb 2010	5	-
	Number of triggers																																
Months	At time BG was implemented	In February 2010																															
Sept 2009	23	0																															
Oct 2009	11	5																															
Nov 2009	13	0																															
Dec 2009	4	1																															
Jan 2010	11	5																															
Feb 2010	5	-																															
		<p>The table above summarizes trigger outcome data only for the last month of the review period. However, data review found that triggers continued to decrease during each month (from September 2009 to February 2010) since the implementation of the Behavior Guidelines. There is no outcome data for the month of February as the Behavior Guidelines were implemented on this month. The reduction in triggers was a function of the reduction in physical aggression targeted by the Behavior Guidelines.</p>																															

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1"> <tr> <td>27.</td> <td><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of psychiatry and psychology progress notes of 14 individuals (AA, AB, AF, DP, DR, EE, GP, JC, JN, JP, MA, MG, RD and RH) found that positive behavior support teams and team psychologists integrated their therapies with other treatment modalities, including drug therapy, in all 14 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	27.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%
27.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and</p>	<p>Current findings on previous recommendation:</p>			

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	<p>Recovery Plan;</p>	<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 488 1887 602"> <tr> <td data-bbox="993 488 1087 602">19.</td> <td data-bbox="1087 488 1793 602"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections.</i></td> <td data-bbox="1793 488 1887 602">97%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 11 individuals with PBS plans or PBS assessments (AF, DP, DS, DWR, EB, JC, JN, KN, LRM, MG and MO) found that all 11 WRPs in the charts had properly discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections.</i>	97%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections.</i>	97%			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (September 2009-February 2010):</p>			

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		<table border="1" data-bbox="993 228 1887 305"> <tr> <td data-bbox="993 228 1087 305">24.</td> <td data-bbox="1087 228 1793 305"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 228 1887 305">100%</td> </tr> </table> <p data-bbox="993 347 1892 415">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 457 1877 634">This monitor's review of PBS plans, outcome data, and WRPs of seven individuals (AF, DP, DWR, EB, JC, JN and MG) found that PBS teams reviewed and revised all seven plans based on data trends, and all seven WRPs contained documentation of the plan implementation data in the Present Status section.</p> <p data-bbox="993 680 1457 748">Current recommendation: Continue to monitor this requirement.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			
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.	<p data-bbox="993 792 1577 824">Current findings on previous recommendation:</p> <p data-bbox="993 867 1457 935">Recommendation, October 2009: Continue to monitor this requirement.</p> <p data-bbox="993 977 1881 1122">Findings: Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of behavior guidelines developed during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1157 1887 1234"> <tr> <td data-bbox="993 1157 1087 1234">21.</td> <td data-bbox="1087 1157 1793 1234"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1793 1157 1887 1234">100%</td> </tr> </table> <p data-bbox="993 1276 1892 1344">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 1386 1892 1416">A review of six PBS plans (AF, DP, DR, JN, MG and RH) found that all six</p>	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%			

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		<p>plans included data on staff training, post-test, and fidelity checks.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.</p> <table border="1" data-bbox="1005 857 1896 1122"> <tr> <td data-bbox="1005 857 1098 932">15.a. i</td> <td data-bbox="1098 857 1787 932"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1787 857 1896 932">100%</td> </tr> <tr> <td data-bbox="1005 932 1098 1006">15.a. ii</td> <td data-bbox="1098 932 1787 1006"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1787 932 1896 1006">100%</td> </tr> <tr> <td data-bbox="1005 1006 1098 1122">15.b</td> <td data-bbox="1098 1006 1787 1122"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1787 1006 1896 1122">100%</td> </tr> </table> <p>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.</p> <p>Current recommendation: Continue current practice.</p>	15.a. i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a. ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%
15.a. i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%									
15.a. ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%									
15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%									

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F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH By Choice Chart Audit Form, ASH assessed its compliance based on an average sample of 22% of the individuals at ASH during this review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 561 1890 638"> <tr> <td data-bbox="991 561 1087 638">2.</td> <td data-bbox="1087 561 1795 638"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i></td> <td data-bbox="1795 561 1890 638">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that all six WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (ES, GP, JSC, RBD, RR and SAD). All six WRPs in the charts also contained documentation that the individual was a participant in his/her By Choice point.</p> <p>This monitor observed four WRPCs (AED, ES, HLC and JJC). Where possible, the WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	100%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	100%			
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1</p>	<p>Current findings on previous recommendation:</p>			

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	<p>registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: ASH has a full DCAT team. Documentation review (training modules and topics) found that the DCAT members have been providing training to ASH staff (for example during New Employee training). The team members received training on PBS/BG-related information including graphing, database utilities, assessment instruments used for functional assessment, and writing of objectives for PBS/BG. They were also receiving weekly individual and group supervision.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Staff interview and review of PSSC meeting minutes (September 2009 through February 2010) found that the PSSC has met regularly and that attendance of the standing members of the Committee at these meetings has been high. The PSSC and ETRC have collaborated to review individuals with medical/behavioral issues, especially individuals who had met trigger thresholds on key indicators (aggression, self-harm, restraint, etc.).</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																				
F.2.f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: As of January 2010, ASH has the full allotment of five Neuropsychologists.</p> <p>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of referrals received each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 894 1881 1268"> <thead> <tr> <th></th> <th></th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a.i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>55</td> <td>67</td> <td>35</td> <td>50</td> <td>36</td> <td>19</td> <td>44</td> </tr> <tr> <td>18.a.ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>9</td> <td>11</td> <td>8</td> <td>9</td> <td>6</td> <td>11</td> <td>9</td> </tr> <tr> <td>18.a.iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>33</td> </tr> </tbody> </table> <p>The table below shows other areas of work conducted by the Neuropsychological services at ASH:</p>			Sep	Oct	Nov	Dec	Jan	Feb	Mean	18.a.i	<i>Number of neuropsychological assessments due for completion in the review month</i>	55	67	35	50	36	19	44	18.a.ii	<i>Of those in 18.a.i, number completed</i>	9	11	8	9	6	11	9	18.a.iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							33
		Sep	Oct	Nov	Dec	Jan	Feb	Mean																														
18.a.i	<i>Number of neuropsychological assessments due for completion in the review month</i>	55	67	35	50	36	19	44																														
18.a.ii	<i>Of those in 18.a.i, number completed</i>	9	11	8	9	6	11	9																														
18.a.iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							33																														

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		2009 / 2010	Sep	Oct	Nov	Dec	Jan	Feb	Mean
		Neuropsychological Focused Assessments completed	9	11	8	9	6	11	9
		Group referrals	7	25		20		10	14
		Number of referrals completed	52	54 ₁₃	37	47 ₇	33 ₂₇		42
		<p>ASH had maintained the mean number of assessments completed since the last review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>							
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Psychologists at ASH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>							

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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cynthia Davis, RN, MSN, Nurse Administrator 2. Donna Hunt, RN, HSS 3. Rosemary Morrison, HSS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. ASH's training rosters 3. Medication Variance Reports for MAR and Narcotic Log blanks 4. Medication Variance Reporting Process Structure 5. Medication Administration Monitoring audit for medication observation 6. Medical records for the following 34 individuals: AC, CDG, CLT, CLW, DAY, DEH, HFH, HKV, HLH, JAA, JCS, JG, JJA, JKS, JS, JWA, KBM, KFB, LRP, MAR, MC, MJG, MT, MTT, MW, PPD, RCM, RDC, RFH, RSC, SAD, SG, TE and TLB <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Observation of shift report on unit 34 2. Medication administration on Unit 17 3. WRPC (Program I, unit 12B) for monthly review of LCC 4. WRPC (Program I, unit 12B) for monthly review of REN 5. WRPC (Program III, unit 21B) for monthly review of FT 6. WRPC (Program IV, unit 2A) for quarterly review of DRM
<p>F.3.a</p>	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally</p>	<p>Compliance: Substantial.</p>

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	<p>accepted professional standards of care, to ensure:</p>							
<p>F.3.a.i</p>	<p>safe administration of PRN medications and Stat medications;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Increase sample size for Stat medication to at least 20%.</p> <p>Findings: ASH has increased the sample size for Stat medications to at least 20%.</p> <p>Recommendation 2, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 58% mean sample of PRNs administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 894 1887 935"> <tr> <td data-bbox="993 894 1087 935">1.</td> <td data-bbox="1087 894 1793 935"><i>Safe administration of PRN medications</i></td> <td data-bbox="1793 894 1887 935">98%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 49% mean sample of Stat medications administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1268 1887 1308"> <tr> <td data-bbox="993 1268 1087 1308">2.</td> <td data-bbox="1087 1268 1793 1308"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 1268 1887 1308">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 79% in the previous review period.</p>	1.	<i>Safe administration of PRN medications</i>	98%	2.	<i>Safe administration of Stat medications</i>	96%
1.	<i>Safe administration of PRN medications</i>	98%						
2.	<i>Safe administration of Stat medications</i>	96%						

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		<p>A review of 210 PRN and Stat orders (190 PRN and 20 Stat) for 23 individuals (AC, DAY, DEH, HFH, HKV, JAA, JCS, JJA, JKS, JS, JWA, KFB, LRP, MJG, MT, MTT, MW, PPD, RDC, RSC, SAD, SG and TLB) found that all included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.3.a.i.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 58% mean sample of PRNs administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 933 1890 1083"> <tr> <td data-bbox="991 933 1087 1083">3.</td> <td data-bbox="1087 933 1793 1083"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 933 1890 1083">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 86% in the previous review period.</p> <p>A review of 190 incidents of PRN medications for 18 individuals (AC, DAY, HFH, HKV, JAA, JCS, JJA, JS, JWA, KFB, MJG, MTT, MW, PPD, RDC, RSC, SAD and TLB) found adequate documentation in the IDNs of the circumstances requiring the PRN in 186 incidents.</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%			

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		<p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 49% mean sample of Stat medications administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 376 1887 526"> <tr> <td data-bbox="991 376 1087 526">4.</td> <td data-bbox="1087 376 1793 526"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 376 1887 526">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% in the previous review period.</p> <p>A review of 20 incidents of Stat medications for five individuals (DEH, JKS, LRP, MT and SG) found adequate documentation in the IDNs of the circumstances requiring the Stat in all 20 incidents.</p> <p>Current recommendation: Continue current practice.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.3.a.i.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 58% mean sample of PRNs administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1305 1887 1416"> <tr> <td data-bbox="991 1305 1087 1416">5.</td> <td data-bbox="1087 1305 1793 1416"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 1305 1887 1416">95%</td> </tr> </table>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	95%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	95%			

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		<p>Comparative data indicated improvement in compliance from 87% in the previous review period.</p> <p>A review of 190 incidents of PRN medications for 18 individuals (AC, DAY, HFH, HKV, JAA, JCS, JJA, JS, JWA, KFB, MJG, MTT, MW, PPD, RDC, RSC, SAD and TLB) found a timely comprehensive assessment in the IDNs of the individual's response in 187 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 49% mean sample of Stat medications administered each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 711 1887 821"> <tr> <td data-bbox="991 711 1087 821">6.</td> <td data-bbox="1087 711 1793 821"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 711 1887 821">95%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 85% in the previous review period.</p> <p>A review of 20 incidents of Stat medications for five individuals (DEH, JKS, LRP, MT and SG) found a timely comprehensive assessment in the IDNs of the individual's response in all 20 incidents.</p> <p>Current recommendation: Continue current practice.</p>	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	95%
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	95%			
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>			

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	<p>variances.</p>	<p>Findings: ASH's process for MVRs continues to include the following steps:</p> <ol style="list-style-type: none"> 1. MVR generated after variance discovered 2. Review by Program HSS - Maintains original MVR 3. Review by Program Unit Supervisor - All MVRs 4. Review by Program Director, as applicable (all actual MVRs) 5. Review by Standards Compliance MVR Team - All MVRs for review/data agreement and identification of serious potential variances 6. Review by Pharmacy (all actual MVRs) - for ORYX benchmarking <p>The Programs immediately contact Standards Compliance of any MVR suspected to be Serious (actual or potential). The information is forwarded to the Medical Director, Central Nursing Services, Medication Management EPPI Team Leader and Standards Compliance - Licensing as applicable. The Medication Management EPPI Team reviews for Intensive Case Analysis (for serious MVRs) or In-Depth Reviews (for serious potential MVRs).</p> <p>ASH continues to put significant effort into improving the medication administration system. At the time of the review, the facility was evaluating strategies to decrease the number of interruptions the medication nurses experience while administering medications. A review of a random sample of MVRs found that ASH had MVRs for the missing initials and signatures on the MARs and Narcotics Log that were reported.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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<p>F.3.c</p>	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See C.2.I.</p> <p>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.I for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement and ensure a sample size of at least 20%.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, ASH assessed its compliance based on an average sample of 27% of the nursing staff:</p> <table border="1" data-bbox="991 1192 1892 1344"> <tr> <td data-bbox="991 1192 1087 1344">8.</td> <td data-bbox="1087 1192 1793 1344"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 1192 1892 1344">98%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</p>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	98%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	98%			

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		<p>at least 90% from the previous review period.</p> <p>In four WRPCs observed, all team members were very familiar with the individuals' goals and interventions in the WRPs. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Increase sample size regarding shift report.</p> <p>Findings: ASH has increased the sample size for shift report to at least 20%.</p> <p>Recommendation 2, October 2009: Continue mentoring the change of shift process.</p> <p>Findings: The Unit Mentors have been completing Shift Change audits since November 2009 in conjunction with Standards Compliance.</p> <p>Recommendation 3, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, ASH assessed its compliance</p>

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		<p>based on a 100% sample of individuals transferred to community hospitals each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 302 1887 527"> <tr> <td data-bbox="991 302 1087 415">1.</td> <td data-bbox="1087 302 1793 415"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 302 1887 415">93%</td> </tr> <tr> <td data-bbox="991 415 1087 527">7.</td> <td data-bbox="1087 415 1793 527"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 415 1887 527">98%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 11 individuals who were transferred to a community hospital/emergency room (CDG, CLT, CLW, HLH, JG, KBM, MAR, MC, RCM, RFH and TE) found significant problematic issues with the nursing documentation for five individuals (CDG, HLH, MAR, MC and RCM), including:</p> <ul data-bbox="991 902 1887 1414" style="list-style-type: none"> • Lack of documentation regarding the status and appropriate assessment of the individual at the time of the onset of the symptoms; • Delays in documentation after the individual was identified as experiencing a change in status; • Lack of documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; • Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; • Lack of a complete nursing assessment upon return to the facility; • Lack of adequate description of the site of complaints for pain; • Lack of neurological checks and mental status documented for individuals with a significant change in mental status; • Illegible progress notes, signatures and titles; 	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	93%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	98%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	93%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	98%						

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		<ul style="list-style-type: none"> • Lack of assessment of bowel sounds and abdomen for individuals with constipation; • Lack of documentation that status changes had been timely reported to physician; including name of physician; • Lack of specific values documented in the progress notes for vital signs rather than "WNL" (within normal limits) for individuals experiencing a change of status; • The inconsistent use of the Change of Status forms; and • Duplication of documentation in progress notes and the Change of Status form. <p>These findings do not comport with ASH's data. In discussion with this monitor, Nursing reported that it is now auditing the nursing section of change in status to ensure that the nursing assessments and documentation are being adequately reviewed for quality.</p> <p>Using the DMH Nursing Services Audit, ASH also assessed its compliance based on a 78% sample of Change of Shift Reports observed during in the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 930 1890 1044"> <tr> <td data-bbox="991 930 1087 1044">10.</td> <td data-bbox="1087 930 1793 1044"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 930 1890 1044">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit 34 found that ASH has continued to make significant progress in providing clinically relevant information to the oncoming shift.</p> <p>Compliance: Partial.</p>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%			

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. 2. 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:	<p>Compliance: Substantial.</p>			
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 86% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 933 1890 1010"> <tr> <td>11.</td> <td><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>From observations of medication administration on Unit 17, the medication nurse demonstrated good interaction with the individuals and provided appropriate medication education as well as asking individuals about side effects and effectiveness of medications. The medication nurse followed the appropriate medication administration protocol. Also, the facility nurse observing medication administration provided appropriate feedback and correction when appropriate.</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	97%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	97%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 86% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 711 1890 786"> <tr> <td>12.</td> <td><i>Education is provided to individuals during medication administration.</i></td> <td>92%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for reviewer's findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	12.	<i>Education is provided to individuals during medication administration.</i>	92%
12.	<i>Education is provided to individuals during medication administration.</i>	92%			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 86% of level of</p>			

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		<p>care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 266 1892 342"> <tr> <td data-bbox="993 266 1087 342">13.</td> <td data-bbox="1087 266 1793 342"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1793 266 1892 342">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for reviewer's findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	100%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	100%			
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, October 2009:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure full implementation of recent corrective actions to address variances in the medication administration system. <p>Findings: Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 86% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 1122 1892 1232"> <tr> <td data-bbox="993 1122 1087 1232">14.</td> <td data-bbox="1087 1122 1793 1232"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 1122 1892 1232">99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>ASH was able to produce MVRs for the blanks found on the MARs and</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	99%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	99%			

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		<p>Narcotic Logs during the review period. The facility has put in a significant amount of effort into analyzing and modifying the current medication administration system and was in process of evaluating strategies to ensure provision of the time that medication nurses need to appropriately administer medications and interact with the individuals during medication administration.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement in the event this issue arises.</p> <p>Findings: There were no bed-bound individuals during this review period.</p> <p>Compliance: Not applicable.</p> <p>Current recommendation: Continue to monitor this requirement in the event this issue arises</p>
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:	<p>Compliance: Substantial.</p>
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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	the individual's status;	<p>Findings: ASH's training rosters indicated that all 15 newly hired nursing staff needing training addressing the requirements of Section F.3.h.i-iii completed and passed the competency-based training.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis	<p>Current findings on previous recommendation:</p>

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	<p>thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH's training rosters verified that 945 of the 966 licensed nursing staff due for annual training received and completed competency-based training on Medication Administration. See F.3.h.i for data regarding new employee training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Kathy Runge, Occupational Therapist 2. Ladonna Decou, Chief of Rehabilitation 3. Rachelle Rianda, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for September 2009-February 2010 2. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 18 individuals participating in observed PSR Mall groups: AF-1, AF-2, AFC, AH, AKG, ARC, DH, DN, JL, JSB, KH, MBM, MER, MF, RMS, RWG, SDH and VMG 4. List of individuals who received direct physical therapy services from September 2009-February 2010 5. List of individuals who received direct speech therapy services from September 2009-February 2010 6. List of individuals who received direct occupational therapy services from September 2009-February 2010 7. Records of the following 14 individuals who received direct physical therapy and occupational therapy services from September 2009-February 2010: ACR, CE, DB, FAT, JAJ, JB, JRF, JZR, LJR, MJ, RA, RS, RWG and TC 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Record of the following individual with 24-Hour Rehabilitation Support Plan: DPP 10. List of individuals at high risk for falls 11. Records for the following two individuals at high risk for falls: CDB and RMG 12. List of individuals with three or more falls in 30 days or falls resulting in major injury during the review period

