

**REPORT 10**

**ATASCADERO STATE HOSPITAL**

**April 18-22, 2011**

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

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

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

HOM	Hospital Oversight and Monitoring
HSS	Health Services Specialist
HTN	Hypertension
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IED	Intermittent Explosive Disorder
IER	Independent External Review
IM	Intramuscularly
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MAS	Medical Ancillary Services
MBS	Modified barium swallow
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
NAO	New admission orientation
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NFA	Neuropsychological Focused Assessment
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPH [insulin]	Neutral Protamine Hagedorn [insulin]
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations

OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POC	Plan of Correction
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PWT	Program-Wide Trainer
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician

RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SLU	Social Learning Unit
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator

STA	Secure Treatment Area
START	Simple Triage and Rapid Treatment
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
Tx	Treatment
UCR	Urgent Care Room
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
VRMC	Violence Risk Management Committee
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

## Introduction

### A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (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 18-22, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

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

## **B. Methodology**

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and the 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 result 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:

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

**D. Findings**

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

1. Key Indicator Data

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for 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 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. The facility has utilized all available DMH standardized auditing tools for all applicable sections of the EP.

- b. The facility's self-assessment data were well-organized and internally consistent.
- c. ASH presented process and clinical outcome data regarding its medical services showing that ASH has maintained positive outcomes in this area.
- d. ASH presented data regarding process and clinical outcomes for its mental health services. Although more work is needed to optimize outcomes in the area of aggression reduction, the facility's data demonstrated positive outcomes in general.
- e. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.
- f. 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 DMH 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. ASH has maintained its progress in the implementation of the EP and solidified its status as the overall leading California facility in this regard. This progress is outlined in each corresponding section in the body of the report, including areas of need in a few areas (e.g. admission violence risk assessment and nursing reassessments). Both the leadership and practitioners

of ASH should be commended for their continued commitment to this process and for using this process as a blueprint to improve their systems of clinical care in a variety of domains.

- b. Regarding the review of nursing reassessments of significant changes in the physical status of the individuals, there was general evidence of some progress in this area, including timely communications to the medical staff of necessary data to ensure adequate medical care. Based on a review of a sample of individuals who required transfer to outside facilities for medical care, this monitor did not find evidence of delay in medical attention or improper medical care as a result of nurse/physician communications. However, the nursing expert on the CM's team found some persistent and significant breakdowns in the processes of nursing reassessment that should be corrected to ensure a formalized and self-sustaining system of nursing care that comports with generally accepted nursing procedures. The facility must ensure timely correction of the findings in this area.
- c. It is important to reiterate that ultimate success in this process must include, at a minimum, compliance with the requirements that are essential to the safety and well-being of the individuals. The monitor is aware that incidents, including serious incidents, can happen in any facility, particularly in facilities that care for individuals who are seriously mentally ill and also have histories of involvements with the criminal justice system and that certain adverse events can be explained by factors outside the control of the facility, some of which may be independent of clinical performance. However, all facilities are expected to have an effective Risk and Quality Management and administrative oversight systems that ensure proper and timely identification of high-risk situations, remedial actions without delay, continuous and critical assessment of patterns and trends of these situations and development and implementation of data-based corrective actions and of systems to monitor the appropriateness and efficacy of these actions.
- d. ASH has maintained progress in its risk management procedures regarding the care of individuals who met a variety of high-risk triggers and thresholds. This monitor found general evidence of adequate implementation of the current Risk Management SO including, the following areas:
  - i. Documentation of the incident;
  - ii. Review of the incident by the treating or on-call psychiatrists within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individuals and/or others;
  - iii. Attention by the WRPT to the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;
  - iv. Timeliness and quality of behavioral interventions, as indicated;
  - v. Tracking by risk management staff of the incidents that constitute triggers or thresholds requiring progressive levels of reviews;
  - vi. Review by the Program Review, Enhanced Trigger Review and PSSC Committees and documentation of treatment recommendations based on these reviews; and
  - vii. Follow-up by the WRPTs on recommendations from higher levels of reviews.

- e. ASH has an effective and functional system of performance improvement, including oversight by the Quality Council, access to real-time data from multiple sources including SIR and key indicator data and structures and reporting channels that facilitate the following:
  - i. Identification, by the individual practitioners, the WRPTs, various risk management committees and the Quality Council, of risk profiles of specific individuals and of aggregate data on trends and patterns addressing actual and potential high-risk situations;
  - ii. Analysis of trends and patterns of high-risk events (based on both SIR and KI data);
  - iii. Development and implementation of data-based corrective actions to reduce the risk of harm; and
  - iv. Determination of the outcome of corrective actions.

In reviewing the facility's key indicator data, this monitor found preliminary evidence of positive outcomes of this system. For example, the long-term rate of aggression to others resulting in injury has remained stable despite a significant increase in the admission rate and the admission to the facility of higher-risk mentally disordered offenders. Additionally, comparing the data regarding individuals with two or more aggressive incidents within seven days to individuals with four or more aggressive incidents within 30 days showed a persistent gap that suggested effectiveness of the current risk management system. The key indicators regarding medical care have, in general, also demonstrated positive outcomes of care.
- f. This review found that ASH has the most effective senior administrative leadership in the current system of care in the four CA facilities under the CM process.
- g. DMH should proceed with full implementation of the streamlined versions of the WRPs and some disciplinary assessments and reassessments with input from its clinical staff. The main purpose of this task is to achieve a more reasonable balance between time allocated for direct care services and time allocated for documentation and monitoring of the implementation of these services. Leadership and coordination by the facilities' Medical Directors are critical in this endeavor. This monitor will accommodate appropriate modifications in the facilities' self-assessment data that may be necessary as a result of this process and will modify, as needed, the process.
- h. ASH has maintained progress in the psychosocial rehabilitation of its individuals as specified in relevant sections of this report. As mentioned previously, all four facilities have achieved a system of assessment and care of individuals with cognitive impairments that is a model for the public mental health system nationwide.
- i. 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.
- j. Although much progress has been made, the DMH must continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.

4. Staffing

The table below shows the staffing pattern at ASH as of February 25, 2011:

<b>Atascadero State Hospital Vacancy Totals as of 2/25/11</b>				
<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>			
	<b>10/11 FY</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
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	0	1	100.00%
Clinical Dietician	12.3	9.2	3.1	25.20%
Clinical Laboratory Technologist (Safety)	2.5	2.5	0	0.00%
Clinical Social Worker (Health Facility/S)	62.4	53	9.4	15.06%
Communications Supervisor	1	1	0	0.00%
Communications Operator	10	8	2	20.00%
Coordinator of Nursing Services	1	1	0	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%
Dietic Technician (Safety)	5.6	4.5	1.1	19.64%
E.E.G. Technician (Psych Tech)	1	1	0	0.00%
Food Service Technician I	56.5	47.5	9	15.93%

**Atascadero State Hospital Vacancy Totals  
as of 2/25/11**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>			
	<b>10/11 FY</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Food Service Technician II	31	31	0	0.00%
Hospital Police Officers	110	102	8	7.27%
Hospital Police Sergeant	16	14	2	12.50%
Hospital Police Lieutenant	4	4	0	0.00%
Hospital Worker	0	0	0	0.00%
Health Record Technician	5.3	5	0.3	5.66%
Health Record Technician II (Spec)	6	5	1	16.67%
Health Record Technician II (Supv)	1	0	1	100.00%
Health Record Technician III	0	0	0	0.00%
Health Services Specialist (Safety)	26	22	4	15.38%
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	11	1	8.33%
Nurse Instructor	13	12	1	7.69%
Nurse Practitioner (Safety)	21	21	0	0.00%
Nursing Coordinator (Safety)	9	6	3	33.33%
Office Technician	54.5	49.5	5	9.17%
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%
Pharmacy Services manager	1	1	0	0.00%
Pharmacy Technician, D/MH & DS	15	15	0	0.00%