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		<p>13. Records for the following four individuals who had three or more falls in 30 days or a fall with a major injury during the review period: CJK, DLG, JJA and RLJ</p> <p>14. List of individuals at high risk for skin breakdown</p> <p>15. Records for the following individuals at high risk for skin breakdown: JNB and MC</p> <p>16. List of individuals with an incident of a decubitus ulcer during the review period</p> <p>17. Records for the following three individuals with an incident of a decubitus ulcer during the review period: ACR, DLL and TR</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Increasing Motivation Through Music PSR Mall group 2. Beginning Guitar PSR Mall group 3. Sports Stacking PSR Mall group 4. Drumming for Drummers PSR Mall group 5. Problem Solving PSR Mall group 6. Mental Health Wellness PSR Mall group 7. WRPC for individual SH
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:	<p>Compliance: Substantial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue current efforts to achieve compliance.</p> <p>Findings: The table below presents the number of hours scheduled versus number</p>

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		<p>of hours provided of direct OT, PT and SLP treatment during the week of 2/22/10:</p> <table border="1" data-bbox="989 302 1587 456"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>47</td> <td>40</td> </tr> <tr> <td>OT</td> <td>29</td> <td>20</td> </tr> <tr> <td>SLP</td> <td>28</td> <td>25</td> </tr> </tbody> </table> <p>The facility reported that the discrepancy in OT hours was due to refusal by eight individuals and a conflicting medical appointment for one individual. The discrepancy in PT hours was due to refusal by three individuals and rescheduling of four individuals. The discrepancy in SLP hours was due to individual refusal.</p> <p>Recommendation 2, October 2009: Develop and implement a process by which recommendations made by OT, PT, and/or SLP are implemented by direct care staff.</p> <p>Findings: The facility implemented a process by which the speech therapist would attend the shift report following the completion of a focused assessment in which recommendations for communicating with the individual are made. Evidence of integration of SLP recommendations was verified by record review and observation of the treatment team's use of the SLP's recommendations when interacting with the individual (SH) during the WRPC.</p> <p>Other findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 26% of individuals receiving occupational, speech, or physical therapy direct treatment during the review period September 2009-February 2010:</p>		Scheduled	Provided	PT	47	40	OT	29	20	SLP	28	25
	Scheduled	Provided												
PT	47	40												
OT	29	20												
SLP	28	25												

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		<table border="1"> <tr> <td data-bbox="974 190 1079 267">1.</td> <td data-bbox="1079 190 1793 267"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 190 1902 267">100%</td> </tr> </table>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	100%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	100%			
<p>Comparative data indicated improvement in compliance from 81% in the previous review period.</p> <p>A review of the records of 14 individuals receiving direct occupational, physical, and/or speech therapy direct treatment to assess compliance with F.4.a.i criteria found 13 records in substantial compliance (ACR, CE, DB, FAT, JAJ, JB, JRF, JZR, LJR, MJ, RA, RS and RWG) and one record in partial compliance (TC).</p> <p>In terms of individual outcomes, objectives were either met or evidence of progress towards objectives was noted in 12 out of 14 records reviewed.</p> <p>During record review, it was noted that many individuals with direct treatment objectives related to cognitive skills and physical skills such as strength had objectives that pertained to performance on one-on one-treatment interventions (e.g., computerized modules, pounds of grip on dynamometer), rather than to a functional skill (e.g., adequate attention to participate in a 50-minute PSR Mall group, strength to open a milk carton). During the maintenance phase, it is recommended that therapists work to ensure that all direct treatment goals are focused on developing functional skills that can be generalized across performance contexts and environments.</p> <p>Current recommendation: Continue to enhance current practice.</p>					
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	Current findings on previous recommendation:			

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		<p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility reported that no individuals met criteria for an individualized physical or occupational therapy program implemented by nursing during the review period, as none were clinically indicated.</p> <p>Current recommendation: Continue to assess individuals and provide this service if clinically indicated.</p>
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility reported that 33 out of 33 nurses identified as requiring training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance and improve current practice.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 8% (385 out of 5166) of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period September 2009-February 2010:</p> <table border="1" data-bbox="989 488 1885 602"> <tr> <td data-bbox="989 488 1087 602">4.</td> <td data-bbox="1087 488 1793 602"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 488 1885 602">98%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups to assess compliance with F.4.c criteria found all records in substantial compliance.</p> <p>Observation of six PSR Mall groups found that in all groups the appropriate lesson plan was in use and the groups provided activities that were in line with the individuals' assessed needs.</p> <p>The facility reported that training of Rehabilitation Therapists during the review period was provided based on identified need in the areas of the role of the RT in the WRPC, focus 9 and 10 alignment, WRP alignment, transfer reviews, POST liaison, and the task tracker process.</p> <p>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% (total of one) of individuals with a 24-hour support plan during the review period September 2009-February 2010:</p> <table border="1" data-bbox="989 1377 1885 1412"> <tr> <td data-bbox="989 1377 1087 1412">4.b</td> <td data-bbox="1087 1377 1793 1412"><i>Each State hospital shall ensure that individuals are</i></td> <td data-bbox="1793 1377 1885 1412">100%</td> </tr> </table>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	98%	4.b	<i>Each State hospital shall ensure that individuals are</i>	100%
4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	98%						
4.b	<i>Each State hospital shall ensure that individuals are</i>	100%						

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		<table border="1"> <tr> <td></td> <td><i>provided with timely and adequate rehabilitation therapy services.</i></td> <td></td> </tr> <tr> <td>a.</td> <td><i>The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.</i></td> <td>100%</td> </tr> <tr> <td>b.</td> <td><i>The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP</i></td> <td>100%</td> </tr> </table>		<i>provided with timely and adequate rehabilitation therapy services.</i>		a.	<i>The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.</i>	100%	b.	<i>The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP</i>	100%	<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>During review of POST assessments and individuals at high risk, it was noted that many individuals could have benefitted from a 24-hour plan and appeared to meet criteria for 24-hour plan development and implementation. It is essential that 24-hour plans are developed when clinically indicated by assessment data and plan criteria, as it does not seem at this point that treatment teams are aware of this service, and may not therefore consistently refer individuals for the service in a timely manner.</p> <p>A review of the record of one individual with a 24-hour support plan to assess compliance with F.4.c criteria found the record in substantial compliance.</p> <p>The table below presents the number of hours scheduled versus number of hours provided of PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 2/22/10:</p> <table border="1"> <thead> <tr> <th></th> <th></th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>267</td> <td>265</td> </tr> <tr> <td>Voc Rehab</td> <td>36</td> <td>36</td> </tr> </tbody> </table>			Provided	RT	267	265	Voc Rehab	36	36
	<i>provided with timely and adequate rehabilitation therapy services.</i>																				
a.	<i>The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.</i>	100%																			
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		Provided																			
RT	267	265																			
Voc Rehab	36	36																			

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		<p>Other findings: A review of individuals who had three or more falls in 30 days or a fall resulting in major injury found that when clinically indicated, one record (CJG) had adequate documentation of both therapy services assessment and plan (e.g., 24-hour support plan, objective and intervention) to remediate fall risk and/or future occurrence, and two did not (DLG and RLJ). A review of individuals who had an incident of decubitus or who were at high risk for skin integrity issues found that when clinically indicated, one record (DLL) had adequate documentation of both therapy services assessment and plan (e.g., 24-hour support plan) to remediate decubitus risk and/or future occurrence, and two records (MC and TR) did not.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. During the maintenance period, develop and implement a process to ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan to improve function or decrease risk of harm receive this service. 2. Continue to improve and enhance current practice.
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period September 2009-February 2010:</p>

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		<table border="1"> <tr> <td data-bbox="976 190 1087 305">e.</td> <td data-bbox="1087 190 1793 305"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 190 1919 305">100%</td> </tr> <tr> <td data-bbox="976 305 1087 380">f.</td> <td data-bbox="1087 305 1793 380"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 305 1919 380">100%</td> </tr> <tr> <td data-bbox="976 380 1087 454">g.</td> <td data-bbox="1087 380 1793 454"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 380 1919 454">100%</td> </tr> <tr> <td data-bbox="976 454 1087 529">h.</td> <td data-bbox="1087 454 1793 529"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 454 1919 529">100%</td> </tr> <tr> <td data-bbox="976 529 1087 604">i.</td> <td data-bbox="1087 529 1793 604"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 529 1919 604">100%</td> </tr> </table> <p data-bbox="976 646 1919 721">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="976 760 1136 824">Compliance: Substantial.</p> <p data-bbox="976 870 1457 935">Current recommendation: Continue to enhance current practice.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%															
f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%															
g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dawn Hartman, Assistant Director of Dietetics 2. Erin Dengate, Assistant Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from September 2009-February 2010 for each assessment type Records of the following 47 individuals with types a-j.ii assessments from September 2009-February 2010: ADS, AF, AG, AM, AMM, ARC, BNT, CD, CM, CSS, DAB, DEW, DLB, DRR, DY, EME, FKB, GD, HP, JDC, JHG, JJC, JJF, JN, JNA, JPM, JRR, KEP, LC, LCP, LJR, MAR, MF, MJG, MN, MR, PMM, RA, RB, RR-1, RR-2, TAQ, TAR, TC, TJP, TMH and WSW 2. Meal Accuracy Report audit data from September 2009-February 2010 3. Nutrition Care Monitoring Tool audit data from September 2009-February 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 4. List of individuals with choking incidents during the review period 5. List of individuals at risk for choking 6. List of individuals at risk for aspiration 7. Records for the following individuals at risk for choking: BG and BLB 8. Record for the following individual with an incident of choking during the review period: JM 9. Records for the following individual at risk for aspiration: BT 10. List of individuals with new diabetes diagnosis during the review period 11. List of individuals at risk for metabolic syndrome 12. Records for the following individuals with new diabetes diagnosis of

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		<p>diabetes during the review period: AD and LCR</p> <p>13. Records for the following individuals at high risk for metabolic syndrome: BLB and ICA</p> <p>14. Records for the following individuals participating in the Diabetes Management PSR mall group: JNB, RC and RJS</p> <p><u>Observed:</u> Diabetes Management PSR Mall group</p>						
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 31% of Nutrition Assessments (all types) due each month from September 2009-February 2010 (total of 496 out of 1618):</p> <table border="1" data-bbox="989 932 1887 1083"> <tr> <td data-bbox="989 932 1087 971">7.</td> <td data-bbox="1087 932 1793 971"><i>Nutrition education is documented</i></td> <td data-bbox="1793 932 1887 971">99%</td> </tr> <tr> <td data-bbox="989 971 1087 1083">8.</td> <td data-bbox="1087 971 1793 1083"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 971 1887 1083">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 48 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records but one in substantial compliance (RA was in partial compliance).</p>	7.	<i>Nutrition education is documented</i>	99%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
7.	<i>Nutrition education is documented</i>	99%						
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%						

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		<p>ASH assessed its compliance with tray accuracy based on an average sample of 52% of the average daily census from September 2009-February 2010 (total of 3203 out of 6148) and found that 97% of trays audited were in 100% compliance.</p> <p>Other findings: A review of records of individuals at high risk for metabolic syndrome and with a new diagnosis of diabetes found that all four individuals had evidence of a nutrition assessment that addressed either risk factors or appropriate contributing factors and that all four had evidence of an objective and intervention in place to reduce risk, either implemented by the dietitian or by nursing and in line with findings of nutrition assessment and recommendations.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>			
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with WRP integration based on an average sample of 31% of Nutrition Assessments (all types) due each month from September 2009-February 2010 (496 out of 1618):</p> <table border="1" data-bbox="989 1338 1885 1414"> <tr> <td data-bbox="989 1338 1087 1414">19.</td> <td data-bbox="1087 1338 1793 1414"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 1338 1885 1414">98%</td> </tr> </table>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	98%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	98%			

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		<p>20. <i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></p>	<p>99%</p>
<p>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</p>		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 14 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p>Other findings: A review of records for three individuals participating in the Diabetes Management PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found all three records in substantial compliance.</p> <p>Observation of the Diabetes Management PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p>	

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	<p>and interventions for mealtimes and other activities involving swallowing.</p>	<p>Findings: Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>No incidences of aspiration pneumonia were reported during the review period.</p> <p>Other findings: A review of individuals who were at risk for choking, aspiration, or had an incident of choking found that when clinically indicated, all four had adequate documentation of therapy services assessment and open focus, objective and intervention to remediate risk and/or future occurrence. However, it was noted that while one individual (JM) had good documentation of speech therapy assessment and recommendations following a choking incident, there was not adequate documentation of why the temporary focus for choking was closed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>
<p>F.5.d</p>	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: One new Dietitian was hired during the review period and was trained to competency on basic issues related to aspiration and dysphagia.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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6. Pharmacy Services																																											
	<p>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:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> Jean Dansereau, MD, Chief of Psychiatry Ronald O'Brien, PharmD, Acting Pharmacy Services Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> ASH self-assessment monitoring data Pharmacists' recommendations on new and continuing psychotropic medication orders 																																									
<p>F.6.a</p>	<p>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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: ASH presented the following data regarding the recommendations made during the current review period:</p> <table border="1" data-bbox="991 971 1873 1393"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>19</td> <td>33</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>30</td> <td>14</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>43</td> <td>25</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>82</td> <td>43</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>17</td> <td>12</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>4</td> <td>3</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>17</td> <td>21</td> </tr> <tr> <td>8.</td> <td>Others</td> <td>73</td> <td>79</td> </tr> <tr> <td colspan="2">Total number of recommendations*</td> <td>285</td> <td>230</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	19	33	2.	Side effects	30	14	3.	Need for laboratory testing	43	25	4.	Dose adjustment	82	43	5.	Indications	17	12	6.	Contraindications	4	3	7.	Need for continued treatment	17	21	8.	Others	73	79	Total number of recommendations*		285	230
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 748 1797 1013"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>285</td> <td>230</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>0</td> <td>0</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	Recommendations followed	285	230	Recommendations not followed, but rationale documented	0	0	Recommendations not followed and rationale/response not documented	0	0
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ali Akhavan, MD, Physician and Surgeon 2. Ana Onglao, MD, Physician and Surgeon 3. Art Onglao, MD, Physician and Surgeon 4. Cynthia Davis, RN, Nurse Administrator 5. Douglas Shelton, MD, Chief Physician and Surgeon 6. Hani Boutros, MD, Physician and Surgeon 7. Hussein Akhavan, MD, Physician and Surgeon 8. Phil Wichmann, MD, Physician and Surgeon 9. Robert Taylor, MD, Physician and Surgeon 10. Willard Towle, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 12 individuals: CDG, CLT, CLW, HLH, JG, KBM, MAR, MC, RCM, RFH, SW and TE 2. Quarterly Progress Notes on the following 11 individuals: CE, JDE, KCC, LP, MLD, NSS, RAB, RR, SB, SC and SDP 3. Mortality Review Report on individual CDG 4. List of all individuals admitted to external hospitals and/or the facility's medical unit during the review period 5. Medical Risk Management Committee Minutes: 2/24/10, 12/23/09 and 9/16/09 6. Medical Services Policies and Procedures: <ul style="list-style-type: none"> • General Policy • XIII - Treatment of Individual with Prolonged Seizure and/or Status Epilepticus • XIV - Seizure Management Group Policies and Procedures 7. Seizure/Neurology Clinic Notes on the following three individuals: DG, JN and RJ 8. After-hours schedule of Medical Officer of the Day (MOD) coverage

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		<p>during the review period</p> <ol style="list-style-type: none"> 9. Summary information on Medical Emergency Response Drills conducted during the review period 10. ASH Medical-Surgical Progress Note Audit summary data (September 2009-February 2010) 11. ASH Integration of Medical Conditions into the WRP Audit summary data (September 2009-February 2010) 12. ASH Medical Emergency Response Drill Audit summary data (September 2009-February 2010) 13. ASH Medical Transfer Audit summary data (September 2009-February 2010) 14. Hospital Paperwork Received within Seven Days of Patient Admitted to ASH summary data (September - December 2009) 15. ASH Diabetes Mellitus Audit summary data (September 2009-February 2010) 16. ASH Hypertension Audit summary data (September 2009-February 2010) 17. ASH Dyslipidemia Audit summary data (September 2009-February 2010) 18. ASH Asthma/COPD Audit summary data (September 2009-February 2010) 19. ASH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: <ul style="list-style-type: none"> • Diabetes Mellitus • Dyslipidemia • Obesity • Hypertension • Bowel Dysfunction • Falls • Aspiration Pneumonia • Seizure Disorder • Unexpected Mortalities
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<p>F.7.a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Implement corrective actions to address this monitor's findings of deficiencies related to seizure management, including findings in section C.2.c.</p> <p>Findings: ASH implemented adequate corrective actions in response to this recommendation. The following is a summary:</p> <ol style="list-style-type: none"> 1. The Mortality Review Committee reconvened to assess the Court Monitor's findings regarding the nursing and medical management of the individual who expired in the context of recurrent seizure activity. As a result, the Department of Medicine finalized and implemented in December 2009 a Policy and Procedure for Treatment of Individual with Prolonged Seizure and/or Status Epilepticus. The Nursing Procedure 102.1 for the Care of the Individual with Seizure/Epilepsy was reviewed and found to be adequate. Training of the nursing staff was completed to assure compliance with the NP. 2. A Seizure Management Group was established in January 2010 to gather data and facilitate management of all individuals with Seizure Disorders. The Group consists of a Family Nurse Practitioner as the Seizure Management Facilitator, a Pharmacist, a Neurologist, a Database Facilitator and the Chief Physician and Surgeon. The group implemented the first weekly Seizure Clinic on February 5, 2010, and the Seizure Database has been established and will be updated regularly to include: <ol style="list-style-type: none"> a. Morphological Diagnosis regarding the type of seizure disorder; b. Medications including medication history, older generation anti-epileptics, anti-epileptic medications used for psychiatric conditions, and rationale for medication use; c. Seizure activity including typical seizure description and
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		<p>refractory seizures;</p> <p>d. Past history including head trauma, drug use and prior testing;</p> <p>e. Cognitive impairments and cognitive testing; and</p> <p>f. Current neurological findings, treatment and recommendations.</p> <p>Recommendation 2, October 2009: Provide a summary outline of any changes in policies and procedures regarding medical care to individuals during the review period.</p> <p>Findings: Same as above. In addition, the General Medical Services EPPI Team met twice each month to review audited data and develop plans of correction. The actions included the directive from the Chief Physician and Surgeon that abdominal x-rays ordered for individuals to rule out an Acute Abdomen or an obstruction will include four views including a Flat Plate, Upright, Left Lateral Decubitus and PA Chest views; and all EKGs are to have a written interpretation and dated initial or signature immediately on stat EKGs or within two working days for routine EKGs. Draft Policies for these directives are pending approval and finalization.</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility (and/or the facility's medical unit) during this reporting period, and interviewed the physicians and surgeons involved in their care. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="989 1263 1883 1412"> <thead> <tr> <th data-bbox="989 1263 1157 1339">Individual</th> <th data-bbox="1157 1263 1381 1339">Date/time of MD evaluation</th> <th data-bbox="1381 1263 1883 1339">Reason for transfer</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1339 1157 1412">1.</td> <td data-bbox="1157 1339 1381 1412">9/9/09</td> <td data-bbox="1381 1339 1883 1412">Chest pain, R/O Myocardial Infarction</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1.	9/9/09	Chest pain, R/O Myocardial Infarction
Individual	Date/time of MD evaluation	Reason for transfer						
1.	9/9/09	Chest pain, R/O Myocardial Infarction						

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		2.	10/14/09	Ileus and Fever
		3.	10/19/09	Renal Obstruction, Diabetes Mellitus, Hypertension and Hepatitis C
		4.	10/27/09	Gastrointestinal Bleed
		5.	11/9/09	R/O Pancreatitis (mortality)
		6.	11/14/09	R/O Gastrointestinal Bleed
		7.	11/23/09	R/O Appendicitis
		8.	1/2/10	Coffee ground emesis
		9.	1/21/10	Prolonged seizure activity
		10.	1/22/10	R/O Tuberculosis
		11.	1/22/10	Delirium and Diabetic Ketoacidosis
		12.	2/1/10	R/O CVA
		<p>The review and interviews found general evidence of timely and appropriate care to these individuals. A few process deficiencies were found as follows:</p> <ol style="list-style-type: none"> 1. The nursing assessment of an individual who experienced significant abdominal pain did not include an examination of the abdomen (CLT). 2. There was no documentation of an acceptance evaluation by the unit Physician and Surgeon upon the return transfer of an individual (CLT) from the facility's medical unit (unit 1). The individual had experienced upper gastrointestinal bleeding secondary to gastritis. The discharge assessment from unit 1 did not include a plan for ongoing care. However, the subsequent quarterly medical assessment included an adequate review of the circumstances and plan of care regarding that transfer. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 		

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		<ol style="list-style-type: none"> 2. Implement corrective actions to address this monitor's findings of process deficiencies. 3. Provide a summary outline of any changes in policies and procedures regarding medical care to individuals during the review period. 									
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, ASH assessed its compliance based on an average sample of 24% of all individuals with at least one diagnosis on Axis III during the review period (September 2009-February 2010):</p> <table border="1"> <tr> <td>1.</td> <td><i>There is a Quarterly note that documents re-assessment of the individual's medical status.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>If applicable, there is an appropriate and timely response and documentation from the primary care physician meeting the standards of care for the condition being treated.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>If applicable, the primary care physician (PCP) documents in the PPN necessary communication between the PCP and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</p>	1.	<i>There is a Quarterly note that documents re-assessment of the individual's medical status.</i>	100%	2.	<i>If applicable, there is an appropriate and timely response and documentation from the primary care physician meeting the standards of care for the condition being treated.</i>	100%	3.	<i>If applicable, the primary care physician (PCP) documents in the PPN necessary communication between the PCP and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	99%
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		<p>at least 90% from the previous review period for items 2 and 3. The compliance rate for item 1 improved from 89% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Medical Transfer Auditing Form, ASH assessed its compliance based on an average sample of 100% of medical transfers during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1005 1887 1414"> <tr> <td data-bbox="991 1005 1087 1118">1.</td> <td data-bbox="1087 1005 1793 1118"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1005 1887 1118">93%</td> </tr> <tr> <td data-bbox="991 1118 1087 1268">2.</td> <td data-bbox="1087 1118 1793 1268"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 1118 1887 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1414">3.</td> <td data-bbox="1087 1268 1793 1414"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care. These forms shall accompany the individual to the acute medical facility or be faxed within two hours of</i></td> <td data-bbox="1793 1268 1887 1414">93%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	93%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	100%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care. These forms shall accompany the individual to the acute medical facility or be faxed within two hours of</i>	93%
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			<i>transport.</i>	
		4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	98%
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	96%
		6.	<i>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.</i>	97%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	98%
		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>ASH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 22% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (September 2009-February 2010). The following is a summary of the data:</p>		
		1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i>	100%
		2.	<i>The WRP includes each medical condition listed on the Medical Conditions form.</i>	100%
		3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	99%

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		<table border="1"> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate intervention(s) for each objective.</i></td> <td>99%</td> </tr> </table>	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	99%	5.	<i>There are appropriate intervention(s) for each objective.</i>	99%															
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<table border="1"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>89%</td> <td>100%</td> </tr> <tr> <td>2.</td> <td>92%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>77%</td> <td>99%</td> </tr> <tr> <td>4.</td> <td>88%</td> <td>99%</td> </tr> <tr> <td>5.</td> <td>78%</td> <td>99%</td> </tr> </tbody> </table>				period	Current period	Mean compliance rate			1.	89%	100%	2.	92%	100%	3.	77%	99%	4.	88%	99%	5.	78%	99%
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<p>Using the same tool, the facility reviewed a 63% sample of individuals who have refused medical treatment or laboratory tests. The following is a summary of the data:</p>																							
		<table border="1"> <tr> <td>6.</td> <td><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i></td> <td>98%</td> </tr> </table>	6.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i>	98%																		
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<p>Comparative data indicated improvement from 34% in the previous review period.</p>																							
<p>Using the DMH Medical Emergency Drill MH-C 9129 auditing tool, the facility's Emergency Care Committee reviewed and analyzed the medical emergency drills that were conducted on each shift on a quarterly basis (September 2009 to February 2010). The following is summary outline of the issues that were identified as requiring corrective action and the</p>																							

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		<p>responses:</p> <table border="1"> <thead> <tr> <th data-bbox="991 266 1451 305">Issue</th> <th data-bbox="1451 266 1904 305">Response</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="991 305 1904 344">First-quarter drills (hypoglycemia)</td> </tr> <tr> <td data-bbox="991 344 1451 493">Lack of knowledge on the use of Insta-Glucose</td> <td data-bbox="1451 344 1904 493">Program HSS reviewed the Nursing procedure on Insta-Glucose with all staff (December 31, 2009)</td> </tr> <tr> <td data-bbox="991 493 1451 605">The Stryker Chair (used to transfer an individual down stairs) too far away from the unit</td> <td data-bbox="1451 493 1904 605">Chairs were procured for all upstairs units (December 29, 2009)</td> </tr> <tr> <td data-bbox="991 605 1451 717">Inadequate knowledge on using suction device</td> <td data-bbox="1451 605 1904 717">Unit supervisors provided training (April 1, 2010) and ongoing reminders to staff</td> </tr> <tr> <td data-bbox="991 717 1451 867">Improper application of Head Band on Stryker Chair</td> <td data-bbox="1451 717 1904 867">Unit supervisors provided training (March 15, 2010) and Training Department notified to include this in yearly training</td> </tr> <tr> <td data-bbox="991 867 1451 979">Radios for ASH Code Blue calls not identifying where call originated</td> <td data-bbox="1451 867 1904 979">Caller ID was added to the line (October 31, 2009)</td> </tr> <tr> <td data-bbox="991 979 1451 1166">Incomplete information from the initial code blue call</td> <td data-bbox="1451 979 1904 1166">Dispatch and Communications Operations staff were instructed on questions to ask (regarding level of consciousness, breathing and bleeding/injury)</td> </tr> <tr> <td colspan="2" data-bbox="991 1166 1904 1205">Second-quarter drills (hanging)</td> </tr> <tr> <td data-bbox="991 1205 1451 1354">More experience needed using the Stryker Chair</td> <td data-bbox="1451 1205 1904 1354">Training included more hands-on classroom teaching (January 15, 2010 and ongoing)</td> </tr> <tr> <td data-bbox="991 1354 1451 1424">Transport cart needing to be turned around on arrival at the</td> <td data-bbox="1451 1354 1904 1424">All involved departments (DPS, NOD and Fire Department) were</td> </tr> </tbody> </table>	Issue	Response	First-quarter drills (hypoglycemia)		Lack of knowledge on the use of Insta-Glucose	Program HSS reviewed the Nursing procedure on Insta-Glucose with all staff (December 31, 2009)	The Stryker Chair (used to transfer an individual down stairs) too far away from the unit	Chairs were procured for all upstairs units (December 29, 2009)	Inadequate knowledge on using suction device	Unit supervisors provided training (April 1, 2010) and ongoing reminders to staff	Improper application of Head Band on Stryker Chair	Unit supervisors provided training (March 15, 2010) and Training Department notified to include this in yearly training	Radios for ASH Code Blue calls not identifying where call originated	Caller ID was added to the line (October 31, 2009)	Incomplete information from the initial code blue call	Dispatch and Communications Operations staff were instructed on questions to ask (regarding level of consciousness, breathing and bleeding/injury)	Second-quarter drills (hanging)		More experience needed using the Stryker Chair	Training included more hands-on classroom teaching (January 15, 2010 and ongoing)	Transport cart needing to be turned around on arrival at the	All involved departments (DPS, NOD and Fire Department) were
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F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p data-bbox="989 1015 1577 1047">Current findings on previous recommendation:</p> <p data-bbox="989 1089 1415 1122">Recommendation, October 2009:</p> <p data-bbox="989 1122 1318 1154">Continue current practice.</p> <p data-bbox="989 1203 1104 1235">Findings:</p> <p data-bbox="989 1235 1892 1341">ASH has maintained its practice. The current SO regarding provision of medical care and other policies and procedures and monitoring instruments adequately outline these duties and responsibilities.</p>												

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: ASH continues to maintain an adequate system of after-hours coverage as required by the EP. This monitor has reviewed the schedule of after-hours coverage during this review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: The facility presented data based on a 100% sample of individuals returning from outside medical treatment during the review period (September 2009-February 2010) tracking whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 90%.</p>

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		<p>In the previous tour, ASH indicated that the compliance rate was 98% in the two months for which this requirement was tracked (March and June 2009).</p> <p>The facility reported that all hospital paperwork was received by ASH within seven days except for paperwork from one provider who would wait to complete discharge summaries until the 14-day requirement of the acute hospital. The Chief Physician and Surgeon spoke with this physician in January and he agreed to complete all discharge summaries and make them available to ASH within seven days. ASH has also pursuing access to the electronic medical records of its acute hospitals. This is near completion for the most frequently used of the three acute hospitals.</p> <p>Other findings: This monitor's reviews (see F.7.a) found that discharge assessments were available in all the charts reviewed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.7.c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: 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).</p> <p>Findings: ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and</p>

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asthma/COPD. The average samples were 23% (diabetes mellitus), 20% (hypertension), 27% (dyslipidemia) and 18% (COPD/asthma) of individuals diagnosed with these disorders during the review months (September 2009-February 2010). The following tables summarize the facility's data:

Diabetes Mellitus

1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	100%
2.	<i>HgbA1C was ordered quarterly.</i>	99%
3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%
4.	<i>Blood sugar is monitored regularly.</i>	99%
5.	<i>Urinary micro albumin is monitored annually.</i>	100%
6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	100%
7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%
8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	98%
9.	<i>Blood pressure is monitored weekly.</i>	100%
10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	99%
11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	99%
12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	99%
13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	99%
14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	100%
15.	<i>Focus 6 for Diabetes has appropriate objectives and</i>	100%

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		<p><i>interventions for this condition.</i></p>																								
<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for items 2, 3, 6, 7, 9, 11, 12, 14 and 15, and improved the compliance rate for the remaining indicators as follows:</p>																										
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<table border="1"> <tbody> <tr> <td data-bbox="976 906 1087 984">1.</td> <td data-bbox="1087 906 1793 984"><i>Has the individual been evaluated and supporting documentation completed at least quarterly?</i></td> <td data-bbox="1793 906 1921 984">100%</td> </tr> <tr> <td data-bbox="976 984 1087 1024">2.</td> <td data-bbox="1087 984 1793 1024"><i>Is blood pressure monitored weekly?</i></td> <td data-bbox="1793 984 1921 1024">100%</td> </tr> <tr> <td data-bbox="976 1024 1087 1135">3.</td> <td data-bbox="1087 1024 1793 1135"><i>Is blood pressure less than 140/90 or is there an appropriate plan of care in place to reduce blood pressure?</i></td> <td data-bbox="1793 1024 1921 1135">99%</td> </tr> <tr> <td data-bbox="976 1135 1087 1213">4.</td> <td data-bbox="1087 1135 1793 1213"><i>If the individual is 40 or older, has aspirin been ordered, unless contraindicated?</i></td> <td data-bbox="1793 1135 1921 1213">98%</td> </tr> <tr> <td data-bbox="976 1213 1087 1253">5.</td> <td data-bbox="1087 1213 1793 1253"><i>Is Hypertension addressed in Focus 6 of the WRP?</i></td> <td data-bbox="1793 1213 1921 1253">100%</td> </tr> <tr> <td data-bbox="976 1253 1087 1321">6.</td> <td data-bbox="1087 1253 1793 1321"><i>Does Focus 6 have appropriate objectives and interventions for Hypertension?</i></td> <td data-bbox="1793 1253 1921 1321">100%</td> </tr> <tr> <td data-bbox="976 1321 1087 1396">7.</td> <td data-bbox="1087 1321 1793 1396"><i>Within the last 12 months, has a dietary consult been completed and recommendations followed?</i></td> <td data-bbox="1793 1321 1921 1396">98%</td> </tr> </tbody> </table>			1.	<i>Has the individual been evaluated and supporting documentation completed at least quarterly?</i>	100%	2.	<i>Is blood pressure monitored weekly?</i>	100%	3.	<i>Is blood pressure less than 140/90 or is there an appropriate plan of care in place to reduce blood pressure?</i>	99%	4.	<i>If the individual is 40 or older, has aspirin been ordered, unless contraindicated?</i>	98%	5.	<i>Is Hypertension addressed in Focus 6 of the WRP?</i>	100%	6.	<i>Does Focus 6 have appropriate objectives and interventions for Hypertension?</i>	100%	7.	<i>Within the last 12 months, has a dietary consult been completed and recommendations followed?</i>	98%			
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		8.	<i>Is the BMI \leq 25 and the waist circumference $<$ 40 (M) or $<$ 35 (F) or has weight management program been initiated?</i>	100%
		9.	<i>Has an exercise program been initiated?</i>	100%
		10.	<i>If the individual is currently a smoker, is smoking cessation discussed and included in the WRP?</i>	N/A
	<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items except items 4 and 9, which improved from 89% and 80% respectively in the previous review period. Item 10 was not applicable in either period.</p>			
	<p><u>Dyslipidemia</u></p>			
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
		2.	<i>A lipid panel was ordered at least quarterly.</i>	100%
		3.	<i>The HDL level is $>$40(M) or $>$50(F) or a plan of care is in place.</i>	100%
		4.	<i>The LDL level is \leq 130 or a plan of care is in place.</i>	100%
		5.	<i>The Triglyceride level is \leq 200 or a plan of care is in place.</i>	100%
		6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	100%
		7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%
		8.	<i>A dietary consultation has been completed and the recommendation followed, as applicable.</i>	97%
		9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	100%
		10.	<i>An exercise program has been initiated.</i>	100%

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.7.d	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, October 2009:</p> <ul style="list-style-type: none"> • Utilize the Medical Services EPPI Team in the review and analysis of all the medical triggers/key indicators and establishment of any additional indicators of process and clinical outcomes. • Implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. • Identify trends and patterns based on clinical and process outcomes. <p>Findings: During this review period, ASH began to gather both process and clinical outcome data for the current reporting period. The indicators were developed during a meeting between the chiefs of medical services and this monitor. The following is a summary outline of the data:</p> <ol style="list-style-type: none"> 1. Process outcomes tracked: <ol style="list-style-type: none"> a. Number of individuals newly diagnosed with diabetes mellitus b. Number of new diagnoses of diabetes mellitus in individuals receiving new generation antipsychotics c. Percentage of individuals whose BMI is tracked monthly d. Number of individuals with 3+ falls in 30 days e. Total number of falls f. Seizure data review g. Review process for unexpected deaths

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		<p>2. Clinical outcomes tracked:</p> <ul style="list-style-type: none"> a. Percentage of individuals with dyslipidemia with LDL <130 b. Percentage of individuals with diabetes mellitus with LDL <100 c. Number/percentage of individuals with BMI >25 d. Percentage of individuals with hypertension with blood pressure < 140/90 e. Percentage of individuals with diabetes mellitus and blood pressure <130/80 f. Number of individuals hospitalized for bowel dysfunction g. Individuals with falls with major injury h. Number of individuals diagnosed with aspiration pneumonia i. Number of individuals with refractory seizures j. Number of individuals with status epilepticus <p>In several instances (for example, indicators related to diabetes mellitus, obesity and bowel dysfunction), the facility reported as clinical outcomes what were in fact process outcomes.</p> <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p>The formalized physician peer review system utilizing indicators aligned with the standards and expectations outlined in F.7.a was implemented on 10/14/2009. Charts of individuals reviewed included all Medical Transfers to Acute Care Hospitals. All physician and surgeon medical care was reportedly found to meet the generally accepted medical standards of care and no physician and surgeons are on remedial plans.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ul style="list-style-type: none"> 1. Continue to monitor this requirement.
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		2. Ensure that the process and clinical outcome data are reported in alignment with the framework agreed to by the facility medical directors in December 2009.
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brandi Norico, PHN II 2. Gina M. Dusi, PHN II <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Infection Control Follow-Up Instructions for audit data 3. Memos from Infection Control addressing WRP issues with Nursing 4. ASH Public Health Services Infection Report for February 2010 5. Infection Control Committee meeting minutes dated 9/24/09, 10/29/09, 11/23/09, 12/17/09, 1/28/10, 2/25/10 6. HSS Committee meeting minutes for September 2009 - March 2010 7. Department of Medicine minutes dated 10/15/09, 11/18/09, 12/17/09, 1/21/10, 2/18/10 8. ASH's revised Infection Control policies/procedures: ICM III-I, Monitoring & Controlling of Refrigerator/Freezer Temperatures; ICM VI-F, Protocol for the Diagnosis & Treatment of Scabies; ICM V-A, Atascadero State Hospital Employee Infection Control Program; ICM V-H, Employee with Streptococcal- Staphylococcal Infection &/ or Carrier; ICM V-I, Volunteer Services Health Screening; ICM V-J, Employee with Hepatitis A (HAV) Infection or Exposure; ICM V-K, Employee Referral/Reporting of Infection or Exposure; ICM V-M, Health Screening for Contracted Employee 9. Medical records for the following 111 individuals: AJW, ASV, AT, BDT, BKR, CB, CLP, CRJ, CS, CW, DAP, DC, DCC, DCJ, DEC, DFG, DG, DJW, DLA, DLB, DLS, DLY, DPP, DR, DRD, DS, DSB, DU, EAM, EC, EH, ELB, ELS, EM, ES, EWB, EWS, FA, FG, FSA, GDJ, GV, HAD, HAT, HT, HVH, IC, JAD, JB, JBJ, JDM, JJF, JJM, JMH, JML, JOS, JPW, JRS, JSC, JW, JWB, JWC, KC, KFB, KLW, KSC, LW, LWH, MAB, MAG, MAR, MAW, MDM, MEA, MHM, MJC, MLC, MLP, MM, MN, MP,