**Atascadero State Hospital Vacancy Totals  
as of 2/25/11**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>			
	<b>10/11 FY</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Physician & Surgeon (Safety)	17	17	0	0.00%
Podiatrist D/MH & DS	0	0	0	0.00%
Pre-licensed Pharmacist	0	0	0	0.00%
Pre-licensed Psychiatric Technician (Safety)	0	0	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)	7	5	2	28.57%
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	7	2	22.22%
Psychiatric Nursing Education Director	1	1	0	0.00%
Psychiatric Technician (Safety)	591	583	8	1.35%
Psychiatric Technician Trainee (Safety)	31	29.9	1.1	3.55%
Psychiatric Technician Assistant (Safety)	1	1	0	0.00%
Psychiatric Technician Instructor	0	0	0	0.00%
Psychologist-HF, Clinical (Safety)	62.7	55.5	7.2	11.48%
Public Health Nurse I (D/MH &DS)	0	0	0	0.00%
Public Health Nurse II	3	3	0	0.00%
Radiologic Technologist	0	0	0	0.00%
Registered Nurse (Safety)	297	262.8	34.2	11.52%
Rehabilitation Therapist S.F., Art-Safety	4	3.5	0.5	12.50%
Rehabilitation Therapist S.F., Dance-Safety	0	0	0	0.00%

**Atascadero State Hospital Vacancy Totals  
as of 2/25/11**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>			
	<b>10/11 FY</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Rehabilitation Therapist S.F., Music-Safety	16	16	0	0.00%
Rehabilitation Therapist S.F., Occup-Safety	2	2	0	0.00%
Rehabilitation Therapist S.F., Rec.-Safety	39.2	34.8	4.4	11.22%
Senior Psychiatrist (Specialist)	3	2	1	33.33%
Senior Psychiatrist, CF, (Supervisor)	9	4	5	55.56%
Senior Psychologist, H.F. (Specialist)	10	10	0	0.00%
Senior Psychologist, C.F. (Supervisor)	12	11	1	8.33%
Senior Psychiatric Technician (Safety)	93	86	7	7.53%
Sr.Radiologic Technologist(Specialist-Saftey)	1	1	0	0.00%
Senior Special Investigator I, D/MH & DS	2	2	0	0.00%
Senior Vocational Rehab Counselor	1	1	0	0.00%
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)	59.2	18.5	40.7	68.75%
Supervising Registered Nurse (Safety)	2	1	1	50.00%
Teacher-Adult Educ.	13.9	10	3.9	28.06%
Teaching Assistant	7	7	0	0.00%
Unit Supervisor (Safety)	32	33	-1	-3.13%
Vocational Services Instructor	4	4	0	0.00%
Vocational Rehabilitation Counselor	0	0	0	0.00%

Key vacancies at this time include senior and staff psychiatrists, special investigators, registered nurses and clinical social workers.

## E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; 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. When a facility maintains substantial compliance with any section of the EP for 18 months, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance.

## F. Next Steps

1. The Court Monitor's team is scheduled for a final evaluation of Atascadero State Hospital October 17-21, 2011.
2. The Court Monitor's team is scheduled to tour Patton State Hospital June 6-10, 2011 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<b>C. Integrated Therapeutic and Rehabilitation Services Planning</b>		
	<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><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. ASH has maintained substantial compliance with the process of WRP reviews by the WRPTs. and maintained substantial compliance with all requirements in Section C.1.</li> <li>2. ASH has attained substantial compliance with the requirements in Section C.2.</li> <li>3. ASH has consolidated its WRP training and mentoring programs. The current program appears to be sufficient to maintain progress in the implementation of EP requirements in Sections C.1 and C.2.</li> <li>4. ASH has begun implementation of DMH streamlined templates for the WRPs. If properly implemented, these templates can meet the current needs of the facilities in achieving reasonable balance of practitioners' time between direct care and documentation of care while meeting EP requirements.</li> <li>5. ASH has made significant improvement in assessing and intervening on PSR Mall group non-adherence.</li> <li>6. ASH had developed and implemented a comprehensive policy towards addressing clinical appointment cancellations.</li> <li>7. ASH has introduced a conceptually sound new program called the "Program Incentive BINGO" through the By Choice program that is in part a way to reduce violence on the units.</li> </ol>

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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charlie Joslin, Clinical Administrator</li> <li>2. Donna Nelson, Director, Standards Compliance Department</li> <li>3. Jan Alarcon, PhD, WRP Master Trainer</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH WRP Observation Monitoring summary data (September 2010 - February 2011)</li> <li>2. ASH Clinical Chart Auditing Form summary data (September 2010 - February 2011)</li> <li>3. ASH WRP Team Facilitator Observation Monitoring Form summary data (September 2010 - February 2011)</li> <li>4. ASH data regarding staffing ratios on admissions and long-term units (September 2010 - February 2011)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit 11) for quarterly review of MAS</li> <li>2. WRPC (Program I, unit 26) for monthly review of WEJ</li> <li>3. WRPC (Program III, unit 17) for quarterly review of CRA</li> <li>4. WRPC (Program III, unit 7) for monthly review of MD</li> <li>5. WRPC (Program V, unit 33) for quarterly review of RR</li> <li>6. WRPC (Program VI, unit 1) for monthly review of TE</li> <li>7. WRPC (Program VI, unit 7) for quarterly review of KVK</li> <li>8. WRPC (Program VI, unit 9) for quarterly review of GEC</li> <li>9. WRPC (Program VII, unit 22) for quarterly review of MDG</li> <li>10. WRPC (Program VII, unit 23) for 14-day review of DLL</li> <li>11. WRPC (Program VII, unit 23) for 14-day review of JCW</li> <li>12. WRPC (Program VII, unit 26) for monthly review of WRK</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.a</p>	<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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period.</p> <p><b>Findings:</b> The following summarizes the current status of the WRP training/ mentoring activities during review period:</p> <ol style="list-style-type: none"> <li>1. The Mentoring Program was phased out on August 16, 2010.</li> <li>2. WRP training/mentoring responsibilities were taken over by the WRP Master Trainer, the Program Clinical Management Teams (CMTs) and Central Nursing Service's Nurse Mentors. The specific responsibilities are outlined as follows:             <ol style="list-style-type: none"> <li>a. The Master Trainer:                 <ol style="list-style-type: none"> <li>i. Provides a three-hour group training on the Wellness and Recovery Manual consisting of an overview of the Recovery Model, Wellness and Recovery treatment planning and the WRPC process to all new clinical staff (psychiatrists, psychologists, social workers, rehabilitation therapists, nurses, and psychiatric technicians) during their first month of employment.</li> <li>ii. Provides an eight-hour group training on the WRP and WRPC consisting of an overview of Engagement Principles, Case Formulation, Foci and Objectives, Interventions and Mall Integration, and Discharge Planning to all new clinical staff during their first month of employment.</li> <li>iii. Provides discipline-specific individualized training on the WRP and WRPC to all psychiatrists, psychologists, social workers and rehabilitation therapists during their first two months of employment.</li> <li>iv. Creates and disseminates new training material to all clinical</li> </ol> </li> </ol> </li> </ol>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and management staff. New training materials are derived from information received from the Court Monitor, DMH Oversight and Monitoring Team, and training needs as identified by the WRP Master Trainer and the Program Clinical Management Team.</p> <ul style="list-style-type: none"><li>v. In addition, the WRP Master Trainer and Program Assistant identify WRPT and discipline-specific training needs of continuing clinical employees based on a review of the clinical aspects of admission and non-admission WRPs and feedback from clinical staff. A course of remediation including at least bimonthly training and monitoring identified outcome measures are provided by the Master WRP Trainer and members of the Clinical Management Team as appropriate.</li><li>b. The Program Clinical Management Team:<ul style="list-style-type: none"><li>i. Reviews on a monthly basis all WRP audit data to identify team and individual clinician-based issues. Senior clinicians in collaboration with Program Management address, mentor and/or re-train staff as needed. The training is specific to the area of the deficiency and performance is audited until improvement is consistent.</li><li>ii. Contacts the WRP Master Trainer if further training needs are identified.</li></ul></li><li>c. Central Nursing Service's Nurse Mentors provide discipline-specific WRP training for new nursing staff as follows:<ul style="list-style-type: none"><li>i. Registered Nurses receive 12 hours practical hands-on training consisting of how to write a Focus 6 plan of care.</li><li>ii. Psychiatric Technicians receive four hours of training focused on their input into the WRP.</li><li>iii. Both disciplines receive eight hours of WRP theory and instructions on how to navigate WaRMSS.</li></ul></li></ul> <p>At this stage, ASH's WRP training/mentoring program appears to be sufficient to meet the facility's needs.</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Recommendation 2, October 2010:</b> Continue efforts to streamline the process (and content) of WRP review and documentation of this review.</p> <p><b>Findings:</b> The DMH HOM Team continues the implementation and oversight of WRP streamlining efforts. A pilot of the streamlined Monthly WRP was initiated on two units at ASH from January 24 to February 4, 2011. In February 2011, streamlined templates for the Annual and Quarterly WRPs were approved by the Medical Directors of the facilities and corresponding audit tools were forwarded to the hospitals for approval on April 4, 2011.</p> <p><b>Recommendation 3, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WPRCs held each month (September 2010 - February 2011):</p> <table border="1" data-bbox="982 1003 1879 1339"> <tr> <td data-bbox="982 1003 1077 1154">1.</td> <td data-bbox="1077 1003 1787 1154"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 1003 1879 1154">99%</td> </tr> <tr> <td data-bbox="982 1154 1077 1339">2.</td> <td data-bbox="1077 1154 1787 1339"><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="1787 1154 1879 1339">96%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</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>	96%
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>	96%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>at least 90% from the previous review period for both items.</p> <p><b>Other findings:</b> The monitor and his experts attended 12 WRPCs. The meetings demonstrated that ASH has maintained its progress in the overall process of the team meetings and that the current training/mentoring program has been effective in ensuring substantial compliance in this area.</p> <p>In order to optimize the time of practitioners during the review of the WRPs, the WRPTs should avoid, as clinically appropriate, the unnecessary duplication of some processes such as the presentation of disciplinary assessments more than once during the meeting. Additionally, in the update of the individual's present status, the WRPTs should focus on the current status of symptoms rather than reviewing the individual's history in this area.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice in WRP training/mentoring and provide a summary outline of any changes in this area during the reporting period.</li> <li>2. Provide an update on the status of implementation of the streamlined templates for the WRPs.</li> <li>3. Continue to monitor this requirement.</li> </ol>
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 100% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 672 1885 974"> <tr> <td>1.</td> <td><i>The team psychiatrist was present.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The team facilitator ensured that the interventions were linked to the objectives.</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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present.</i>	96%	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>	96%												
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.	<b>Current findings on previous recommendation:</b>												

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		<p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Audit, ASH reported a compliance rate of 99% based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 100% for the review period, based on a 10% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="982 857 1879 1044"> <tr> <td data-bbox="982 857 1077 1044">5.</td> <td data-bbox="1077 857 1780 1044"><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></td> <td data-bbox="1780 857 1879 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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	100%
5.	<i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	100%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.h</p>	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH presented core WRPT member attendance data based on an average sample of 10% of quarterly and annual WRPCs held during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="982 561 1747 906"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>94%</td> <td>97%</td> </tr> <tr> <td>Psychiatrist</td> <td>95%</td> <td>96%</td> </tr> <tr> <td>Psychologist</td> <td>83%</td> <td>86%</td> </tr> <tr> <td>Social Worker</td> <td>76%</td> <td>82%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>85%</td> <td>86%</td> </tr> <tr> <td>Registered Nurse</td> <td>98%</td> <td>97%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>88%</td> <td>91%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous review period	Current review period	Individual	94%	97%	Psychiatrist	95%	96%	Psychologist	83%	86%	Social Worker	76%	82%	Rehabilitation Therapist	85%	86%	Registered Nurse	98%	97%	Psychiatric Technician	88%	91%
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Registered Nurse	98%	97%																								
Psychiatric Technician	88%	91%																								
<p>C.1.i</p>	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data on average case load ratios:</p>																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	Previous review period	Current review period
<b>Admission Units</b>		
MDs	1:15	1:15
PhDs	1:13	1:15
SWs	1:15	1:17
RTs	1:15	1:16
RNs	1:8	1:10
PTs	1:9	1:7
<b>Long-Term Units</b>		
MDs	1:16	1:25
PhDs	1:19	1:25
SWs	1:19	1:25
RTs	1:18	1:25
RNs	1:12	1:15
PTs	1:8	1:8

The facility attributed the relative increase in the case loads for some core members in long-term units to the increase in the average patient census at the facility from 1071 during the previous period to 1161 during this reporting period.

**Compliance:**  
Substantial.

**Current recommendations:**

1. Continue to monitor this requirement.
2. Provide an explanation of significant change in case ratios for any discipline.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.j</p>	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as C.1.a through C.1.f.</p> <p><b>Findings:</b> Same as C.1.a through C.1.f.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as C.1.a through C.1.f.</p>
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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><b>Methodology:</b></p> <ol style="list-style-type: none"> <li>1. Abdul Malik, MD, Psychiatrist</li> <li>2. Alvarellas, MD, Psychiatrist</li> <li>3. Angelique Stansbury, Psychiatric Nurse Practitioner</li> <li>4. Bettina Hodel, DCAT</li> <li>5. Charlie Joslin, Clinical Administrator</li> <li>6. Dawn Hartman, Assistant Director of Dietetics</li> <li>4. Donna Nelson, Director, Standards Compliance Department</li> <li>7. Erin Dengate, Assistant Director of Dietetics</li> <li>8. Jan Alarcon, PhD, WRP Master Trainer</li> <li>9. Janet Bouffard, LCSW, Chief of Social Work</li> <li>10. Jennifer Owens, PT</li> <li>11. John Corsolin, Nurse Practitioner</li> <li>12. John DeMorales, Executive Director for ASH</li> <li>13. Kathy Runge, Occupational Therapist</li> <li>5. Killorin Riddell, PhD, Coordinator Psychology Specialty Services</li> <li>14. Kristin Lowry, PhD, Psychologist</li> <li>15. Ladonna Decou, Chief of Rehabilitation</li> <li>16. Lesa Morgan, RN</li> <li>6. Linda Persons, Hospital Administrator.</li> <li>17. Mark Ferris, RT</li> <li>18. Matthew Hennessy, PhD, Mall Director</li> <li>19. Michael Groom, LCSW, Social Worker</li> <li>20. Michael Ostash, LCSW, Social Worker</li> <li>21. Rachelle Rianda, Acting Senior Rehabilitation Therapist</li> <li>22. Rank Stass, MD, Psychiatrist</li> <li>23. Reggie Cruz, PT</li> <li>24. Richard Murray, PhD, Senior Supervising Psychologist</li> <li>25. Tao-Hsing Wang, RT</li> <li>26. Tzu-Chen Cheng, Ph.D, Psychologist</li> <li>27. Vladimir Bokarius, MD, Psychiatrist</li> <li>28. Wendi Stivers, PT, PBS</li> </ol>