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		MR, MRD, MTR, MV, MWT, PM, PRI, RAG, RB, RBD, RDM, RJZ, RNG, RRR, RSC, RTB, RV, SEE, SEM, SJP, SQ, SR, SS, STS, SWC, TK, VC, VCI, WM and WRL
F.8.a	Each State hospital shall establish an effective infection control program that:	Compliance: Substantial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Since the last review, Public Health Services has continued to work with IT regarding the Public Health database conversion and continues to collaborate with Nursing Services regarding the development of quality infection control WRP objectives and interventions. The PHNs have continued to liaise with the program HSSs and level of care RNs to ensure that quality infection control-related nursing objectives and interventions are completed for individuals having acute and chronic infectious processes. In addition, ASH has revised a number of Infection Control Manual policies/procedures, including the following:</p> <ul style="list-style-type: none"> • ICM III-I, Monitoring & Controlling of Refrigerator/Freezer Temperatures • ICM VI-F, Protocol for the Diagnosis and Treatment of Scabies • ICM V-A, Atascadero State Hospital Employee Infection Control Program • ICM V-H, Employee with Streptococcal- Staphylococcal Infection and/or Carrier • ICM V-I, Volunteer Services Health Screening • ICM V-J, Employee with Hepatitis A (HAV) Infection or Exposure • ICM V-K, Employee Referral/Reporting of Infection or Exposure

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		<ul style="list-style-type: none"> • ICM V-M, Health Screening for Contracted Employee <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital with a negative PPD in the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 487 1890 868"> <tr> <td data-bbox="991 487 1087 560">1.</td> <td data-bbox="1087 487 1795 560"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1795 487 1890 560">100%</td> </tr> <tr> <td data-bbox="991 560 1087 633">2.</td> <td data-bbox="1087 560 1795 633"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1795 560 1890 633">100%</td> </tr> <tr> <td data-bbox="991 633 1087 706">3.</td> <td data-bbox="1087 633 1795 706"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1795 633 1890 706">100%</td> </tr> <tr> <td data-bbox="991 706 1087 779">4.</td> <td data-bbox="1087 706 1795 779"><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1795 706 1890 779">100%</td> </tr> <tr> <td data-bbox="991 779 1087 868">5.</td> <td data-bbox="1087 779 1795 868"><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1795 779 1890 868">N/A</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all applicable items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	N/A
1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%															
2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%															
3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%															
4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%															
5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	N/A															

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		<p>A review of the records of 20 individuals admitted during the review period (AJW, BDT, CRJ, DCC, DLB, ES, FG, GV, HAT, JB, JDM, JJF, JSC, KC, MAG, RJZ, RRR, SEM, SQ and WRL) found that all had a physician's order for PPD upon admission and were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals needing an annual PPD during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 634 1887 937"> <tr> <td data-bbox="991 634 1087 711">1.</td> <td data-bbox="1087 634 1793 711"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 634 1887 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 787">2.</td> <td data-bbox="1087 711 1793 787"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 711 1887 787">100%</td> </tr> <tr> <td data-bbox="991 787 1087 863">3.</td> <td data-bbox="1087 787 1793 863"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 787 1887 863">100%</td> </tr> <tr> <td data-bbox="991 863 1087 937">4.</td> <td data-bbox="1087 863 1793 937"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 863 1887 937">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%												
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%												

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p>A review of the records of 17 individuals requiring an annual PPD during the review period (AT, CW, DG, DR, EM, HVH, IC, JMH, JWB, MAW, MM, MN, MV, SR, SS, VC and WM) found that all had a physician's order for an annual PPD and the annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital in the review months (September 2009-February 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 708 1887 1347"> <tr> <td data-bbox="991 708 1087 821">1.</td> <td data-bbox="1087 708 1793 821"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 708 1887 821">100%</td> </tr> <tr> <td data-bbox="991 821 1087 935">2.</td> <td data-bbox="1087 821 1793 935"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 821 1887 935">100%</td> </tr> <tr> <td data-bbox="991 935 1087 1049">3.</td> <td data-bbox="1087 935 1793 1049"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 935 1887 1049">100%</td> </tr> <tr> <td data-bbox="991 1049 1087 1162">4.</td> <td data-bbox="1087 1049 1793 1162"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1049 1887 1162">100%</td> </tr> <tr> <td data-bbox="991 1162 1087 1276">5.</td> <td data-bbox="1087 1162 1793 1276"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 1162 1887 1276">100%</td> </tr> <tr> <td data-bbox="991 1276 1087 1390">6.</td> <td data-bbox="1087 1276 1793 1390"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 1276 1887 1390">100%</td> </tr> <tr> <td data-bbox="991 1390 1087 1347">7.</td> <td data-bbox="1087 1390 1793 1347"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1793 1390 1887 1347">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</p>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%																					
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%																					
3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%																					
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%																					
5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%																					
6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%																					
7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%																					

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		<p>at least 90% from the previous review period for items 1-6 and improved compliance for item 7 from 87% in the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals who were admitted Hepatitis C positive during the review period (ASV, CB, CLP, CS, DCJ, DEC, DFG, EH, ES, EWB, GDJ, JAD, JOS, JRS, MJC, RSC, RTB, RV, TK and VCI) found that all 20 contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, ASH assessed its compliance based on a 100% sample (eight individuals) of individuals who were positive for HIV antibody in the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 1226 1887 1411"> <tr> <td data-bbox="991 1226 1087 1339">1.</td> <td data-bbox="1087 1226 1793 1339"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 1226 1887 1339">100%</td> </tr> <tr> <td data-bbox="991 1339 1087 1411">2.</td> <td data-bbox="1087 1339 1793 1411"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody</i></td> <td data-bbox="1793 1339 1887 1411">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody</i>	100%
1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%						
2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody</i>	100%						

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			<i>test.</i>	
		3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%
		4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A
		5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%
		6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%
		7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%
		8.	<i>Appropriate interventions are written.</i>	100%
		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all applicable items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p>A review of the records of eight individuals who were admitted during the review period with HIV (DLA, DLS, ELB, JWC, KFB, MDM, MR and</p>		

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		<p>MTR) found that all eight were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 524 1890 862"> <tr> <td data-bbox="991 524 1087 597">1.</td> <td data-bbox="1087 524 1793 597"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 524 1890 597">100%</td> </tr> <tr> <td data-bbox="991 597 1087 670">2.</td> <td data-bbox="1087 597 1793 670"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 597 1890 670">100%</td> </tr> <tr> <td data-bbox="991 670 1087 743">3.</td> <td data-bbox="1087 670 1793 743"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 670 1890 743">100%</td> </tr> <tr> <td data-bbox="991 743 1087 862">4.</td> <td data-bbox="1087 743 1793 862"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 743 1890 862">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%												
2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%												
3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%												
4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%												

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		<p>A review of the records of 15 individuals (AJW, DJW, DU, ELS, HAD, JML, KSC, LW, LWH, MAB, MEA, MLC, MLP, PM and RBD) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, ASH assessed its compliance based on a 73% sample of individuals in the hospital who refused to take their immunizations during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 672 1887 1159"> <tr> <td data-bbox="991 672 1087 782">1.</td> <td data-bbox="1087 672 1793 782"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1793 672 1887 782">100%</td> </tr> <tr> <td data-bbox="991 782 1087 862">2.</td> <td data-bbox="1087 782 1793 862"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 782 1887 862">100%</td> </tr> <tr> <td data-bbox="991 862 1087 935">3.</td> <td data-bbox="1087 862 1793 935"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 862 1887 935">100%</td> </tr> <tr> <td data-bbox="991 935 1087 1045">4.</td> <td data-bbox="1087 935 1793 1045"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 935 1887 1045">100%</td> </tr> <tr> <td data-bbox="991 1045 1087 1159">5.</td> <td data-bbox="1087 1045 1793 1159"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 1045 1887 1159">N/A</td> </tr> </table> <p>Comparative data indicated overall improvement in compliance from the previous review period:</p>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	100%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	100%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	100%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%															
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	100%															
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	100%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	100%															
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A															

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		<table border="1" data-bbox="991 227 1890 535"> <thead> <tr> <th></th> <th>period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>2.</td> <td>81%</td> <td>100%</td> </tr> <tr> <td>3.</td> <td>55%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td>50%</td> <td>100%</td> </tr> <tr> <td>5.</td> <td>100%</td> <td>N/A</td> </tr> </tbody> </table> <p data-bbox="991 576 1480 641"><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p data-bbox="991 690 1690 755"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p data-bbox="991 803 1575 868"><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p data-bbox="991 909 1816 974"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p data-bbox="991 1023 1890 1161">A review of the records of 11 individuals who refused immunizations during the review period (BKR, DLY, EAM, EWS, MP, MRD, PRI, RAG, SJP, SS and SWC) found that all 11 WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p data-bbox="991 1209 1890 1388"><u>MRSA</u> Using the DMH IC MRSA Audit, ASH assessed its compliance based on a 100% sample (11 individuals) of individuals in the hospital who tested positive for MRSA during the review months (September 2009-February 2010):</p>		period	Current period	Mean compliance rate			1.	100%	100%	2.	81%	100%	3.	55%	100%	4.	50%	100%	5.	100%	N/A
	period	Current period																					
Mean compliance rate																							
1.	100%	100%																					
2.	81%	100%																					
3.	55%	100%																					
4.	50%	100%																					
5.	100%	N/A																					

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		<table border="1"> <tr> <td data-bbox="989 228 1087 337">1.</td> <td data-bbox="1087 228 1793 337"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 228 1885 337">100%</td> </tr> <tr> <td data-bbox="989 337 1087 446">2.</td> <td data-bbox="1087 337 1793 446"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 337 1885 446">100%</td> </tr> <tr> <td data-bbox="989 446 1087 526">3.</td> <td data-bbox="1087 446 1793 526"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 446 1885 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 605">4.</td> <td data-bbox="1087 526 1793 605"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 526 1885 605">100%</td> </tr> <tr> <td data-bbox="989 605 1087 714">5.</td> <td data-bbox="1087 605 1793 714"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1793 605 1885 714">100%</td> </tr> <tr> <td data-bbox="989 714 1087 753">6.</td> <td data-bbox="1087 714 1793 753"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 714 1885 753">100%</td> </tr> <tr> <td data-bbox="989 753 1087 833">7.</td> <td data-bbox="1087 753 1793 833"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 753 1885 833">100%</td> </tr> <tr> <td data-bbox="989 833 1087 904">8.</td> <td data-bbox="1087 833 1793 904"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 833 1885 904">100%</td> </tr> </table> <p data-bbox="989 948 1898 1013">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 1057 1482 1088"><u>F.8.a.ii: Assesses these data for trends</u></p> <p data-bbox="989 1096 1898 1198">Compliance in November and December 2009 for items 3, 6, 7 and 8 was N/A because the sites were healed by the time the culture results were received.</p> <p data-bbox="989 1242 1688 1273"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p> <p data-bbox="989 1281 1178 1312">None required.</p> <p data-bbox="989 1356 1572 1386"><u>F.8.a.iv: Identifies necessary corrective action</u></p> <p data-bbox="989 1395 1402 1425">No corrective action was needed.</p>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%																								
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7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%																								
8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%																								

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p>A review of the records of 11 individuals with MRSA (DC, DPP, DRD, EC, FA, JBJ, JPW, JW, JWC, MAR and MWT) found that for four individuals (FA, JBJ, JPW and JW), the site was healed prior to the facility obtaining the cultures results, one individual (MAR) was hospitalized during the time infected; and the remaining six individuals were placed on contact precautions and the appropriate antibiotic and had appropriate objectives and interventions in their WPRs.</p> <p><u>Positive PPD</u></p> <p>Using the DMH IC Positive PPD Audit, ASH assessed its compliance based on 100% of individuals in the hospital (four individuals) who had a positive PPD test during the review months (September 2009-February 2010):</p> <table border="1"> <tr> <td data-bbox="991 820 1087 894">1.</td> <td data-bbox="1087 820 1793 894"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 820 1887 894">100%</td> </tr> <tr> <td data-bbox="991 894 1087 935">2.</td> <td data-bbox="1087 894 1793 935"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1793 894 1887 935">75%</td> </tr> <tr> <td data-bbox="991 935 1087 1010">3.</td> <td data-bbox="1087 935 1793 1010"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1793 935 1887 1010">100%</td> </tr> <tr> <td data-bbox="991 1010 1087 1123">4.</td> <td data-bbox="1087 1010 1793 1123"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1793 1010 1887 1123">N/A</td> </tr> <tr> <td data-bbox="991 1123 1087 1164">5.</td> <td data-bbox="1087 1123 1793 1164"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1793 1123 1887 1164">100%</td> </tr> <tr> <td data-bbox="991 1164 1087 1278">6.</td> <td data-bbox="1087 1164 1793 1278"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1793 1164 1887 1278">100%</td> </tr> <tr> <td data-bbox="991 1278 1087 1391">7.</td> <td data-bbox="1087 1278 1793 1391"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 1278 1887 1391">100%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	75%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%
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7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%																					

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		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for items 1, 3 and 5-7. The compliance rate for item 2 was 75% in both periods. Item 4 was not applicable in either period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> September 2009 data for item 2 was 0% due to one individual not having a chest x-ray completed; the individual was discharged before it was obtained.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> In September 2009, the individual was discharged prior to receiving a lateral chest x-ray.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> ASH will continue to monitor this requirement.</p> <p>A review of the records of four individuals who had a positive PPD (DAP, DSB, FSA and HT) found that three individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all four WRPs contained appropriate objectives and interventions.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, ASH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (September 2009-February 2010):</p>
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		<table border="1"> <tr> <td data-bbox="989 228 1087 378">1.</td> <td data-bbox="1087 228 1793 378"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 228 1887 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 456">2.</td> <td data-bbox="1087 378 1793 456"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 378 1887 456">100%</td> </tr> <tr> <td data-bbox="989 456 1087 534">3.</td> <td data-bbox="1087 456 1793 534"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 456 1887 534">100%</td> </tr> <tr> <td data-bbox="989 534 1087 612">4.</td> <td data-bbox="1087 534 1793 612"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 534 1887 612">100%</td> </tr> </table> <p data-bbox="989 646 1887 716">Comparative data indicated overall improvement in compliance from the previous review period:</p> <table border="1"> <thead> <tr> <th data-bbox="989 753 1522 831"></th> <th data-bbox="1522 753 1713 831">period</th> <th data-bbox="1713 753 1887 831">Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="989 831 1887 870">Mean compliance rate</td> </tr> <tr> <td data-bbox="989 870 1522 906">1.</td> <td data-bbox="1522 870 1713 906">100%</td> <td data-bbox="1713 870 1887 906">100%</td> </tr> <tr> <td data-bbox="989 906 1522 941">2.</td> <td data-bbox="1522 906 1713 941">93%</td> <td data-bbox="1713 906 1887 941">100%</td> </tr> <tr> <td data-bbox="989 941 1522 977">3.</td> <td data-bbox="1522 941 1713 977">58%</td> <td data-bbox="1713 941 1887 977">100%</td> </tr> <tr> <td data-bbox="989 977 1522 1013">4.</td> <td data-bbox="1522 977 1713 1013">52%</td> <td data-bbox="1713 977 1887 1013">100%</td> </tr> </tbody> </table> <p data-bbox="989 1062 1887 1131"><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p data-bbox="989 1174 1887 1243"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p data-bbox="989 1286 1887 1356"><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p data-bbox="989 1398 1887 1425"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u></p>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	100%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	100%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%		period	Current period	Mean compliance rate			1.	100%	100%	2.	93%	100%	3.	58%	100%	4.	52%	100%
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2.	93%	100%																														
3.	58%	100%																														
4.	52%	100%																														

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		<p>ASH will continue to monitor this requirement.</p> <p>A review of the records of ten individuals who refused admitting or annual labs/diagnostics (DS, JJM, JW, KLW, MHM, RB, RDM, RNG, SEE and STS) found that all ten refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> ASH had no cases of STDs during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Other findings: ASH's key indicator data from the facility accurately reflected the infection control trends.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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		<p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	<p>integrates this information into each State hospital's quality assurance review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Review of meeting minutes verified that IC data are discussed at meetings of the Infection Control Committee and other discipline committees. Additional areas addressed by Infection Control noted in meeting minutes included:</p> <ul style="list-style-type: none"> • Hospital-wide collaboration to ensure ongoing reduction of infection-related risks ; • Infection Reporting Surveillance Folders for outbreaks, infections and H1N1 activity; • Recommendations for the ASH Intranet Website Visitor and Family Information section regarding IC issues; • Collaboration with Standards Compliance to ensure accurate sexual exposure data findings; • Review of N95 mask storage requirements, influenza shot for employees, fit training and fit testing related to H1N1; • Collaboration with Department of Protective Services, Nursing Services and Volunteer Services in the development and implementation of the Visitor Health Questionnaire process;

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		<ul style="list-style-type: none"> • CDC Mandated Guillain-Barre Syndrome Surveillance and Reporting; • Infection Control Committee review of Seasonal and H1N1 influenza issues including resident/staff vaccine availability, pregnant employee vaccine availability, Unit 20 Airborne Unit, related supplies for surge capacity, employee infection surveillance, fit training and fit testing, finger guards for pulse oximeter use and review of Nutritional Policy/Procedure #1401; • Safe use of alcohol hand sanitizer when dispensing to residents; • Infection Control Committee review of H1N1 activities, hand hygiene, annual TST refusals and implementation of QuantiFERON process; • Review of San Luis Obispo County notification of Nationwide Salmonella Montevideo Outbreak; and • Influenza vaccination availability to staff and individuals <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Jeff Sheppard, DDS 2. Nolan Nelson, DDS 3. Ronald Arnoldsen, DDS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Dental log for refusals 3. Medical records for the following 82 individuals: AAG, AC, ACR, ADT, AFD, AHN, AJW, AM, AT, BDT, BJB, CDP, CE, CEH, CP, CRJ, CW, DCC, DG, DH, DLB, DLG, DR, EAM, EC, EM, EP, ERM, ES, FG, FW, GFP, GP, GPH, GV, HAD, HAT, HVH, IC, ICT, JAM, JB, JD, JDM, JEP, JJF, JL, JMH, JN, JSC, JTJ, JWB, KC, KCC, MAG, MAW, MBM, MIM, MM, MN, MR, MV, PDN, PJC, RAL, RDB, RF, RJZ, RKR, RR, RRR, SB, SEM, SFS, SJG, SQ, SR, SS, VC, WCL, WM and WRL
<p>F.9.a</p>	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: No new staff have been added to the Dental Department since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 32% mean sample of individuals scheduled for comprehensive dental exams during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="993 711 1892 751"> <tr> <td data-bbox="993 711 1087 751">1.a</td> <td data-bbox="1087 711 1793 751"><i>Comprehensive dental exam was completed</i></td> <td data-bbox="1793 711 1892 751">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (AJW, BDT, CRJ, DCC, DLB, ES, FG, GV, HAT, JB, JDM, JJF, JSC, KC, MAG, RJZ, RRR, SEM, SQ and WRL) found all 20 individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 20% mean sample of individuals who have been in the hospital for 90 days or less during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1230 1892 1271"> <tr> <td data-bbox="993 1230 1087 1271">1.b</td> <td data-bbox="1087 1230 1793 1271"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 1230 1892 1271">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%	1.b	<i>If admission examination date was 90 days or less</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%						
1.b	<i>If admission examination date was 90 days or less</i>	100%						