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		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 145 individuals: AA, AB, ADD, ADH, AM, AMS, AN, AR, AS, AT, AV, AW, AY, BER, BGC, BH, BJS, BM, BNP, BPN, BT, BWB, CA, CBD, CC, CDC, CJ, CLC, CRA, DBP, DC, DDB, DEC, DFW, DH, DLL, DLR, DMM, DRM, DRR, DRS, DS, EGM, EN, ES, EWS, FP, GBT, GC, GDH, GMB, GMW, GR, GT, HAC, HAS, IM, JAB, JAH, JAL, JC, JD, JDE, JDL, JDS, JED, JHF, JJP, JKS, JLD, JLM, JLR, JM, JMH, JMR, JRA, JS, JSB, JSL, KB, KJB, KJR, KRI, KS, KWH, LCS, LE, LEB, LF, LMR, LP, LR, LRS, LS, MAA, MAS, MB, MC, MDW, MER, MJG, MP, MR, MSG, PA, PAP, PC, QJAJ, RAG, RAM, RBT, RC, RD, RE, RH, RJ, RKG, RKH, RLS, RO, RR, RSO, RUC, RW, SAJ, SBH, SDF, SDM, SMB, SMW, SW-1, SW-2, TDT, TR, TSR, VLK, WAV, WEJ, WF, WLF, WLP, WLW, WPT, ZA and ZDS</li> <li>2. One WRP per team for the following 53 individuals: AAN, ADW-1, ADW-2, ALJ, ASW, AW, CDB, CL, CLW, DCF, DJB, DRM, DVP, EAM, EF, ERA, FAA, FJG, GCD, IAH, IC, JC, JEC, JJ, JMH, KDP, KFB, KM, LJ, LRG, LW, MDH, MS, MSL, MW, RAL, REM, RH-1, RH-2, RLS, RP, RR, RSP, SAJ, SDF, SDM, SEP, SVG, TAN, THD, TRC, WMH and WRK</li> <li>3. Document comparing current and previous review period; hours and types of cognitive remediation groups and summary of any process changes. (electronic copy only)</li> <li>4. Lesson plans for the following:             <ul style="list-style-type: none"> <li>• Brain Fitness: Get with It for AW</li> <li>• Brain Fitness: Basics for HAC and LEB</li> <li>• Brain Fitness: Reasoning (general)</li> <li>• Brain Fitness: Attention (general)</li> <li>• Brain Fitness: Memory (general)</li> </ul> </li> <li>5. WRP and corresponding PSR Mall Progress Notes for the following six individuals: EN, JSL, RAG, RD, RR, and WAV</li> <li>6. ASH WRP Observation Monitoring summary data (September 2010 - February 2011)</li> <li>7. ASH Clinical Chart Auditing Form summary data (September 2010 -</li> </ol>
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		<p>February 2011)</p> <ol style="list-style-type: none"> <li>8. ASH Chart Auditing Form summary data (September 2010 - February 2011)</li> <li>9. ASH Substance Abuse Auditing Form summary data (September 2010 - February 2011)</li> <li>10. Substance Abuse Clinical Outcome summary data (September 2010 - February 2011).</li> <li>11. Substance Abuse Process Outcome summary data (September 2010 - February 2011)</li> <li>12. Substance Abuse Individual Satisfaction Survey summary data (September 2010 - February 2011)</li> <li>13. Medication Education Assessment tool; revised March 2011 (electronic copy only)</li> <li>14. Mall Participation Survey data</li> <li>15. Administrative Directive #553 (Section - Medical Nursing Services)</li> <li>16. Completed Mall facilitator audit forms</li> <li>17. PSR Mall Non-adherence survey data</li> <li>18. ASH Violence Study Document</li> <li>19. PSR Mall Curriculums</li> <li>20. PSR Mall Schedules</li> <li>21. ASH Integration of Medical Conditions in WRP Auditing Form summary data (September 2010 - February 2011)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Contemplation 1 (Contemplation), Mirella Ramos and Chuck Watson, Psychiatric Technicians, facilitators</li> <li>2. PSR Mall Group: Self Discovery (Action), Douglas Erb and Chuck Watson, Psychiatric Technicians, facilitators.</li> <li>3. PSR Mall Group: Communication 2 (Action), Trina Robbins and Mirella Ramos, Psychiatric Technicians, facilitators</li> <li>4. WRPC (Program I, unit 11) for quarterly review of MAS</li> <li>5. WRPC (Program I, unit 26) for monthly review of WEJ</li> <li>6. WRPC (Program III, unit 17) for quarterly review of CRA</li> </ol>
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		<p>7. Mall Group: Substance Abuse Recovery, Relapse Prevention, Action Stage</p> <p>8. Mall Group: Substance Abuse Recovery, Relapse Prevention, Preparation/Action Stage</p> <p>9. Mall Group: Substance Abuse Recovery, Contemplation Stage</p> <p>10. Mall Group: Coping with Life Sentence</p> <p>11. Mall Group: Medication Education: Depression Management</p> <p>12. Mall Group: General Health</p>
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the WRPCs held each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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	<b>Current findings on previous recommendation:</b>

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	<p>("A-WRP") are completed within 24 hours of admission;</p>	<p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i-iii (September 2010 - February 2011). Based on an average sample of 10% 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><b>Other findings:</b> A review of the charts of 12 individuals admitted during the review period (AMD, DAP, DEC, EN, FAWR, FN, KJB, LLH, MTG, RD, RSD and RWW) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Based on an average sample of 10% of the 7-day WRPs, the facility reported a mean compliance rate of 100% with this requirement. 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><b>Other findings:</b> A review of the charts of 12 individuals admitted during the review period (AMD, DAP, DEC, EN, FAWR, FN, KJB, LLH, MTG, RD, RSD and RWW) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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 12<sup>th</sup> monthly review is the annual review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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>10%</td> <td>100%</td> </tr> <tr> <td>Monthly</td> <td>10%</td> <td>100%</td> </tr> <tr> <td>Quarterly</td> <td>10%</td> <td>97%</td> </tr> <tr> <td>Annual</td> <td>8%</td> <td>96%</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 items.</p> <p><b>Other findings:</b> A review of the charts of 12 individuals admitted during the review period (AMD, DAP, DEC, EN, FAWR, FN, KJB, LLH, MTG, RD, RSD and RWW) found compliance in all cases.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	10%	100%	Monthly	10%	100%	Quarterly	10%	97%	Annual	8%	96%
WRP Review	Mean sample size	Mean compliance rate															
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH assessed compliance using the DMH WRP Clinical Chart Auditing Form. The sample for the main indicator was 10% and the samples for the sub-indicators ranged from 12% (substance use disorders) to 100% (cognitive and seizure disorders) of the relevant population during the review period (September 2010 - February 2011).</p> <table border="1" data-bbox="991 894 1885 1416"> <tr> <td data-bbox="991 894 1087 1081">2.</td> <td data-bbox="1087 894 1791 1081"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 894 1885 1081">96%</td> </tr> <tr> <td data-bbox="991 1081 1087 1192">2.a</td> <td data-bbox="1087 1081 1791 1192"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1081 1885 1192">90%</td> </tr> <tr> <td data-bbox="991 1192 1087 1304">2.b</td> <td data-bbox="1087 1192 1791 1304"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1192 1885 1304">100%</td> </tr> <tr> <td data-bbox="991 1304 1087 1416">2.c</td> <td data-bbox="1087 1304 1791 1416"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1304 1885 1416">96%</td> </tr> </table>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	96%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	90%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	100%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	96%
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		<p>Comparative data indicated that ASH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 11 individuals who were diagnosed with a variety of cognitive disorders:</p> <ol style="list-style-type: none"> <li>1. Borderline Intellectual Functioning (AY and HAC);</li> <li>2. Dementia Due to General Medical Condition (DRS).</li> <li>3. Dementia Due to Parkinson's Disease and Mild Mental Retardation (JS);</li> <li>4. Dementia NOS (LMR);</li> <li>5. Mild Mental Retardation (MJG and SW);</li> <li>6. Mild Mental Retardation and Cognitive Disorder NOS (GC);</li> <li>7. Moderate Mental Retardation (AW);</li> <li>8. Vascular Dementia (RR); and</li> <li>9. Vascular Dementia with Delusions (LEB).</li> </ol> <p>In addition, this monitor reviewed the charts of eight individuals diagnosed with seizure disorders (AT, AY, DEC, JDE, KJR, LEB, SW and TDT). The reviews found general evidence that ASH has maintained progress in the following areas:</p> <ul style="list-style-type: none"> <li>• Review of seizure activity (AY, KJR, LEB, SW and TDT) and cognitive functioning (DRS, JS, LEB, RR and SW) in the Present Status section of the case formulation;</li> <li>• The use of learning-based objectives and interventions to address the needs of individuals diagnosed with cognitive impairments and/or seizure disorders (e.g. SW);</li> <li>• The performance of cognitive assessments/screening tests (AW, AY, GC, HAC and LEB) and/or neuropsychological testing (GC and MJG) to</li> </ul>
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		<p>determine the level and scope of cognitive dysfunction and assist in the cognitive diagnosis;</p> <ul style="list-style-type: none"> <li>• Provision of formal and informal cognitive remediation interventions for individuals diagnosed with cognitive disorders. Examples include the following:             <ul style="list-style-type: none"> <li>○ Brain Fitness-Get With It (AW);</li> <li>○ Brain Fitness-Get With It (in Spanish) (LMR);</li> <li>○ Brain Fitness-Basics (HAC and LEB); and</li> <li>○ Ready Set Go (JS and MJG).</li> </ul> </li> <li>• Completion of timely neurological consultations to address the needs of individuals with seizure disorders;</li> <li>• Caution in the use of long-term high risk medications (anticholinergics and benzodiazepines) for individuals diagnosed with cognitive impairments, with a few exceptions (e.g. AY and MG); and</li> <li>• Formulation of the status and needs of an individual (RR) who had severe Vascular Dementia who was unable to participate in formal cognitive testing.</li> </ul> <p>The review found the following process deficiencies:</p> <ul style="list-style-type: none"> <li>• There were no focus or objective statements for an individual with Mild Mental Retardation (SW). However, this individual received appropriate group intervention- "Ready, Set, Go" that met his needs. This individual was also diagnosed with seizure disorder but his WRP did not address the cognitive risks of treatment with an older anticonvulsant agent (phenytoin).</li> <li>• The WRP of one individual (JS) did not reconcile the diagnoses of Dementia Due to General Condition and Mild Mental Retardation.</li> <li>• The WRP of a newly admitted individual diagnosed with Borderline Intellectual Functioning and seizure disorder receiving treatment with two high-risk agents (phenytoin and benztropine) did not address the cognitive risks of treatment (AY).</li> </ul>
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.d	<p>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:</p>	<p><b>Compliance:</b> Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, ASH reported a compliance rate of 99% based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from 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> <p><b>Recommendation 2, October 2010:</b> Continue efforts to streamline the WRPs to minimize duplication (in</p>

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		<p>WRPs and the psychiatric progress notes) in the documentation of planned modifications of treatment for individuals who require the use of restrictive interventions.</p> <p><b>Findings:</b> The review of the WRPs found that ASH has implemented this recommendation.</p> <p><b>Other findings:</b> This monitor reviewed one WRP per team for the following 53 individuals: AAN, ADW-1, ADW-2, ALJ, ASW, AW, CDB, CL, CLW, DCF, DJB, DRM, DVP, EAM, EF, ERA, FAA, FJG, GCD, IAH, IC, JC, JEC, JJ, JMH, KDP, KFB, KM, LJ, LRG, LW, MDH, MS, MSL, MW, RAL, REM, RH-1, RH-2, RLS, RP, RR, RSP, SAJ, SDF, SDM, SEP, SVG, TAN, THD, TRC, WMH and WRK. In general, there was evidence that ASH has maintained its progress in meeting this requirement.</p> <p>However, the facility must make additional effort to ensure proper alignment of information in the predisposing, precipitating and perpetuating factors sections of the case formulation with information derived from the violence risk assessment (as part of the admission/comprehensive psychiatric assessment). This alignment is necessary so that treatment and rehabilitation interventions address individualized targets based on the delineation of the type of violence as assessed upon the admission of individuals.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this recommendation.</li> <li>2. Address the monitor's finding mentioned above.</li> </ol>
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and	The facility reported a compliance rate of 97%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.

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	present status;	
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	The facility reported a compliance rate of 100%. 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;	The facility reported a compliance rate of 100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
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	The facility reported a compliance rate of 96%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
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.	The facility reported a compliance rate of 99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, ASH reported a compliance rate of 99% based on an average sample of 10% of the quarterly and</p>

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		<p>annual WRPs due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b>  This monitor reviewed the records of 15 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.e. Fourteen records were in substantial compliance (AB, AV, DRM, DRS, JAL, JC, JDS-1, JLR, JMH, KJB, KWH, MDW, PA and SBH) and one record was in partial compliance (JDS-2).</p> <p>This monitor also reviewed the records of nine individuals who had IA:RTS assessments and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>Finally, this monitor reviewed the records of nine individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in	Please see sub-cells for compliance findings.

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	the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 97%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>

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	<p>(e.g., quality of life activities);</p>	<p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Streamline the WRPs to ensure that all objectives are relevant to the individual's current needs.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> 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><b>Other findings:</b> Chart reviews found substantial compliance in six charts (EN, JSL, RAG, RD, RR, and WAV) and partial compliance in one (JCW). The chart of</p>

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		<p>JCW included a generic objective based on teaching the individual unspecified strategies to "cope with stress" without the identification (in the case formulation) of the type of stressors or the individual's needs in this area.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Improve the delineation of specified coping strategies to assist the individuals in coping with specified stressors.</li> </ol>
C.2.f.iv	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (DEC, EN, JSL, RAG, RSO and WAV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>C.2.f.v</p>	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.f.vi</p>	<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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor hours of active treatment (scheduled and attended).</li> <li>• Continue to 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).</li> <li>• 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.</li> </ul>

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**Findings:**

ASH presented the following data for the review period (September 2010 - February 2011):

Number of individuals by category		
	Mean scheduled hours	Mean attended hours
N	1228	1228
Hours:		
0-5	138	779
6-10	233	259
11-15	506	157
16-20	351	33

Mall Attendance		
	Previous period	Current period
<b>Mean number of individuals</b>		
0-5 hours	670	779
6-10 hours	261	259
11-15 hours	152	157
16-20+ hours	37	33

As the tables above indicate, attendance at the 16-20 hour category continues to be low. A majority of the individuals attend the 0-5 hour category.