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		<p>A review of the records of 20 individuals (AJW, BDT, CRJ, DCC, DLB, ES, FG, GV, HAT, JB, JDM, JJF, JSC, KC, MAG, RJZ, RRR, SEM, SQ and WRL) found that all 20 individuals were timely seen for their admission exams.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals due for annual routine dental examinations during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 561 1890 638"> <tr> <td data-bbox="991 561 1087 638">1.c</td> <td data-bbox="1087 561 1793 638"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 561 1890 638">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals (AT, CW, DG, DR, EM, HVH, IC, JMH, JWB, MAW, MM, MN, MV, SR, SS, VC and WM) found that all 17 annual exams were timely completed.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals with dental problems identified on admission or annual examination during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 1118 1890 1230"> <tr> <td data-bbox="991 1118 1087 1230">1.d</td> <td data-bbox="1087 1118 1793 1230"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1118 1890 1230">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 37 individuals (AJW, AT, BDT, CRJ, CW, DCC,</p>	1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%
1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%						
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%						

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		<p>DG, DLB, DR, EM, ES, FG, GV, HAT, HVH, IC, JB, JDM, JJF, JMH, JSC, JWB, KC, MAG, MAW, MM, MN, MV, RJZ, RRR, SEM, SQ, SR, SS, VC, WM and WRL) found that all 37 individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 561 1887 711"> <tr> <td data-bbox="991 561 1087 711">1.e</td> <td data-bbox="1087 561 1793 711"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 561 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals (AC, AHN, AM, CE, DH, EAM, EC, EP, JAM, JB, JD, JTJ, KCC, MBM, MM, RF, SJG and WCL) found that all 18 individuals received timely follow-up care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals scheduled for follow-up dental</p>			

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		<p>care during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 264 1887 378"> <tr> <td data-bbox="991 264 1087 378">2.</td> <td data-bbox="1087 264 1793 378"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1793 264 1887 378">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 37 individuals (AJW, AT, BDT, CRJ, CW, DCC, DG, DLB, DR, EM, ES, FG, GV, HAT, HVH, IC, JB, JDM, JJF, JMH, JSC, JWB, KC, MAG, MAW, MM, MN, MV, RJZ, RRR, SEM, SQ, SR, SS, VC, WM and WRL) found compliance with the documentation requirements in all 37 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%
2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals due for annual routine dental examinations during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="991 1268 1887 1382"> <tr> <td data-bbox="991 1268 1087 1382">3.a</td> <td data-bbox="1087 1268 1793 1382"><i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 1268 1887 1382">100%</td> </tr> </table>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i>	100%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals (AC, AHN, AM, CE, DH, EAM, EC, EP, JAM, JB, JD, JTJ, KCC, MBM, MM, RF, SJG and WCL) found that all 18 individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="993 597 1892 675"> <tr> <td data-bbox="993 597 1087 675">3.c</td> <td data-bbox="1087 597 1793 675"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 597 1892 675">100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals (AT, CW, DG, DR, EM, HVH, IC, JMH, JWB, MAW, MM, MN, MV, SR, SS, VC and WM) found that all 17 individuals received restorative care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% mean sample of individuals who had tooth extractions during the review months (September 2009-February 2010):</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="993 228 1892 492"> <tr> <td data-bbox="993 228 1087 492">4.</td> <td data-bbox="1087 228 1793 492"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></td> <td data-bbox="1793 228 1892 492">100%</td> </tr> </table> <p data-bbox="993 532 1906 597">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 646 1906 743">A review of the records of 20 individuals (AAG, ADT, AFD, BJB, CP, DLG, ERM, FW, GFP, HAD, ICT, JEP, JL, MIM, PDN, RKR, RR, SB, SFS and SS) found that all 20 records were in compliance with this requirement.</p> <p data-bbox="993 792 1457 857">Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%			
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p data-bbox="993 906 1577 930">Current findings on previous recommendation:</p> <p data-bbox="993 979 1457 1044">Recommendation, October 2009: Continue to monitor this requirement.</p> <p data-bbox="993 1092 1877 1263">Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 24% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="993 1304 1892 1416"> <tr> <td data-bbox="993 1304 1087 1416">5.</td> <td data-bbox="1087 1304 1793 1416"><i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health,</i></td> <td data-bbox="1793 1304 1892 1416">100%</td> </tr> </table>	5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health,</i>	100%
5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health,</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 191 1894 267"> <tr> <td data-bbox="991 191 1087 267"></td> <td data-bbox="1087 191 1793 267"><i>medications, allergies, and current dental status and complaints.</i></td> <td data-bbox="1793 191 1894 267"></td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 37 individuals (AJW, AT, BDT, CRJ, CW, DCC, DG, DLB, DR, EM, ES, FG, GV, HAT, HVH, IC, JB, JDM, JJF, JMH, JSC, JWB, KC, MAG, MAW, MM, MN, MV, RJZ, RRR, SEM, SQ, SR, SS, VC, WM and WRL) found that all records were in compliance with the documentation requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>medications, allergies, and current dental status and complaints.</i>	
	<i>medications, allergies, and current dental status and complaints.</i>				
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Implement strategies addressing this requirement.</p> <p>Findings: See F.9.e addressing dental refusals.</p> <p>Recommendation 2, October 2009: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data on missed appointments:</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="8">Dental Refusals and Reason</th> </tr> <tr> <th></th> <th></th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>75</td> <td>55</td> <td>33</td> <td>53</td> <td>55</td> <td>52</td> <td>54</td> </tr> <tr> <td>n</td> <td>75</td> <td>55</td> <td>33</td> <td>53</td> <td>55</td> <td>52</td> <td>54</td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>% due to refusal</td> <td>99</td> <td>95</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>99</td> </tr> <tr> <td>% due to transportation</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>% due to staffing</td> <td>1</td> <td>5</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> </tr> </tbody> </table> <p>N= Number of Non attendance of Dental Appointment n= Number audited</p> <p>A review of the Dental appointment logs verified that staffing and transportation issues did not preclude individuals from attending dental appointments.</p> <p>See F.9.e for findings regarding dental refusals.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Dental Refusals and Reason										Oct	Nov	Dec	Jan	Feb	Mean	N	75	55	33	53	55	52	54	n	75	55	33	53	55	52	54	%S	100	100	100	100	100	100	100	% due to refusal	99	95	100	100	100	100	99	% due to transportation	0	0	0	0	0	0	0	% due to staffing	1	5	0	0	0	0	1
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F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.9.d.</p> <p>Findings: Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals scheduled for but refusing to</p>																																																																

Section F: Specific Therapeutic and Rehabilitation Services

		<p>attend dental appointments during the review months (September 2009-February 2010):</p> <table border="1" data-bbox="993 302 1887 453"> <tr> <td data-bbox="993 302 1087 453">7.</td> <td data-bbox="1087 302 1793 453"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 302 1887 453">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 17% in the previous review period.</p> <p>In October 2009, ASH developed a process to review all refusals in "real time" where the WRPTs address all refusals in the WRPs. Refusals are triaged at the unit level to distinguish refused appointments from missed appointments. Missed appointments are rescheduled and documented in the Task Tracker, including the reason why the appointment was missed. Actual refusals receive a risk rating and the WRPTs develop strategies to address the refusal. The oversight of this system takes place in the Program Review Committee (PRC) and the Psychology Specialty Services Committee (PSSC) meetings. In addition, in March 2010, Dental along with the psychologists implemented a tour of the dental clinic for individuals who have refused dental appointments. During the tour, individuals are introduced to the dental staff and are given information regarding what types of dental treatments are offered at ASH. Individuals are encouraged to ask questions and express concerns if efforts to alleviate any fears.</p> <p>A review of the records of 13 individuals who refused dental appointments (ACR, AM, CDP, CEH, DH, GP, GPH, JAM, JN, MR, PJC, RAL and RDB) found that one (CEH) did not have an open focus and 11 had basically the exact same template in the WRPs, even when the focus statement identified a specific reason the individual refused to attend the dental appointment. Consequently, none had appropriate individual-</p>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	93%
7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	93%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>specific WRPs addressing dental refusals, which does not comport with ASH's data. However, the WRP for one individual (RDB) was found to be exceptional in addressing the specific reason that the individual refused the appointment in the focus statement, with objectives and interventions in alignment with the individual's reason for the refusal. With ASH's attention focused on refusals, this area should come into compliance by the next review provided that the WRP addresses the individual's reasons for not attending the appointments.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. WRPTs need to ensure that WRPs addressing refusals are individualized.2. Continue to monitor this requirement.
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Section G: Documentation

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

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. ASH continues to be committed to decreasing the use of restraint and seclusion and has made significant progress in this area since the last review. It is expected that the facility will attain substantial compliance with all Section H requirements by the next review. 2. ASH has made significant progress regarding documentation pertaining to seclusion and restraint and has attained substantial compliance with related EP requirements.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donna Nelson, Standards Compliance Director 2. Stan Wilt, RN, Central Nursing Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Prone Stabilization report 3. ASH's Violence Risk Management Six-Month Progress Report 4. ASH's training rosters 5. Medical records for the following 38 individuals: AGG, AM, AW, AY, BBR, CHM, CK, DEH, DJW, DWH, EAM, EGG, EPP, ET, GD, JAA, JG, JKS, JLN, JMC, JV, KA, LRP, MAG, MJB, MJG, MSB, OMG, RAA, RAS, RK, RKH, RR, RS, RWB, THN, TT and WEJ
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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

	<p>expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Findings: ASH's Standards Compliance continues to review episodes of prone stabilization. Review of documentation for 86 episodes of prone stabilization prior to seclusion and restraint found four incidents of prone transportation early in the review period (September/October 2009) and none for November 2009 through February 2010. Upon further review, two of the four incidents were in fact documentation errors and the individuals were not transported in a prone position. ASH needs to continue to monitor this issue to ensure that the use of prone restraint, prone containment and prone transportation is prohibited in alignment with the requirements of the Enhancement Plan. ASH need to continue to collect information on and review these episodes.</p> <p>Compliance: Partial due to two events of prone transportation, which is prohibited by the requirements of the Enhancement Plan.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to collect information on and review episodes of prone stabilization/ transportation. 2. Provide documentation of corrective action in the event that prone restraint, prone containment and/or prone transportation were used. 3. Continue to monitor this requirement.
<p>H.2</p>	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p>Compliance: Substantial.</p>
<p>H.2.a</p>	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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

		<p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial seclusion orders each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 375 1887 602"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of 26 episodes of seclusion for 17 individuals (AGG, AM, AW, BBR, CHM, DEH, DJW, EPP, JLN, JV, KA, LRP, MSB, OMG, RAA, RAS and RR) found that the documentation for 25 episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial restraint orders each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1154 1887 1382"> <tr> <td>1.</td> <td><i>Restraint is used in a documented manner.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>96%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	100%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	97%	1.	<i>Restraint is used in a documented manner.</i>	100%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	96%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of 30 episodes of restraint for 22 individuals (AW, AY, CK, DWH, EAM, EGG, ET, GD, JAA, JG, JKS, JMC, MAG, MJB, MJG, RK, RKH, RS, RWB, THN, TT and WEJ) found that the documentation for all 30 episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all 30 episodes and orders that included specific behaviors were found in all 30 episodes.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial seclusion orders each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1079 1890 1414"> <tr> <td data-bbox="991 1079 1087 1156">4.</td> <td data-bbox="1087 1079 1795 1156"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1795 1079 1890 1156">95%</td> </tr> <tr> <td data-bbox="991 1156 1087 1232">5.</td> <td data-bbox="1087 1156 1795 1232"><i>The individual has been in seclusion and the staff did NOT....</i></td> <td data-bbox="1795 1156 1890 1232">100%</td> </tr> <tr> <td data-bbox="991 1232 1087 1414">6.</td> <td data-bbox="1087 1232 1795 1414"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH1 185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical</i></td> <td data-bbox="1795 1232 1890 1414">100%</td> </tr> </table>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	95%	5.	<i>The individual has been in seclusion and the staff did NOT....</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH1 185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%;"><i>justification as to why they were not used.</i></td> <td style="width: 10%;"></td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of 26 episodes of seclusion for 17 individuals (AGG, AM, AW, BBR, CHM, DEH, DJW, EPP, JLN, JV, KA, LRP, MSB, OMG, RAA, RAS and RR) found that there was documentation in all 26 WRPs addressing behaviors, objectives and interventions. Documentation in 24 episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial restraint orders each month during the review period (September 2009-February 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">4.</td> <td style="width: 85%;"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td style="width: 10%;">93%</td> </tr> <tr> <td>5.</td> <td><i>The individual has been in restraint and the staff did NOT....</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH₁ 185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of 30 episodes of restraint for 22 individuals (AW, AY, CK, DWH, EAM, EGG, ET, GD, JAA, JG, JKS, JMC, MAG, MJB, MJG, RK, RKH, RS, RWB, THN, TT and WEJ) found that there was documentation in all 22 WRPs addressing behaviors, objectives and interventions.</p>		<i>justification as to why they were not used.</i>		4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	93%	5.	<i>The individual has been in restraint and the staff did NOT....</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH₁ 185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Documentation in 29 episodes indicated that the individual was released when calm</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
H.2.c	<p>are not used as part of a behavioral intervention; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendation: See F.2.c.iv.</p>			
H.2.d	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of episodes of seclusion each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="993 1193 1887 1268"> <tr> <td data-bbox="993 1193 1087 1268">7.</td> <td data-bbox="1087 1193 1793 1268"><i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 1193 1887 1268">93%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>	7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	93%
7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	93%			

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		<p>See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of episodes of restraint each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 414 1887 492"> <tr> <td data-bbox="991 414 1087 492">7.</td> <td data-bbox="1087 414 1793 492"><i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 414 1887 492">94%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	94%
7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	94%			
H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial seclusion orders each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1193 1887 1344"> <tr> <td data-bbox="991 1193 1087 1344">8.</td> <td data-bbox="1087 1193 1793 1344"><i>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 within one hour.</i></td> <td data-bbox="1793 1193 1887 1344">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 81% in the</p>	8.	<i>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 within one hour.</i>	92%
8.	<i>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 within one hour.</i>	92%			

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		<p>previous review period.</p> <p>A review of 26 episodes of seclusion for 17 individuals (AGG, AM, AW, BBR, CHM, DEH, DJW, EPP, JLN, JV, KA, LRP, MSB, OMG, RAA, RAS and RR) found that the RN conducted a timely assessment in 24 episodes and that the individual was timely seen by a psychiatrist in 24 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 21% mean sample of initial restraint orders each month during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 597 1887 748"> <tr> <td data-bbox="991 597 1087 748">8.</td> <td data-bbox="1087 597 1793 748"><i>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 restraint within one hour.</i></td> <td data-bbox="1793 597 1887 748">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p>A review of 30 episodes of restraint for 22 individuals (AW, AY, CK, DWH, EAM, EGG, ET, GD, JAA, JG, JKS, JMC, MAG, MJB, MJG, RK, RKH, RS, RWB, THN, TT and WEJ) found that the RN conducted a timely assessment in 27 episodes and that the individual was timely seen by a psychiatrist in 28 episodes.</p> <p>ASH's training rosters indicated that 15 staff that were required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p>Compliance: Substantial.</p>	8.	<i>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 restraint within one hour.</i>	92%
8.	<i>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 restraint within one hour.</i>	92%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The Standards Compliance Department continues to compare the ORYX and PLATO data regarding restraint and seclusion monthly to ensure accuracy. In the event a discrepancy is found, the Department notifies the specific Program and the data are checked against the Program's raw data. The NOC shift also conducts nightly audits of the MARs and compares the PRN/Stat data to the data contained in the Quick Hits database. In addition, the Ongoing Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly and initiate QI process for any developing trends.</p> <p>A review of the PRN/Stat medications and seclusion and restraints lists provided found no incidents that were not included in the ASH databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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	<p>plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Findings: Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 76% sample of individuals who were in seclusion more than three times in 30 days during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 451 1890 638"> <tr> <td data-bbox="991 451 1087 638">9.</td> <td data-bbox="1087 451 1793 638"><i>Required to review within three business days the therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 451 1890 638">99%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 43% in the previous review period.</p> <p>A review of the records of seven individuals who were in seclusion more than three times in 30 days during the review period (AM, BBR, DEH, MSB, OMG, RAA and RR) found that all seven WRPs included documentation within three business days.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 66% sample of individuals who were in restraint more than three times in 30 days during the review period (September 2009-February 2010):</p> <table border="1" data-bbox="991 1157 1890 1377"> <tr> <td data-bbox="991 1157 1087 1377">9.</td> <td data-bbox="1087 1157 1793 1377"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 1157 1890 1377">93%</td> </tr> </table>	9.	<i>Required to review within three business days the therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	99%	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	93%
9.	<i>Required to review within three business days the therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	99%						
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	93%						

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		<p>Comparative data indicated improvement in compliance from 41% in the previous review period.</p> <p>A review of the records of 12 individuals who were in restraint more than three times in 30 days during the review period (AW, EGG, ET, GD, JG, JKS, JMC, MAG, RKH, RS, RWB and THN) found that 11 WRPs included documentation within three business days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized	<p>Current findings on previous recommendation:</p>

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	behaviors.	<p>Recommendation, October 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendation: See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the	<p>Current findings on previous recommendation:</p>

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	administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Recommendation, April 2009: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p> <p>Findings: See F.3.h.i</p> <p>Compliance: Substantial.</p> <p>Current recommendation: See F.3.h.i</p>
H.8	Each State hospital shall:	<p>Compliance: Not applicable.</p>
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to monitor this requirement.</p>