This monitor reviewed the charts of six individuals, focusing 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:

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		Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
		CA	15	15	2
		DC	15	15	8
		ES	13	13	1
		GR	18	18	9
		LS	13	14	6
		WF	11	11	3
		<p>As the table above shows, the WPR and MAPP scheduled hours are well aligned with little discrepancy between them. This is the first time that the two have aligned this well. According to the WRPTs interviewed, the hours of scheduling are based on the individual's mental and physical status and his ability to tolerate routines and daily schedules including the Mall hours. This clinical decision-making is, in part, some of the reasons for not having all individuals scheduled in the 11-15 and 16-20 Mall hour ranges.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	This requirement is not applicable to ASH at this time.			
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and	<b>Current findings on previous recommendation:</b>			

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	<p>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><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on a mean sample of 12% of the quarterly and annual WRPs due each month for the review period (September 2010 - February 2011) and reported a mean compliance rate of 100%. 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 nine individuals found substantial compliance in all nine (CC, CJ, DC, DH, GT, JS, LCS, LP and LR). The individuals were enrolled in appropriate Mall groups addressing their DSM diagnoses and discharge criteria, life goals where appropriate, and enrichment activities.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>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><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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><b>Other findings:</b> This monitor reviewed the charts of six individuals and found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV). This monitor also reviewed the records of 14 individuals receiving direct occupational, physical and speech therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 96% based on an average sample of 65% of individuals placed in seclusion and/or restraint each month during the review period (September 2010 - February 2011). Comparative data indicated that</p>

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		<p>ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period. The review focused on whether or not the WRPs properly addressed the events that led to the use of seclusion and/or restraint. The following table outlines the reviews:</p> <table border="1" data-bbox="991 561 1881 867"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td>AMS</td> <td>12/15/10</td> <td>12/16/11</td> </tr> <tr> <td>AW</td> <td>4/3/11</td> <td>4/5/11</td> </tr> <tr> <td>GBT</td> <td>3/6/11</td> <td>3/16/11</td> </tr> <tr> <td>MP</td> <td>2/25/11</td> <td>3/17/11</td> </tr> <tr> <td>SMB</td> <td>3/30/11</td> <td>4/14/11</td> </tr> <tr> <td>WLF</td> <td>3/16/11</td> <td>3/22/11</td> </tr> </tbody> </table> <p>This review found substantial compliance in all charts.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	AMS	12/15/10	12/16/11	AW	4/3/11	4/5/11	GBT	3/6/11	3/16/11	MP	2/25/11	3/17/11	SMB	3/30/11	4/14/11	WLF	3/16/11	3/22/11
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GBT	3/6/11	3/16/11																					
MP	2/25/11	3/17/11																					
SMB	3/30/11	4/14/11																					
WLF	3/16/11	3/22/11																					
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, consistent with his/her legal status; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>																					

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		<p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 100% based on an average sample of 10% of the quarterly and annual WRPCs held each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV). In particular, the chart of RAG included a model review of the individual's progress towards the achievement of discharge criteria.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH reported a compliance rate of 99% based on an average sample of 10% of the</p>

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		<p>quarterly and annual WRPs due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor's chart reviews focused on the proper completion (and filing) of Mall progress notes for each group intervention specified for Focus 1. The review found substantial compliance in all cases (EN, JSL, RAG, RD, RR and WAV).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<b>Compliance:</b> Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its</p>

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		<p>compliance based on an average sample of 12% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 100%. 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 nine individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in eight WRPs in the charts (CC, CJ, DC, DH, GT, JS, LP and LR).</p> <p><b>Other findings:</b> This monitor reviewed the records of 15 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><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Audit Form, ASH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1339 1890 1412"> <tr> <td data-bbox="991 1339 1087 1412">7.</td> <td data-bbox="1087 1339 1795 1412"><i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i></td> <td data-bbox="1795 1339 1890 1412">100%</td> </tr> </table>	7.	<i>All objectives are written in a way that tells you what we will see or hear the individual doing.</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 seven individuals found that all seven WRPs in the charts contained objectives written in a measurable/ observable manner and directly linked to a relevant focus of hospitalization (CC, CJ, DH, GT, JS, LP and LR).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See C.2.f.viii.</p> <p><b>Findings:</b> See C.2.f.viii.</p> <p><b>Current recommendation:</b> See C.2.f.viii.</p>
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Facilitator Observation Audit, ASH assessed its compliance based on an average sample of 6% of Mall group facilitators each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 100%.</p>

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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 WRPs of 10 individuals found that all 10 WRPs had specified the strengths of the individual in all active interventions reviewed (GC, GR, LCS, LR, MB, PAP, PC, RAM, RJ and RO). The individual's strengths, preferences, and interests were documented under the Present Status sections of the WRPs. This monitor's reviews of the individuals' Integrated Assessments: Social Work and Psychology Sections found that strengths, interests, and preferences were also documented in these assessment reports.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 12% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1154 1887 1341"> <tr> <td data-bbox="991 1154 1087 1341">9.</td> <td data-bbox="1087 1154 1793 1341"><i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.</i></td> <td data-bbox="1793 1154 1887 1341">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	9.	<i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.</i>	100%
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		<p>least 90% from the previous review period.</p> <p>A review of the WRPs of nine individuals found that the individual's vulnerabilities were documented in the case formulation section in all nine WRPs (AM, AN, BT, CRA, DEC, EN, EWS, GC and GR) and where appropriate, the vulnerabilities were updated in the subsequent WRPs.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Facilitator Mall Observation Monitoring Form, ASH assessed its compliance based on an average sample of 6% of the Mall group facilitators each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 98%. 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 cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in five WRPs (CRA, EWS, GR, LCS and PAP). Cognitive screening had not been conducted in the remaining case (JAB) because the individual had refused to participate, and documentation showed that the staff continues to approach the individual to complete the assessment.</p> <p>A review of five records (GR, JAB, QJAJ, WEJ and WLF) comparing the individual's identified cognitive levels, scheduled Mall groups, and the relevant objectives and interventions in the individual's WRP found that</p>