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		<p>Findings: ASH had no use of side rails during the review period.</p> <p>Compliance: Not applicable.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8.b	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendation: See H.8.a.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The facility continues to develop and implement initiatives for reducing violence and improving the quality of life in the facility. The soon-to-be opened snack and beverage kiosk in the main courtyard is the most recent example. 2. In the semi-annual report of the Violence Risk Management Committee, the facility presents a comprehensive review of many factors that may be associated with violence in the facility. Among the factors investigated is age of aggressors and victims, location of incidents of aggression, staffing and length of stay. This data is presented to the Quality Council in an attractive format accompanied by insightful analysis. 3. Items 1 and 2 have contributed to the recent decrease in violence. In the current review period, the monthly incidence of violent incidents ranged from a low of 52 to a high of 88 violent acts per month. In the previous review period the range was 86 to 126. 4. The IMRC members began receiving a copy of the full investigation prior to meeting to review A/N/E incidents starting with the meeting on November 12, 2009. Review of several programmatic recommendations tracked on the IMRC Task Tracking form found that they had been implemented. 5. The facility continues to remain in substantial compliance with EP requirements for annual A/N/E training and background checks. 6. The facility is investigating incidents of verbal abuse using the SIR definition—a reform initiated since the last review. 7. The facility maintains information technology systems that successfully support its incident management and risk management functions. The facility will convert to WaRMSS when it believes the system is reliable. 8. The WRPTs of individuals on high risk lists referenced the risk. 9. A review of the WRPs of individuals who had been reviewed at an ETRC meeting found that the recommendations made had been implemented or

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		<p>a rationale provided for why implementation was not advisable.</p> <p>10. The facility continues to make environmental changes that increase the safety of individuals. Following a suicide attempt in February 2010, Plant Operations personnel were at the scene within an hour to assess the environmental hazard. Interim measures have been taken to prevent the recurrence, and a long-term plan was developed to permanently fix the hazard.</p>
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Williams, Standards Compliance 2. D. Karas, Program Director 3. D. Landrum, Hospital Administrative Resident II 4. D. Nelson, Standards Compliance Director 5. L. Persons, Hospital Administrator 6. Lt. D. Landrum, DPS 7. M. Kelly, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 12 SIRs 2. 11 DPS and OSI investigation reports 3. Incident Management Review Committee (IMRC) minutes 4. IMRC Task Tracking Form 5. 12 Headquarters Reportable Briefs 6. Incident listings from the Record Management System 7. Graphed incident data 8. Information from 16 staff members' personnel and training records 9. 13 clinical records for notification of rights 10. Mortality Interdisciplinary Review Committee (MIRC) minutes and supporting documents related to two deaths
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Substantial.</p>

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I.1.a.i	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: See I.1.a.v for examples of corrective actions taken by ASH in instances in which staff members failed to report A/N/E allegations in the manner required by policy.</p> <p>Current recommendation: Ensure that the facility responds to all staff members who fail to report A/N/E allegations.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Implement the corrective action taken in ensuring that verbal abuse is recognized as a policy violation and the staff member is held accountable for his/her actions.</p> <p>Findings: The facility has implemented the corrective action plan that identifies verbal abuse as a policy violation and is using the definition of verbal abuse in SO 227.08. The identification and reporting of verbal abuse was incorporated into A/N/E annual training in February 2010. Several investigations illustrate the facility's attention to verbal abuse allegations. For example, the investigation of the allegation of verbal abuse reported by KT on 11/30/09 was determined sustained when the named staff acknowledged that she referred to KT in derogatory terms. In the investigation of verbal abuse of TR reported on 11/6/09, the staff member reported that he called TR a derogatory term in a joking manner. The allegation of verbal abuse was sustained.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: In the investigations reviewed, the language the facility used in documenting decisions about whether to remove staff members named in allegations of abuse/neglect varied slightly. Some investigations cited whether the staff member posed a threat or risk; other investigations cited whether the staff member posed "an immediate threat" in making the decision. Another investigation stated that the staff member was not removed because the individual's "safety is not at risk."</p> <p>Other findings: DMH is working on a guidance document applicable to all of the facilities that will describe a consistent method for determining when a named staff member should be removed.</p> <p>Current recommendation: Implement the DMH guidance document when it becomes available.</p>
I.1.a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: As shown in the table below, three of the 16 staff members sampled were</p>

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		<p>overdue for annual A/N training, but only by one month.</p> <table border="1" data-bbox="953 266 1822 1029"> <thead> <tr> <th></th> <th colspan="4">Date of:</th> </tr> <tr> <th>Staff member*</th> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr><td>_M</td><td>9/24/07</td><td>7/20/07</td><td>7/20/07</td><td>3/15/10</td></tr> <tr><td>_C</td><td>9/3/02</td><td>3/14/00</td><td>9/3/02</td><td>3/5/10</td></tr> <tr><td>_O</td><td>5/27/08</td><td>3/25/08</td><td>5/27/08</td><td>3/1/10</td></tr> <tr><td>_K</td><td>2/11/08</td><td>10/11/07</td><td>10/5/07</td><td>1/15/10</td></tr> <tr><td>_F</td><td>1/7/85</td><td>1/7/85</td><td>3/5/87</td><td>11/1/09</td></tr> <tr><td>_L</td><td>7/7/03</td><td>3/29/02</td><td>7/7/03</td><td>8/8/09</td></tr> <tr><td>_A</td><td>7/14/09</td><td>2/10/09</td><td>2/10/09</td><td>7/25/09</td></tr> <tr><td>_M</td><td>1/22/07</td><td>7/31/06</td><td>11/17/06</td><td>6/17/09</td></tr> <tr><td>_M</td><td>12/29/02</td><td>7/2/02</td><td>12/9/02</td><td>6/8/09</td></tr> <tr><td>_S</td><td>12/16/85</td><td>12/16/85</td><td>12/1/85</td><td>6/8/09</td></tr> <tr><td>_C</td><td>2/25/08</td><td>3/16/07</td><td>3/16/07</td><td>5/15/09</td></tr> <tr><td>_B</td><td>8/14/06</td><td>6/21/06</td><td>8/19/06</td><td>4/15/09</td></tr> <tr><td>_D</td><td>3/25/02</td><td>2/2/00</td><td>3/25/02</td><td>4/7/09</td></tr> <tr><td>_D</td><td>7/17/06</td><td>3/25/05</td><td>7/17/06</td><td>3/5/09</td></tr> <tr><td>_F</td><td>6/18/90</td><td>6/18/90</td><td>6/18/90</td><td>3/5/09</td></tr> <tr><td>_H</td><td>4/29/02</td><td>2/27/02</td><td>4/29/02</td><td>3/1/09</td></tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p> <p>Current recommendation: Continue to ensure that staff members receive annual A/N training in a timely fashion.</p>		Date of:				Staff member*	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_M	9/24/07	7/20/07	7/20/07	3/15/10	_C	9/3/02	3/14/00	9/3/02	3/5/10	_O	5/27/08	3/25/08	5/27/08	3/1/10	_K	2/11/08	10/11/07	10/5/07	1/15/10	_F	1/7/85	1/7/85	3/5/87	11/1/09	_L	7/7/03	3/29/02	7/7/03	8/8/09	_A	7/14/09	2/10/09	2/10/09	7/25/09	_M	1/22/07	7/31/06	11/17/06	6/17/09	_M	12/29/02	7/2/02	12/9/02	6/8/09	_S	12/16/85	12/16/85	12/1/85	6/8/09	_C	2/25/08	3/16/07	3/16/07	5/15/09	_B	8/14/06	6/21/06	8/19/06	4/15/09	_D	3/25/02	2/2/00	3/25/02	4/7/09	_D	7/17/06	3/25/05	7/17/06	3/5/09	_F	6/18/90	6/18/90	6/18/90	3/5/09	_H	4/29/02	2/27/02	4/29/02	3/1/09
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_H	4/29/02	2/27/02	4/29/02	3/1/09																																																																																								
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p>																																																																																										

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	<p>All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Findings: As shown in the table above, 14 of the 16 sampled staff members signed the mandatory reporting form on or prior to their date of hire.</p> <p>Other findings: In two of the investigations reviewed, three staff members were determined to have failed to report the allegation of A/N as required by policy. The corrective measures taken in response were provided by the HR Department as follows:</p> <ul style="list-style-type: none"> • In the sustained case of neglect (10/10/09) of DE, the staff member who witnessed but did not report the neglect in a timely manner was given a Letter of Instruction. This same staff member had received a Letter of Expectations re: reporting responsibilities in July 2009. • In the sustained case of verbal abuse of TR, the named staff member and a staff witness failed to report the incident. HR did not report any action regarding the named staff member and the staff witness was provided verbal instruction. <p>Current recommendation: Follow principles of progressive discipline in addressing failure to report allegations of A/N/E. Ensure that no incident of failure to report receives no response.</p>
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: As indicated in the table below, all of the 13 individuals sampled had signed the notification of rights within the last year.</p>

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		<table border="1" data-bbox="961 228 1535 764"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr><td>CF</td><td>4/7/10</td></tr> <tr><td>DH</td><td>3/16/10</td></tr> <tr><td>KC</td><td>3/16/10</td></tr> <tr><td>LC</td><td>3/16/10</td></tr> <tr><td>AK</td><td>3/10/10</td></tr> <tr><td>DH</td><td>3/8/10</td></tr> <tr><td>HG</td><td>3/3/10</td></tr> <tr><td>TC</td><td>1/26/10</td></tr> <tr><td>JS</td><td>12/22/09</td></tr> <tr><td>GM</td><td>11/24/09</td></tr> <tr><td>MS</td><td>10/17/09</td></tr> <tr><td>RP</td><td>8/31/09</td></tr> <tr><td>JP</td><td>7/14/09</td></tr> </tbody> </table> <p data-bbox="953 808 1283 873">Current recommendation: Continue current practice.</p>	Individual	Date of most recent signing	CF	4/7/10	DH	3/16/10	KC	3/16/10	LC	3/16/10	AK	3/10/10	DH	3/8/10	HG	3/3/10	TC	1/26/10	JS	12/22/09	GM	11/24/09	MS	10/17/09	RP	8/31/09	JP	7/14/09
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p data-bbox="953 922 1541 951">Current findings on previous recommendation:</p> <p data-bbox="953 995 1377 1060">Recommendation, October 2009: Continue current practice.</p> <p data-bbox="953 1104 1776 1169">Findings: Each unit visited had a Rights poster on the wall in a common area.</p> <p data-bbox="953 1213 1283 1278">Current recommendation: Continue current practice.</p>																												
I.1.a. viii	procedures for referring, as appropriate, allegations of abuse or neglect to law	<p data-bbox="953 1330 1541 1359">Current findings on previous recommendation:</p>																												

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	<p>enforcement; and</p>	<p>Recommendation, October 2009: Continue current practice, including self-monitoring and data analysis, as warranted.</p> <p>Findings: The IMRC minutes of 12/24/09 cite an individual facing misdemeanor charges as a result of his behavior at ASH. During the incident that resulted in an allegation of physical abuse (individual believed he was being poisoned by medication), the named staff member was seriously injured by the complainant. This case was forwarded to the District Attorney for assault charges.</p> <p>Current recommendation: Continue current practice.</p>												
<p>I.1.a.ix</p>	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure HR is tracking all findings of violation of statute and policy to ensure appropriate action is taken.</p> <p>Findings: Five of six named staff members in sustained investigations reviewed received some form of instruction/counseling/ discipline, according to the report from HR.</p> <table border="1" data-bbox="955 1154 1898 1417"> <thead> <tr> <th>Incident type</th> <th>Incident date</th> <th>Response</th> </tr> </thead> <tbody> <tr> <td>Verbal abuse allegation Sustained</td> <td>10/22/09</td> <td>Counseling for discourteous treatment</td> </tr> <tr> <td>Verbal abuse allegation Sustained</td> <td>11/30/09</td> <td>Letter of Instruction and verbal counseling</td> </tr> <tr> <td>Verbal abuse allegation Sustained</td> <td>11/5/09</td> <td>No response reported</td> </tr> </tbody> </table>	Incident type	Incident date	Response	Verbal abuse allegation Sustained	10/22/09	Counseling for discourteous treatment	Verbal abuse allegation Sustained	11/30/09	Letter of Instruction and verbal counseling	Verbal abuse allegation Sustained	11/5/09	No response reported
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		Neglect allegation Sustained	10/10/09	Letter of Instruction
		Neglect allegation Sustained	11/16/09	Letter of Instruction
		Neglect allegation Sustained	12/11/09	Adverse action-pay reduction
		<p>Other findings: The investigator of the allegation of verbal abuse of AL was cognizant of the possibility of threat of retaliation when he asked the individual if he had been threatened not to report the incident. AL replied that he had not.</p> <p>Current recommendation: Continue current practice of asking about threats of retaliation and bribes when circumstances suggest these may have occurred, e.g., when an individual recants an allegation or speaks about not wanting to get a staff member in trouble.</p>		
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:	<p>Compliance: Partial.</p>		
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: During the maintenance phase, ensure that SO 136 and other relevant policies address the issues raised by TT's death (factors affecting the re-emergence of an active seizure disorder).</p> <p>Findings: See F.7.a.</p>		

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		<p>Other findings: The death of CG on 11/11/09 at a community hospital was determined unexpected. No autopsy was performed, but the Independent External Medical Review (dated 12/20/09) cited the cause of death as acute hemorrhagic pancreatitis. Included in the findings from this report is an item that may have related directly to the death and that required facility action: the External Reviewer recommended that the facility ensure that physicians and nurses are "cognizant of the relationship between gemfibrozil and pancreatitis." The final MIRC review on February 10, 2010 makes no specific reference to this recommendation and further states that Standards Compliance would compile an analysis of the recommendations from the Internal and External reports and provide this to the Medical Director. No further information was supplied.</p> <p>The second death during the reporting period was the expected death of LM, who died on 12/11/09 of end-stage liver disease. He had enacted a DNR order. The MIRC was held on 12/24/09. No deficiencies in medical or nursing care were identified.</p> <p>Current recommendation: Ensure follow-up of recommendations made during Internal and External death reviews.</p>
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Hospital police complete the preliminary investigation of allegations of A/N/E and other serious incidents and forward their report to the OSI, where a Special Investigator is assigned to conduct a complete investigation</p>

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		<p>and write the investigation report. This process is handled by persons who have training and experience in conducting investigations.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The interviews of the named staff members are taped. These tapes are logged and secured.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue working toward compliance with this section of the EP, through the close review of the quality and timeliness of investigations.</p> <p>Findings: All of the facilities use an Investigation Compliance Monitoring form to review investigations and ensure that they meet standard procedures and the requirements of the EP. At ASH, the monitoring form is completed by a supervising police officer and again by the Hospital Administrative Resident II. This procedure serves ASH well.</p> <p>Current recommendation: Continue current practice.</p>

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<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility continues to initiate the preliminary investigation as soon as the incident is reported to HPD.</p> <p>Current recommendation: Continue current practice.</p>																																
<p>I.1.b. iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to work to close investigations during the timeframe specified in the EP.</p> <p>Findings: As shown in the table below, all of the sampled investigations were closed within the timeframe specified in the EP.</p> <table border="1" data-bbox="953 1003 1904 1422"> <thead> <tr> <th>Incident type</th> <th>Date incident reported</th> <th>OSI assigned</th> <th>Date closed</th> </tr> </thead> <tbody> <tr> <td>Neglect allegation</td> <td>9/18/09</td> <td>9/22/09</td> <td>10/14/09</td> </tr> <tr> <td>Neglect allegation</td> <td>10/14/09</td> <td>10/20/09</td> <td>11/20/09</td> </tr> <tr> <td>Physical abuse allegation</td> <td>10/21/09</td> <td>10/22/09</td> <td>12/8/09</td> </tr> <tr> <td>Verbal abuse allegation</td> <td>10/22/09</td> <td></td> <td>11/6/09</td> </tr> <tr> <td>Psychological abuse allegation</td> <td>10/29-31/09</td> <td>11/10/09</td> <td>11/30/09</td> </tr> <tr> <td>Verbal abuse allegation</td> <td>11/4/09</td> <td>11/9/09</td> <td>12/11/09</td> </tr> <tr> <td>Neglect allegation</td> <td>11/16/09</td> <td>11/17/09</td> <td>12/1/09</td> </tr> </tbody> </table>	Incident type	Date incident reported	OSI assigned	Date closed	Neglect allegation	9/18/09	9/22/09	10/14/09	Neglect allegation	10/14/09	10/20/09	11/20/09	Physical abuse allegation	10/21/09	10/22/09	12/8/09	Verbal abuse allegation	10/22/09		11/6/09	Psychological abuse allegation	10/29-31/09	11/10/09	11/30/09	Verbal abuse allegation	11/4/09	11/9/09	12/11/09	Neglect allegation	11/16/09	11/17/09	12/1/09
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		Physical abuse allegation	11/23/09	12/1/09	12/18/09
		Abuse allegation	11/30/09	12/1/09	12/9/09
		Neglect allegation	12/11/09	12/17/09	1/12/10
		Psychological abuse allegation	2/2/10	2/5/10	2/26/10
		<p>Other findings: A listing of open OSI cases (as of 4/21/10) showed that the oldest case was opened on 3/4/10, indicating that the OSI is continuing to make timely completion a priority.</p> <p>Current recommendation: Continue current practice!</p>			
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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice of forwarding investigations to appropriate bodies for review and implementation of recommendations.</p> <p>Findings: The investigations reviewed were summarized in an investigation report that concluded with a determination and recommendations to forward the investigation to an appropriate body for recommendations. See also I.1.b.iv.3(viii).</p> <p>Current recommendation: As recommended previously, match the salient facts of the investigation to the definition of the type of incident under review to ensure that findings support determinations.</p>			

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<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including self-monitoring and data analysis, as indicated.</p> <p>Findings: Each investigation report reviewed clearly identified the wrongdoing under investigation. Several investigations identified violations of policies in addition to making determinations on the A/N/E allegation. For example, the investigation report of the sustained allegation of neglect of WT also cited violations of nursing policy, and the investigation of verbal abuse of TR also cited a violation of AD 103: Professional Code of Conduct/Ethics.</p> <p>Current recommendation: Continue current practice, including self-monitoring as indicated.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure, as agreed, that the IMRC reviews sufficient information to form a sound judgment regarding the quality of investigations.</p> <p>Findings: The IMRC began reviewing the entire investigation report with the meeting on November 12, 2009. The investigation reports are provided prior to committee meetings, so that committee members can review them and inform their colleagues of any elements (questions, concerns) they wish to have discussed at the meetings.</p> <p>Other findings: The investigation reports reviewed identified all witnesses interviewed.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Implement the plan described in the 10/20/09 memo to ensure that all closed A/N cases are listed on the A/N Activity Listings.</p> <p>Findings: The facility reports that the Case Activity Report is reviewed each month to ensure that cases without a disposition receive a status, get closed or are monitored until closure.</p> <p>Other findings: All investigations reviewed clearly identified the alleged victim and perpetrator.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure that all persons who may have witnessed an incident are identified and questioned.</p> <p>Findings: In the interview of the alleged victim of psychological abuse (10/29-31/09), the hospital police officer skillfully focused the individual, asking increasingly specific questions.</p>

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		<p>Other findings: All of the investigations reviewed identified the name and role of the persons interviewed.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(v)</p>	<p>a summary of each interview;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice of providing the date, time, location and summary of interviews in the investigation reports.</p> <p>Findings: The investigation reports reviewed provided the information listed above.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: During the maintenance phase, continue current practice of providing a second-level thorough review of all OSI investigations. Ensure this review is completed prior to review by the IMRC.</p> <p>Findings: Interviews and documentation support that the second-level review is occurring and is effectively identifying errors on the Investigation Compliance Monitoring Form.</p> <p>Other findings: Several investigation reports cite in the narrative the review of essential</p>

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		<p>documents. For example:</p> <ul style="list-style-type: none"> • The investigator of the allegation of neglect of JS (12/11/09), in which JS was left unattended by his 1:1 staff member, cited specific provisions of the AD governing enhanced supervision and secured a copy of the physician's order for 1:1 observation. • Similarly, in the investigation of a staff member's failure to maintain an individual in line of sight because he was reading a book and then initialing the observation sheet for a period of time when he was not on duty, the investigator secured a copy of the sally port log to confirm that the staff member was outside security when his signature indicates he was observing the individual. The investigator also specifically referenced Nursing Procedure 104.0, which defines line of sight observation. • The investigation report of the allegation of neglect of RJ (9/16/09) cites AD 518: Monitoring of Individual During R/S Use and AD 103: Professional Code of Conduct/Ethics when making a determination in this case. <p>All investigations reviewed list the documents reviewed by the investigator.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Review the relevant history of the individual (victim) during the review of investigations of abuse/neglect.</p> <p>Findings: Investigators do not customarily review the incident history of the alleged victim. In several investigations reviewed, the investigator spoke with the</p>

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		<p>individual's psychiatrist to determine if the allegation bore any relationship to the individual's mental illness.</p> <p>Other findings: In the investigation reports reviewed, the incident history of the named staff member is included as a separate item. It is not referenced in the investigation, but is presented at the IMRC when the investigation is reviewed. IMRC minutes document this review.</p> <p>Current recommendation: Using the same process, add a review of the alleged victim's investigation history to the review of the staff member's investigation history.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including self-monitoring.</p> <p>Findings: Each of the investigation reports reviewed concluded with a determination. Two of these determinations raised questions and were discussed with IMRC members and will be reviewed again by the Committee.</p> <ul style="list-style-type: none"> • The investigation of the allegation that the named staff member walked away from providing 1:1 observation of RJ, who was in full bed restraints, determined that no neglect occurred because RJ "was in full bed restraints for danger to others, not for danger to self." This determination failed to appreciate the vulnerability of a restrained individual to acts of aggression by others. Since there is no question that the staff member breached his duty, this allegation should have been determined sustained. • A staff member acknowledged making a bizarre, off-color and embarrassing remark to an individual returning from a clinic appointment

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		<p>on 10/22/09. He later apologized to the individual and offered him a candy bar. The individual accepted neither. The staff member characterized the event as a bad joke. The allegation of verbal abuse was determined to be not sustained. The investigation failed to consider psychological abuse. Had psychological abuse been considered, the allegation would have been sustained, since the remark caused emotional distress (the individual reported it and refused the apology) and had this not been the case, the remark would nonetheless reasonably be assumed to cause emotional distress. This reasonable person standard is part of the SIR definition of psychological abuse.</p> <p>Current recommendation: Match the determination with elements of the SIR definition of the incident type under review. Consider both verbal and psychological abuse in all cases in which one of these is the identified incident type.</p>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure that what appear to be irreconcilable accounts of an incident do not go unaddressed.</p> <p>Findings: See I.1.b.iv.4 for the only example of failure to identify and address irreconcilable accounts.</p> <p>Current recommendation: Continue the careful review of investigation reports by supervisors and the second review by the Hospital Administrative Resident.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the</p>	<p>Current findings on previous recommendations:</p>

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	<p>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 addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Recommendation 1, October 2009: Continue current practice of conducting a second review of completed investigations to ensure their compliance with the EP standards.</p> <p>Findings: The facility has maintained this practice.</p> <p>Recommendation 2, October 2009: Match the rationales for determinations with the relevant elements of the incident definitions.</p> <p>Findings: Had the investigations described in I.1.b.iv.3(viii) matched the rationale with the incident definitions, the determinations would have changed to substantiated.</p> <p>Other findings: Supervisor inattention to details was evident in three investigations reviewed.</p> <ul style="list-style-type: none"> • In the investigation of the allegation of verbal abuse of KT, the preliminary investigator wrote that a staff member said he did not hear the remark under review. That same staff member, however, wrote an IDN that stated he "was in the presence of a staff member who called [KT] a piece of ____." The investigation supervisor did not identify the inconsistency and consequently did not require the investigator to re-interview the staff member. • The Preliminary Investigation Monitoring Form scoring 11 items (Y/N) for the investigation of the 10/29-31/09 allegation of psychological abuse was signed by the supervisor but none of the items was completed. • The investigation of the allegation of neglect of DE (10/10/09) was determined substantiated, but the letter to DE said that neither abuse nor neglect occurred. ASH agreed that a corrected letter would be
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		<p>sent to the individual.</p> <p>Current recommendation: Maintain vigilance in reviewing investigations and the accompanying forms and letters.</p>												
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, October 2009: Continue current practice, ensuring that HR addresses and records all corrective actions related to the actions of staff members.</p> <p>Findings: See the table below for evidence of implementation.</p> <p>Recommendation 2, October 2009: Continue the IMRC's current practice of tracking programmatic corrective actions.</p> <p>Findings: As described in the table below, programmatic recommendations tracked through the IMRC Task Tracker were supported with evidence of implementation when requested:</p> <table border="1" data-bbox="953 1078 1890 1414"> <thead> <tr> <th>Task</th> <th>Due date</th> <th>Evidence of Implementation</th> </tr> </thead> <tbody> <tr> <td>HR to create a template for tracking Program recommendations</td> <td>9/24/09</td> <td>Yes. Template complete with required information dating back to early October was supplied.</td> </tr> <tr> <td>Staff be provided retraining on Controlled and Contraband items</td> <td>10/3/09</td> <td>Yes. Sign-in sheets for ½-hour training in AD 805: Contraband provided.</td> </tr> <tr> <td>Form a workgroup to evaluate the process and</td> <td>2/4/10</td> <td>Yes. Minutes of 2/19/10 IMRC cite six recommendations for</td> </tr> </tbody> </table>	Task	Due date	Evidence of Implementation	HR to create a template for tracking Program recommendations	9/24/09	Yes. Template complete with required information dating back to early October was supplied.	Staff be provided retraining on Controlled and Contraband items	10/3/09	Yes. Sign-in sheets for ½-hour training in AD 805: Contraband provided.	Form a workgroup to evaluate the process and	2/4/10	Yes. Minutes of 2/19/10 IMRC cite six recommendations for
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		<p>use of Special Incident Gear.</p> <p>Evaluate eliminating bulletin boards with aluminum frames (frames were used as a weapon).</p>	<p>3/25/10</p>	<p>ensuring proper use of Special Incident Gear.</p> <p>Throughout the portions of the facility observed, metal framed bulletin boards had been replaced with cork boards without framing.</p>
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice, including self-monitoring.</p>		
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Substantial.</p>		
I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including self-monitoring and data analysis.</p> <p>Findings: Review of data on acts of aggression (toward peers and staff) in the period October 2009-March 2010 finds a range from a low of 52 aggressive acts in February 2010 to a high of 88 aggressive acts in October 2009. The high end of the range most recently is nearly the same as the low end of the range in the previous six-month period, when the range spanned 86 acts of aggression in August to 126 in July 2009.</p> <p>The number of individuals making allegations of A/N/E each month has remained fairly consistent from December 2009-April 2010, ranging from</p>		

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		<p>10-15.</p> <p>The number of aggressive acts to self resulting in major injury has remained nearly constant over the period April 2009-January 2010, averaging 4.5 acts/month. In February, the number jumped to 13 acts, but returned to baseline in March and April 2010.</p> <p>Current recommendation: Continue current practice, including periodic analysis of incident and trigger data.</p>
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including self-monitoring and data analysis.</p> <p>Findings: ASH used the RMS information system to produce a report on the staff members who were named as subjects in investigations of A/N/E from September 1, 2009 to February 28, 2010. One staff member was named in more than one case and no staff member was named in more than one substantiated case.</p> <p>A separate listing by incident provides the names of all persons involved in the investigations and their roles as subjects, complainants, reporting parties and witnesses.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, October 2009: During the maintenance phase, identify and take the necessary steps to ensure that the RMS and SIR databases reconcile.</p> <p>Findings: The facility continues to use both databases, as it has not transitioned to WaRMSS. These databases are reconciled on a regular basis.</p> <p>Other findings: Using the RMS information system, ASH prepared a listing of individuals involved as complainants in A/N/E during the period 9/1/09-2/28/10. Five individuals are listed as complainants in more than one incident. One individual was named as complainant in two incidents in which staff misconduct was substantiated.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including self-monitoring and data analysis.</p> <p>Findings: The Violence Risk Management Committee report shows assaults by Program. Specifically, there were approximately 82 assaults in Program 1 during the six-month period Sept 2009-March 2010, 80 assaults in Program 3, 61 in Program 4, 90 in Program 6, and 115 in Program 7. In each case, these numbers represent a decrease from the preceding six-month period. All data in this report was accompanied by analysis.</p> <p>Current recommendation: Continue current practice.</p>

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I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice of presenting data in an attractive and informative format accompanied by analysis as in the reports by the Violence Risk Management Committee.</p> <p>Findings: The current Violence Risk Management Committee report again provides useful data accompanied by thoughtful analysis. For example, the report indicates the distribution of assault incidents as follows:</p> <table border="1" data-bbox="955 634 1713 943"> <thead> <tr> <th>Program</th> <th>AM Assaults</th> <th>PM Assaults</th> <th>NOC Assaults</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>43</td> <td>42</td> <td>1</td> </tr> <tr> <td>3</td> <td>28</td> <td>47</td> <td>6</td> </tr> <tr> <td>4</td> <td>28</td> <td>32</td> <td>5</td> </tr> <tr> <td>5</td> <td>10</td> <td>19</td> <td>1</td> </tr> <tr> <td>6</td> <td>38</td> <td>49</td> <td>4</td> </tr> <tr> <td>7</td> <td>40</td> <td>64</td> <td>10</td> </tr> <tr> <td>Total</td> <td>187</td> <td>253</td> <td>27</td> </tr> </tbody> </table> <p>Hospital-wide, February 2010 saw the lowest number of peer-to-peer assaults since June 2007.</p> <p>Current recommendation: Continue current practice of presenting data with thoughtful analysis.</p>	Program	AM Assaults	PM Assaults	NOC Assaults	1	43	42	1	3	28	47	6	4	28	32	5	5	10	19	1	6	38	49	4	7	40	64	10	Total	187	253	27
Program	AM Assaults	PM Assaults	NOC Assaults																															
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I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p>																																

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		<p>Findings: The facility has looked at the frequency and rate of assaults as related to the commitment status of individuals during 2009 and found that individuals admitted from prisons have a significantly lower rate of assaults (0.5) than individuals admitted from jails, who have the highest rate of assaults (2.4). Additionally, ASH found a clear association between the number of float staff on a unit and the likelihood that there would be an SIR.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d. vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including analysis of the data.</p> <p>Findings: Review of an RMS listing of A/N/E investigations closed during the period 9/1/09-2/28/10 finds that of the 52 investigations, 11 were sustained for A/N/E. Others were sustained for violations of facility policies.</p> <p>Current recommendation: Continue current practice, including analysis of substantiation rate.</p>
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 shall directly supervise volunteers for whom an investigation	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: As shown in the table in I.1.a.iv, all of the sampled staff members had cleared the background check by their date of hire.</p>

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	<p>has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue current practice as related to background checks.2. Follow DMH guidance in applying a consistent system across facilities for determining when to remove a staff member named in an A/N/E allegation.
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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:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. D. Karas, Program Director 2. D. Nelson, Standards Compliance Director 3. J. Dansereau, MD, Chief Psychiatrist 4. K. Riddell, PhD, Coordinator of Psychology Specialist Services 5. L. Persons, Hospital Administrator 6. M. Kelly, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Clinical records for reference to 10 ETRC recommendations 2. WRPs of 17 individuals for reference to high-risk status 3. Seven clinical records for reference to incidents 4. ETRC minutes for January and February 2010 5. Violence Risk Management Committee Progress Report <p><u>Observed:</u> ETRC meeting</p>
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Substantial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility presented the following information:</p>

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	Nov 2008 - Apr 2009	May 2009 - Oct 2009
Peer-to-peer altercations		
Total number	629	412
Monthly mean	105	69
Number of individuals involved in peer-to-peer altercations		
Total number	1003	837
Monthly mean	167	140
Number of positive drug screens		
Total number	75	0
Monthly mean	13	0
<p>A review of the records of 16 individuals who appeared on six different high-risk lists found that the WRPs of all of the individuals referenced the individual's risk:</p>		
Individual	High Risk List for:	Referenced in WRP Risk Factors?
DH	Aggression	Yes--WRP 4/9/10
FE	Aggression	Yes--WRP 4/27/10
HL	Aggression	Yes--WRP 4/21/10
JA	Aggression	Yes--WRP 1/21/10
JC	Aggression	Yes--WRP 4/26/10
MS	Aggression	Yes--WRP 1/20/10
PT	Aggression	Yes--WRP 4/5/10
TJ	Aggression	Yes--WRP 4/30/10
GD	Aggressive acts to self	Yes--WRP 2/17/10
MM	Aggressive acts to self	Yes--WRP 4/29/10
RB	Aggressive acts to self	Yes--WRP 4/20/10
KB	Suicide	Yes--WRP 4/1/10
TG	Suicide	Yes--WRP 2/23/10

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		BG	Victimization	Yes--WRP 4/6/10
		BG	Falls	Yes--WRP 2/8/10
		JC	Falls	Yes--WRP 4/19/10
		TR	Impaired skin integrity	Yes--WRP 2/10/10
<p>A review of the records of seven individuals at risk for a medical condition found objectives and interventions in place to address the condition:</p>				
		BG	At high risk for choking	High risk identified in the Present Status section of the most recent WRP; Focus 6 objective and intervention in place to address choking risk during mealtimes.
		BLB	At high risk for metabolic syndrome	High risk identified in the Present Status section of the most recent WRP, with nursing and dietitian objective and intervention in place, yet present status also discussed taking individual off the high-risk list with no discussion of rationale (individual did not appear to meet exit criteria for removal).
		BLB	At high risk for choking	High risk identified in the Present Status section of the most recent WRP; Focus 6 objective and intervention in place to address choking risk during mealtimes.
		BT	At high risk for aspiration	High risk identified in the Present Status section of the most recent WRP; Focus 6 nursing objective and intervention in place to address aspiration risk during mealtimes.
		CDB	At high risk for	High risk identified in the Present

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			falls	Status section of the most recent WRP; Focus 6 objective and intervention in place to address fall risk.
		ICA	At high risk for metabolic syndrome	High risk identified in the Present Status section of the most recent WRP; Focus 6 objective and intervention in place to address contributing factor (obesity).
		JNB	At high risk for impaired skin integrity	High risk identified in the Present Status section of the most recent WRP; no Focus 6 open to address risk.
		RMG	At high risk for falls	High risk identified in the Present Status section of the most recent WRP; Focus 6 objective and intervention in place to address fall risk.
		<p>Current recommendation: Continue current practice with self-monitoring.</p>		
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to implement the Risk Management Special Order.</p> <p>Findings: The facility data related to WRPT responses for four individuals who reached triggers for suicide attempt (1/1/10-2/28/10) indicates that action was taken in each case. Actions included 1:1 monitoring, medication changes and a Medication Review Committee consultation. A medication change was made for four of the five individuals who reached the trigger for aggression</p>		

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		<p>to self resulting in a major injury in the same time period. A different clinical intervention was implemented for the fifth individual.</p> <p>A review of ETRC minutes found that each meeting includes a review of previous recommendations, in which a current status report on the individual is provided, e.g. response to new medications or the introduction of behavior guidelines, as well as the presentation of new cases. This same sequence occurred at the ETRC meeting attended.</p> <p>A review of five WRPs for individuals who had reached medical triggers found that three adequately addressed the condition, including objectives and interventions:</p> <table border="1" data-bbox="953 672 1908 1416"> <thead> <tr> <th data-bbox="953 672 1129 711">Individual</th> <th data-bbox="1129 672 1520 711">Issue</th> <th data-bbox="1520 672 1908 711">WRP documentation</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 711 1129 932">CJG</td> <td data-bbox="1129 711 1520 932">12/18/2009 met trigger 7.2 for three or more falls in 30 days</td> <td data-bbox="1520 711 1908 932">WRP following trigger addressed fall incidents in the Present Status section and had learning objective and interventions to address falls in Focus 6.</td> </tr> <tr> <td data-bbox="953 932 1129 1153">JJA</td> <td data-bbox="1129 932 1520 1153">2/26/2010 met trigger 7.1 for fall with major injury</td> <td data-bbox="1520 932 1908 1153">WRP following trigger addressed falls in the Present Status section and had learning objective and interventions to address falls in Focus 6.</td> </tr> <tr> <td data-bbox="953 1153 1129 1416">LCR</td> <td data-bbox="1129 1153 1520 1416">New diagnosis of diabetes, report date 10/09/2009</td> <td data-bbox="1520 1153 1908 1416">WRP following diagnosis addressed diabetes diagnosis in the Present Status section and had learning objective and intervention (Diabetes Management PSR mall group)</td> </tr> </tbody> </table>	Individual	Issue	WRP documentation	CJG	12/18/2009 met trigger 7.2 for three or more falls in 30 days	WRP following trigger addressed fall incidents in the Present Status section and had learning objective and interventions to address falls in Focus 6.	JJA	2/26/2010 met trigger 7.1 for fall with major injury	WRP following trigger addressed falls in the Present Status section and had learning objective and interventions to address falls in Focus 6.	LCR	New diagnosis of diabetes, report date 10/09/2009	WRP following diagnosis addressed diabetes diagnosis in the Present Status section and had learning objective and intervention (Diabetes Management PSR mall group)
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				to address diagnosis in Focus 6.
		RLJ	2/22/2010 met trigger 7.1 for fall with major injury	No mention of incident in WRP following incident.
		TR	1/15/2010 diagnosis of Stage 2 pressure ulcers to both hips	WRP following diagnosis mentioned diagnosis but had no discussion of possible etiology or contributing factors in the Present Status section, though there was an objective and intervention in place to address decubiti.
I.2.a. iii	identification of systemic trends and patterns of high risk situations.	<p>Current recommendation: Ensure that the WRPs of persons on high-risk lists for medical conditions address the condition with objectives and interventions.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including data analysis and review of outcomes.</p> <p>Findings: The Violence Risk Management Committee has again produced a comprehensive review of data related to violence at the facility for the period covering October 2009-March 2010. In addition to the findings not reported elsewhere in this report, the report made the following findings:</p> <ul style="list-style-type: none"> • The majority of assault incidents occur during an individual's stay on the admissions unit; • Over time, the majority of individuals responds to treatment and stops assaulting; 		