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		<p>the PSR Mall groups these individuals had been assigned to were aligned with their cognitive and functioning levels. Observation of five Mall groups ("Lifers", Physical Wellness, Medication Education: Depression, and two Substance Abuse Recovery groups) found that the delivery of the subject matter, for the most part, was within the cognitive levels of the individuals in four of the groups. This monitor was unable to evaluate delivery compatibility in the depression group as the primary provider was reading something at the table, uninvolved with the group, while the individuals were watching a video on depression with the co-provider seated among them. According to the primary provider, the co-provider was new.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported the following data, where N equals all progress notes due for all Programs for each month of the review period and n equals the number of progress notes received by the WRPTs:</p> <table border="1" data-bbox="991 1117 1906 1269"> <thead> <tr> <th></th> <th>Sept</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>9941</td> <td>11254</td> <td>11949</td> <td>10930</td> <td>11322</td> <td>10048</td> <td>10907</td> </tr> <tr> <td>n</td> <td>9663</td> <td>10716</td> <td>11361</td> <td>10345</td> <td>10744</td> <td>9512</td> <td>10390</td> </tr> <tr> <td>%C</td> <td>97%</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> </tr> </tbody> </table> <p>A review of the charts of five individuals found that all five contained progress notes (GR, JAB, QJAJ, WLP and ZA). The WRPTs had also incorporated the information from the progress notes into the Present</p>		Sept	Oct	Nov	Dec	Jan	Feb	Mean	N	9941	11254	11949	10930	11322	10048	10907	n	9663	10716	11361	10345	10744	9512	10390	%C	97%	95%	95%	95%	95%	95%	95%
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		<p>Status section of the WRPs. In some cases, the Mall providers had made statements such as "making progress in the objectives", but most simply checked boxes to indicate attendance and participation. Since Mall progress note forms list the individual's objectives pertaining to the group, ASH may want to consider having lines below each objective that the Mall provider could use to update the individual's status for each objective.</p> <p><b>Other findings:</b> This monitor reviewed the records of 15 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.vii. Fourteen records were in substantial compliance (AB, AV, DRM, DRS, JAL, JDS-1, JDS-2, JLR, JMH, KJB, KWH, MDW, PA and SBH) and one record was in partial compliance (JC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																		
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="991 1190 1774 1421"> <thead> <tr> <th></th> <th>Provided hours</th> <th>Attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1228</td> <td>1228</td> </tr> <tr> <td>0-5</td> <td>155</td> <td>779</td> </tr> <tr> <td>6-10</td> <td>302</td> <td>259</td> </tr> <tr> <td>11-15</td> <td>530</td> <td>157</td> </tr> <tr> <td>16-20</td> <td>241</td> <td>37</td> </tr> </tbody> </table>		Provided hours	Attended hours	N	1228	1228	0-5	155	779	6-10	302	259	11-15	530	157	16-20	241	37
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		<p>As the table above indicates, the majority of individuals attend 0-5 hours per week. This trend holds across reviews and across all DMH hospitals. Attendance on any given day is a function of many factors including the individual's mental status, physical health, and availability (e.g., attending medical appointments). The Mall Director further pointed out that many individuals are involved in other activities including vocational hours that are not included in Mall attendance. A review of MAPP and WRP data on Mall scheduled and attended hours for six individuals (CA, DC, ES GR, LS and WF) found that mean scheduled was 14.5 hours per week (range of 11-18 hours) and mean attended was five hours per week (range of 1-8 hours).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> 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> <p><b>Findings:</b> ASH did not care for any bed-bound individuals during this review period.</p> <p><b>Current recommendation:</b> 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>

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C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="993 483 1913 751"> <thead> <tr> <th></th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>3852</td> <td>5084</td> <td>4686</td> <td>2951</td> <td>4512</td> <td>4758</td> <td>4307</td> </tr> <tr> <td>Groups cancelled</td> <td>229</td> <td>261</td> <td>219</td> <td>116</td> <td>180</td> <td>192</td> <td>200</td> </tr> <tr> <td>Cancellation rate</td> <td>6%</td> <td>5%</td> <td>5%</td> <td>4%</td> <td>4%</td> <td>4%</td> <td>5%</td> </tr> </tbody> </table> <p>The mean cancellation rate was 5% in the previous review period.</p> <p>According to the Mall Director, the 5% cancellation rate was mainly due to provider non-availability.</p> <p>The facility presented the following data regarding Mall group facilitation by discipline:</p> <table border="1" data-bbox="993 1084 1860 1390"> <thead> <tr> <th colspan="3"><b>Average weekly hours provided by discipline</b></th> </tr> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Psychiatry Admissions (2)</td> <td>1.17</td> <td>1.91</td> </tr> <tr> <td>Psychiatry Long-Term (4)</td> <td>2.11</td> <td>2.80</td> </tr> <tr> <td>Psychology Admissions (5)</td> <td>2.84</td> <td>2.68</td> </tr> <tr> <td>Psychology Long-Term (10)</td> <td>4.59</td> <td>5.52</td> </tr> <tr> <td>Social Work Admissions (5)</td> <td>3.52</td> <td>3.45</td> </tr> </tbody> </table>		9/10	10/10	11/10	12/10	1/11	2/11	Mean	Groups scheduled	3852	5084	4686	2951	4512	4758	4307	Groups cancelled	229	261	219	116	180	192	200	Cancellation rate	6%	5%	5%	4%	4%	4%	5%	<b>Average weekly hours provided by discipline</b>				Previous review period	Current review period	Psychiatry Admissions (2)	1.17	1.91	Psychiatry Long-Term (4)	2.11	2.80	Psychology Admissions (5)	2.84	2.68	Psychology Long-Term (10)	4.59	5.52	Social Work Admissions (5)	3.52	3.45
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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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to improve on current practice and monitor this requirement.</p>																																															