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		<ul style="list-style-type: none"> • Individuals begin to have fewer triggers with the implementation of Behavior Guidelines; • Older men (50 and over) are less likely to be victims of assault; • Individuals age 26-33 are both more likely to be victims and to be aggressors; • One-quarter of individuals who have been assaulted are repeat victims; and • Assaults against staff that resulted in injury have increased in an upward trend since 2003. Diagnoses of schizoaffective disorder and schizophrenia, paranoid type are associated with the highest numbers of staff assaults. <p>Current recommendation: Continue to produce the Violence Risk Management Committee Progress Report as a springboard for violence reduction initiatives.</p>
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Substantial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including analysis of outcomes.</p> <p>Findings: With the implementation of the Risk Management Special Order, triggers and incidents are reviewed at the Program Review Committee. Behaviors that persist are reviewed at higher-level Risk Management committees, in which interventions are recommended by senior clinicians.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice of identifying and implementing initiatives to reduce violence at the facility.</p> <p>Findings: See I.2.c for specific examples of initiatives to reduce violence.</p> <p>Current recommendation: Continue developing initiatives to reduce violence at the facility.</p>
I.2.b.iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility continues to maintain information technology systems that inform WRPTs of incidents, triggers and high-risk status.</p> <p>Current recommendation: Continue current practice.</p>
I.2.b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Ensure that the WRP cites all incidents that occurred since the last review and addresses them with treatment objectives and interventions as warranted.</p>

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		<p>Findings: As shown below, four of seven WRPs reviewed referenced recent sexual incidents.</p> <table border="1" data-bbox="955 376 1881 1089"> <thead> <tr> <th>Individual</th> <th>Incident type and date</th> <th>Referenced in WRP?</th> </tr> </thead> <tbody> <tr> <td>DB</td> <td>Consensual sexual activity 11/7/09</td> <td>1/12/10 WRP mistakenly states DB is not identified as participating in sexual relationships with peers</td> </tr> <tr> <td>DM</td> <td>Sexual assault (victim) 9/18/09</td> <td>9/25/09 WRP references incident</td> </tr> <tr> <td>FM</td> <td>Consensual sexual activity 2/3/10</td> <td>2/9/10 WRP does not reference incident. FM discharged 2/12/10</td> </tr> <tr> <td>HH</td> <td>Sexual contact between adults 12/1/09</td> <td>Referenced in 1/14/10 WRP</td> </tr> <tr> <td>JD</td> <td>Sexual assault (aggressor) 9/18/09</td> <td>WRP 9/28/09 references incident but mistakenly calls it sexual abuse</td> </tr> <tr> <td>LM</td> <td>Sexual contact between adults 2/4/10</td> <td>WRP 2/10/10 addresses sexual aggression</td> </tr> <tr> <td>WN</td> <td>Sexual assault (aggressor) 9/18/09</td> <td>No mention in 11/17/09 WRP</td> </tr> </tbody> </table> <p>Current recommendation: Remind WRPTs of the need to reference incidents and develop objectives and interventions when warranted.</p>	Individual	Incident type and date	Referenced in WRP?	DB	Consensual sexual activity 11/7/09	1/12/10 WRP mistakenly states DB is not identified as participating in sexual relationships with peers	DM	Sexual assault (victim) 9/18/09	9/25/09 WRP references incident	FM	Consensual sexual activity 2/3/10	2/9/10 WRP does not reference incident. FM discharged 2/12/10	HH	Sexual contact between adults 12/1/09	Referenced in 1/14/10 WRP	JD	Sexual assault (aggressor) 9/18/09	WRP 9/28/09 references incident but mistakenly calls it sexual abuse	LM	Sexual contact between adults 2/4/10	WRP 2/10/10 addresses sexual aggression	WN	Sexual assault (aggressor) 9/18/09	No mention in 11/17/09 WRP
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I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including analysis of outcomes.</p>																								

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		<p>Findings: Review of the WRPT's response to ten recommendations made by the ETRC found that the WRPs incorporated the recommendation or provided a rationale for finding it inadvisable:</p> <table border="1" data-bbox="953 412 1892 1313"> <thead> <tr> <th>Individual</th> <th>ETRC date</th> <th>ETRC recommendation</th> <th>WRP reference/response</th> </tr> </thead> <tbody> <tr> <td>AC</td> <td>1/27/10</td> <td>Get medication level; verify dx is consistent with meds given</td> <td>Level provided in 2/22/20 WRP; diagnosis changed on 2/9</td> </tr> <tr> <td>AF</td> <td>2/10/10</td> <td>Update WRP and risk factors</td> <td>2/17/10 both recommendations implemented</td> </tr> <tr> <td>CV</td> <td>2/10/10</td> <td>Decrease medication</td> <td>3/4/09 WRP medication decreased</td> </tr> <tr> <td>GM</td> <td>2/3/10</td> <td>Determine need for BGs</td> <td>2/24 and 3/24 WRPs state no BGs necessary</td> </tr> <tr> <td>JF</td> <td>2/3/10</td> <td>Begin tapering meds</td> <td>2/10/10 tapering began</td> </tr> <tr> <td>LM</td> <td>2/3/10</td> <td>Increase medications</td> <td>Both medications increased in 2/10</td> </tr> <tr> <td>MV</td> <td>2/3/10</td> <td>Refer to PSSC</td> <td>2/25 and 3/26 WRPs make no mention of referral</td> </tr> <tr> <td>PR</td> <td>1/27/09</td> <td>Consider med adjustment</td> <td>Meds changed in 2/16 WRP</td> </tr> <tr> <td>RK</td> <td>1/27/10</td> <td>Determine need for BGs</td> <td>Team concluded this was a medication compliance issue and BGs not needed at this time</td> </tr> </tbody> </table> <p>Current recommendation: Continue current practice including self-monitoring.</p>	Individual	ETRC date	ETRC recommendation	WRP reference/response	AC	1/27/10	Get medication level; verify dx is consistent with meds given	Level provided in 2/22/20 WRP; diagnosis changed on 2/9	AF	2/10/10	Update WRP and risk factors	2/17/10 both recommendations implemented	CV	2/10/10	Decrease medication	3/4/09 WRP medication decreased	GM	2/3/10	Determine need for BGs	2/24 and 3/24 WRPs state no BGs necessary	JF	2/3/10	Begin tapering meds	2/10/10 tapering began	LM	2/3/10	Increase medications	Both medications increased in 2/10	MV	2/3/10	Refer to PSSC	2/25 and 3/26 WRPs make no mention of referral	PR	1/27/09	Consider med adjustment	Meds changed in 2/16 WRP	RK	1/27/10	Determine need for BGs	Team concluded this was a medication compliance issue and BGs not needed at this time
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<p>I.2.c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice, including analysis of outcomes.</p> <p>Findings: Following a comprehensive review of data related to violence, the facility has engaged in multiple activities to reduce violence. These include:</p> <ul style="list-style-type: none"> • In 2008, there were 13 instances of a chair being used as a weapon during an assault incident. After the provision of hard-to-throw chairs, the number was reduced to two incidents in a year. • Following an incident that resulted in serious injury to a staff member when an individual said he needed a small snack to help him calm down, Nutrition Services implemented a process for stocking snacks so that each Program has a unit in which snacks are available. • After the leg of a conference table was used as a club to break windows, this type of table was removed from all dayrooms and quiet rooms. • By July 2010 it is expected that all doors on single bedrooms will have the new locking system that allows individuals to lock their room from the inside, thereby increasing their sense of safety. • The Peaceful Resolution Committee organized events/activities celebrating "Season of Peace" (time between the birthdays of Martin Luther King and Gandhi) that included an ASH peer and staff concert, the Gandhi movie, and a celebration in the auditorium with posters and snacks. • The Non-Violence Unit Incentives Program is particularly popular. Each unit with three or fewer aggressive incidents in a month earns a 25-point reward. 25 points equals \$25 that the unit can use for recreation supplies, special snacks and take-out food, etc. A unit can also earn 25 points for having the highest number of hours of attendance at evening supplemental activities. • Acknowledging the increased incidence of aggression during early
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		<p>evening hours and theorizing that it may be because there were not enough structured activities at this time, ASH increased CTA/Gym Evening Activities.</p> <ul style="list-style-type: none">• In February 2010, the facility initiated the use of a revised violence risk assessment as part of the Psychiatric Admission Assessment. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current efforts to reduce violence and implement initiatives presently under consideration if, and when, determined appropriate.</p>
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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. E. Dawson, Assistant Hospital Administrator 2. L. Euler, Chief of Plant Operations 3. S. Everett, Health and Safety Officer <p>These staff members and supervisory unit staff led the environmental tour, offered information, and answered questions.</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. HQ Brief for 2/18/10 suicide attempt 2. Clinical records of nine individuals involved in sexual incidents <p><u>Toured:</u></p> <p>Six units: 11, 13, 14, 20, 27 and 30</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Following the August 2009 suicide at Napa State Hospital, ASH checked all light fixtures in the bathrooms, handicapped bathrooms, linen rooms, showers & dorms, and caulked all fixtures where space or gaps between the fixture and the ceiling were found. In February, an individual attempted suicide at ASH by stringing a ligature in the space between the light over the bedroom door and the wall. A $\frac{1}{4}$-inch steel plate was the cause of the gap. To prevent this from recurring, this steel plate will be replaced by sheet metal, which will leave no gap. Until this replacement can be completed, the facility has caulked around all of these light fixtures and</p>

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		<p>staff have been instructed to use a long-handled mirror to inspect the caulking to ensure it has not been tampered with. At the time of this review, the facility was expecting delivery very soon of blue tamper-proof tape that would be placed above the light fixture. If there was any attempt to move the tape and tamper with the caulking to create a gap, the tape would change color and would be immediately observable to the staff member inspecting the light fixture.</p> <p>In questioning staff members on the units, each staff member was aware of the incident and the responsibility to inspect the bedroom light fixtures. On some units, staff said this was done once a day; on other units staff said it was done every shift. Facility escorts agreed to ensure that all staff received the same message about the frequency of the inspections and to instruct the staff to specifically document this activity on the Security Inspection Sheet. The final HQ Brief for this incident clearly and concisely describes the immediate response (within one hour) by Plant Operations in assessing the environmental problem and devising a plan for correcting it.</p> <p>Other environmental measures observed that enhance safety include:</p> <ul style="list-style-type: none">• On all units where requested, staff were able to produce working flashlights for making night rounds;• On unit 27, bathroom stalls have been modified to eliminate the tall uprights, doors have piano hinges, and partitions are mounted flush against the back wall. The plan is to eventually make these modifications in all of the bathrooms;• New bedroom doors have a vertical window and a new locking system that allows the individual to lock the door from the inside in single bedrooms. There is a staff override if needed. The locks are slanted so as not to support a ligature;• In the new section of the facility, shower rooms have plastic hardware that is not a hook and will not support a ligature but which allows individuals to hang towels and clothing. Shower heads are sloped and
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		<p>push buttons turn the shower on;</p> <ul style="list-style-type: none"> • Heavy nightstands have been placed in the dorm bedrooms first. The facility still needs 300 more of these to complete all rooms. <p>According to the escorts, wherever there is a vent directly above a toilet, the vent will be replaced or covered.</p> <p>This monitor's observations included one problem area: on unit 30 in the shower room, two horizontal metal bars cross the opening of the clothing pass-through. These are very heavy metal bars that could withstand substantial weight. In many instances a staff member is in the clothing room on the other side of the bars and hence the bars could not be used as a suicide device. If this is not the case, however, these bars are a hazard. Staff escorts identified how the bars could be eliminated while maintaining the area as the clothing pass-through so that the pass-through still prevents individuals from diving into the clothing room or otherwise attacking the staff member on the other side of the bars.</p> <p>Other findings: The facility reported that it completed a total of 888 environmental inspection checks during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: As planned, make adjustments to the clothing pass-through in the shower room on Unit 30 and continue the bathroom vent and partition project.</p>
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p>

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		<p>Findings: The facility was at a comfortable temperature during the tour.</p> <p>Other findings: The facility reported that it monitored daily temperatures during September and October 2009 and will resume testing in the summer.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility reports that no individuals presently have the problem of incontinence. The facility reports that its internal monitoring found full compliance with expectations regarding the care of individuals who were incontinent in the past.</p> <p>Compliance: A compliance rating is not applicable, but the facility has been in substantial compliance in the past.</p> <p>Current recommendation: Meet the care needs of any individual who may develop the problem of incontinence.</p>

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<p>I.3.d</p>	<p>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 individual's charts in response to instances of sexual contact; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue to advise staff of the requirements of the EP related to sexual incidents.</p> <p>Findings: Staff addressed the sexual incident in eight of the nine incidents reviewed:</p> <table border="1" data-bbox="955 524 1864 1414"> <thead> <tr> <th data-bbox="955 524 1171 597">Individual Incident date</th> <th data-bbox="1178 524 1444 597">Incident type</th> <th data-bbox="1451 524 1864 597">WRPT response</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 602 1171 748">AS 2/4/10</td> <td data-bbox="1178 602 1444 748">Sexual contact between adults</td> <td data-bbox="1451 602 1864 748">RN assessment following incident. Placed on sick call. Seen by physician; no treatment needed.</td> </tr> <tr> <td data-bbox="955 753 1171 899">DB 11/7/09</td> <td data-bbox="1178 753 1444 899">Consensual sexual activity</td> <td data-bbox="1451 753 1864 899">Psychologist will begin individual therapy. Will refer DB to sexuality class. Counseled re STDs.</td> </tr> <tr> <td data-bbox="955 904 1171 1008">DM 9/18/09</td> <td data-bbox="1178 904 1444 1008">Sexual assault (victim)</td> <td data-bbox="1451 904 1864 1008">Transferred to another unit. Placed on 1:1 prior to transfer. Placed on sick call.</td> </tr> <tr> <td data-bbox="955 1013 1171 1192">FM 2/3/10</td> <td data-bbox="1178 1013 1444 1192">Consensual sexual activity</td> <td data-bbox="1451 1013 1864 1192">MD ordered lab work. Counseled that sexual activity is not appropriate in a facility setting. Encouraged to talk to staff.</td> </tr> <tr> <td data-bbox="955 1196 1171 1268">HH 12/1/09</td> <td data-bbox="1178 1196 1444 1268">Sexual contact between adults</td> <td data-bbox="1451 1196 1864 1268">WRP addresses sexual activity. Counseled re HIV and STDs.</td> </tr> <tr> <td data-bbox="955 1273 1171 1414">LM 12/1/09</td> <td data-bbox="1178 1273 1444 1414">Sexual contact between adults</td> <td data-bbox="1451 1273 1864 1414">IDN states it is not clear whether consensual. Counseled this was not appropriate behavior in the facility.</td> </tr> </tbody> </table>	Individual Incident date	Incident type	WRPT response	AS 2/4/10	Sexual contact between adults	RN assessment following incident. Placed on sick call. Seen by physician; no treatment needed.	DB 11/7/09	Consensual sexual activity	Psychologist will begin individual therapy. Will refer DB to sexuality class. Counseled re STDs.	DM 9/18/09	Sexual assault (victim)	Transferred to another unit. Placed on 1:1 prior to transfer. Placed on sick call.	FM 2/3/10	Consensual sexual activity	MD ordered lab work. Counseled that sexual activity is not appropriate in a facility setting. Encouraged to talk to staff.	HH 12/1/09	Sexual contact between adults	WRP addresses sexual activity. Counseled re HIV and STDs.	LM 12/1/09	Sexual contact between adults	IDN states it is not clear whether consensual. Counseled this was not appropriate behavior in the facility.
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		<p>MV 3/26/10</p>	<p>Consensual sexual activity</p>	<p>Team conference scheduled for day after incident. MV moved to a room on the opposite hall. Counseled re STDs. Focus 3 opened. Psychology SIR review completed.</p>
		<p>RC 3/26/10</p>	<p>Consensual sexual activity</p>	<p>Counseled re STDs. Agreed to refrain from future acts. Psychology SIR review completed.</p>
		<p>WN 9//1/09</p>	<p>Sexual assault</p>	<p>No IDN by nurse or physician. WN denied he was assaulted.</p>
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue encouraging staff to document their efforts at counseling, assessing, and comforting as appropriate.</p>		
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: The facility provided no current information regarding the training status of non-clinical Mall providers. [Subsequent to the tour, the facility reported that all non-clinical mall providers are current in the required training. Training courses include TSI-1, Abuse and Neglect, By Choice, Mall Overview, Group Facilitator and Learning Strategies.]</p>		

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		<p>Compliance: Earlier information indicated that the facility was in substantial compliance.</p> <p>Current recommendation: Provide current data at the next monitoring visit.</p>
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Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The HAC members continue to meet and address issues in a systematic and organized manner, listening attentively to one another and acknowledging the work of their peers. 2. HAC members acknowledge the efforts of the facility leadership to improve the quality of life at the facility. Alternately, the individuals clearly articulate the matters that continue to concern them. Most importantly, members are prepared to offer insightful recommendations for correcting problems. 3. Recent survey results show an increase in the percentage of positive responses to questions related to treatment and quality of life.
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.	<p>Methodology:</p> <p><u>Interviewed:</u> Several individuals during tours and at the HAC Chairmen's meeting</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Peaceful Resolution Committee minutes 2. Individuals' Survey results <p><u>Participated in:</u> HAC Chairmen's meeting</p>
J		<p>Current findings on previous recommendation:</p> <p>Recommendation, October 2009: Continue current practice.</p> <p>Findings: Approximately 30 individuals attended the HAC Chairmen's Meeting. These</p>

		<p>men volunteered to discuss initiatives that have, or shortly will, improve the quality of life at ASH. These include:</p> <ul style="list-style-type: none"> • The soon-to-be-opened main courtyard kiosk in which snacks and cold drinks will be available for purchase and as part of the By Choice program; • Improvements in the articles available in the By Choice program, such as ear buds and headsets; • Extended library hours; • The work of the Peaceful Resolution Committee; • Establishment of the ASH Men's Choir; • The Violence Reduction Incentive Program; and • Increased leisure activities, particularly movies and band concerts. <p>The men were likewise clear in expressing issues that continue to concern them and in some cases offering alternatives. These include:</p> <ul style="list-style-type: none"> • The requirement for Mall group attendance does not take into account the inability of some individuals to attend to a topic because of their unstable condition; • By Choice points should be linked to behavior, not only group attendance; • Advanced groups should be developed and made available since many individuals have already mastered the material in the fundamentals course; and • Provide educational groups focused on a specific disorder and invite individuals with that disorder to participate. Coupled with these educational groups, provide support groups for individuals with specific disorders. <p>Other findings: Recent survey results show improvement in all questions sampled.</p>
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Section J: First Amendment and Due Process

Item	Percentage of positive responses	
	Previous period	9/09-2/10
Feel safe?	76%	84%
Treated with respect?	85%	95%
Environment clean and safe?	83%	89%
Helped to meet W&R goals?	84%	90%
Your rights have been explained to you?	77%	
Grievance process works?	62%	72%
If you see A/N, can you report it?	82%	
Able to communicate freely with family, attorney or advocate?	86%	
	74%	
	92%	
Compliance: Substantial.		
		84%
Current recommendation: Continue current practice.		