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		<p><b>Findings:</b> The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 302 1879 492"> <thead> <tr> <th></th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>2364</td> <td>2074</td> <td>NA</td> <td>NA</td> <td>2104</td> <td>1817</td> <td>2090</td> </tr> <tr> <td>Hours offered</td> <td>2364</td> <td>2074</td> <td>NA</td> <td>NA</td> <td>2104</td> <td>1817</td> <td>2090</td> </tr> </tbody> </table> <p>Data was not presented for the months of November and December. According to the Supplemental Activity Coordinator, there was a computer systems switch and data was not available for the two months.</p> <p>Staff interviews and documentation review found that ASH has continued to increase the range of activities offered. The facility now offers activities (cultural activities, board games and movies) in Spanish for its Hispanic residents. Activities are also offered on Tuesday and Wednesday nights.</p> <p>One innovative program offered during this review period is the "Program Incentive BINGO". Units that have three or fewer special incident reports or half of the previous month are offered a night of BINGO as special incentive. Individuals with unstable behaviors and those with PBS/behavior guideline plans are excluded from this criterion. Food prizes including soup, candy, coffee mix (different from the brands/types offered in the canteen and the By Choice store) are made available during the BINGO night. One unit (Unit 18) reportedly met criterion for three consecutive months. This is an excellent program to address behaviors at the unit level. Data on behavior change should be collected, analyzed and reviewed for further improvement and refinement of the program. Reportedly, the funding for this special event comes from the operational expenses, patient benefit fund, and canteen profit. According to the By Choice Coordinator, the patient</p>		9/10	10/10	11/10	12/10	1/11	2/11	Mean	Hours scheduled	2364	2074	NA	NA	2104	1817	2090	Hours offered	2364	2074	NA	NA	2104	1817	2090
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		<p>benefit fund is dwindling and the By Choice program could use some additional funds to keep the new program going.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>																														
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the Therapeutic Milieu Observation Monitoring Form, ASH assessed its compliance based on observations of an average sample of 63% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 821 1887 1390"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>95</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td>99</td> </tr> <tr> <td>3.</td> <td><i>There are unit recognition programs.</i></td> <td>96</td> </tr> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>100</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>100</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>100</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>98</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and courteous manner.</i></td> <td>100</td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>100</td> </tr> <tr> <td>10.</td> <td><i>Staff react calmly in an escalating situation.</i></td> <td>100</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	95	2.	<i>Some staff in the milieu are interacting with individuals, not simply observing them.</i>	99	3.	<i>There are unit recognition programs.</i>	96	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	100	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	100	6.	<i>Staff respect confidentiality.</i>	100	7.	<i>Some staff are actively engaged in listening.</i>	98	8.	<i>Staff interact with individuals in a respectful and courteous manner.</i>	100	9.	<i>Staff respect privacy.</i>	100	10.	<i>Staff react calmly in an escalating situation.</i>	100
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		<p>A review of the charts of nine individuals found that seven contained milieu interventions appropriate to the active intervention (BT, EN, GC, MB, PC, RJ and RO). In the remaining two charts, the milieu interventions documented were not aligned with the active interventions (AN and LR).</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility presented the following data:</p> <table border="1" data-bbox="991 821 1887 1088"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>12/10</th> <th>1/11</th> <th>2/11</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>106</td> <td>111</td> <td>111</td> <td>111</td> <td>116</td> <td>114</td> </tr> <tr> <td>Number of groups needed @ 1x/wk</td> <td>100</td> <td>101</td> <td>100</td> <td>101</td> <td>103</td> <td>100</td> </tr> <tr> <td>Offered/needed</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> <td>&gt;100%</td> </tr> </tbody> </table> <p>ASH continues to offer sufficient numbers of exercise groups for individuals to participate both as a recreation and enrichment activity as well as for individuals with objectives and interventions due to high BMIs. Documentation review and interview found that the groups were being monitored for quality.</p> <p>The facility also presented the following data:</p>	Exercise Groups Offered vs. Needed								9/10	10/10	11/10	12/10	1/11	2/11	Number of groups offered	106	111	111	111	116	114	Number of groups needed @ 1x/wk	100	101	100	101	103	100	Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%
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		BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned
		25 - 30	542	454	84%
		31 - 35	303	278	92%
		36 - 40	86	80	93%
		>40	66	63	95%
		<p>ASH continues to assign individuals with high BMIs to exercise groups. However, as the table above shows, not all individuals are being assigned to such groups. In speaking with WRP staff, it was learned that newly admitted individuals are gradually assigned to groups leading up to 20 hours and sometimes they are assigned to exercise groups after a month or two of admission. In addition, some individuals were considered to be too unwell to be in exercise groups, and the team expects to enroll these individuals to exercise groups when their health improves.</p> <p>A review of records of five individuals with high BMIs (CRA, EWS, GR, LCS and PAP) found that all five WRPs had an appropriate focus and interventions to address the individual's weight-related matters through appropriate Mall group assignments, exercise groups, and dietary manipulations.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
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	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>			

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	<p>for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p><b>Findings:</b> Using the DMH C2k Family Therapy Auditing Form, ASH assessed its compliance using the following indicators based on 100% samples of the relevant populations:</p> <table border="1" data-bbox="991 376 1885 971"> <tr> <td data-bbox="991 376 1066 526">1.</td> <td data-bbox="1066 376 1755 526"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1755 376 1885 526">100%</td> </tr> <tr> <td data-bbox="991 526 1066 748">2.</td> <td data-bbox="1066 526 1755 748"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1755 526 1885 748">100%</td> </tr> <tr> <td data-bbox="991 748 1066 971">3.</td> <td data-bbox="1066 748 1755 971"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1755 748 1885 971">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>Documentation review and staff interview found that ASH continues to assess all individuals for family therapy needs and where appropriate provide the necessary services when consent is obtained and the family is willing and able to participate.</p> <p>This monitor reviewed records of five individuals assessed to need family therapy (CRA, DEC, EWS, GR and JAB). All five individuals had been approached by the SW staff for service provision. Two individuals did</p>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	100%	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%
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		<p>not consent to family contact (EWS and GR). The remaining three families were receiving services in some form. For example, the family of one individual did not want contact with the individual but wanted to keep up with the individual's progress and SW staff had been updating the family.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues.</li> <li>• Continue strategies to ensure that WRPs addressing refusals are individualized.</li> </ul> <p><b>Findings:</b> ASH developed and implemented Administrative Directive 55: Assisting Individuals to Adhere to the Plan of Care (Refusals), dated April 12, 2011, which establishes a facility-wide system addressing and tracking non-adherence issues and the documentation contained in the WRPs.</p> <p><b>Recommendation 3, October 2010:</b> Formalize the process for addressing dental refusals into a written policy/procedure to ensure consistency.</p> <p><b>Findings:</b> See cell F.9.e.</p>

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		<p><b>Recommendation 4, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integration of Medical Conditions in WRP Audit, ASH assessed its compliance based on a 11% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 522 1887 901"> <tr> <td>1.</td> <td><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate interventions for each objective.</i></td> <td>96%</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>A review of the WRPs of 41 individuals (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that ASH has continued to make consistent improvements in this area since the last review, resulting in the majority of the WRPs reviewed for Focus 6 including appropriate objectives and interventions. This comports with ASH's data.</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	99%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	98%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	98%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	98%	5.	<i>There are appropriate interventions for each objective.</i>	96%
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as C.2.o.</p> <p><b>Findings:</b> Same as C.2.o.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as C.2.o.</p>

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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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue to provide summaries of process and clinical outcome data regarding delivery of substance use services.</p> <p><b>Recommendation 2, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The following is a summary of ASH's process outcome data:</p> <table border="1" data-bbox="991 634 1887 1390"> <thead> <tr> <th>Process Outcomes</th> <th>July-Sept 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> </tr> </thead> <tbody> <tr> <td>Individuals with Substance Abuse Dx</td> <td>906</td> <td>960</td> <td>924</td> </tr> <tr> <td>Individuals referred for:</td> <td>619</td> <td>539</td> <td>351</td> </tr> <tr> <td>    o SAS treatment</td> <td>276</td> <td>265</td> <td>225</td> </tr> <tr> <td>    o AA groups</td> <td>172</td> <td>136</td> <td>126</td> </tr> <tr> <td>    o NA groups</td> <td>171</td> <td>138</td> <td>126</td> </tr> <tr> <td>Individuals screened by SAS</td> <td>276</td> <td>265</td> <td>225</td> </tr> <tr> <td>Hours of SAS treatment offered per week</td> <td>95.5</td> <td>99.5</td> <td>80.5</td> </tr> <tr> <td>SAS sessions scheduled</td> <td>661</td> <td>955</td> <td>912</td> </tr> <tr> <td>%SAS sessions held</td> <td>100%</td> <td>99%+</td> <td>99%</td> </tr> <tr> <td>Individuals enrolled in SAS treatment</td> <td>777</td> <td>793</td> <td>945</td> </tr> <tr> <td>Individuals enrolled in AA/NA</td> <td>701</td> <td>599</td> <td>600</td> </tr> <tr> <td>Individuals on wait list</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Hours of staff training provided</td> <td>0</td> <td>8</td> <td>2</td> </tr> <tr> <td>Number of staff trained</td> <td>0</td> <td>32</td> <td>12</td> </tr> <tr> <td>Number of staff monitored for</td> <td>7</td> <td>3</td> <td>2</td> </tr> </tbody> </table>	Process Outcomes	July-Sept 2010	Oct-Dec 2010	Jan-Mar 2011	Individuals with Substance Abuse Dx	906	960	924	Individuals referred for:	619	539	351	o SAS treatment	276	265	225	o AA groups	172	136	126	o NA groups	171	138	126	Individuals screened by SAS	276	265	225	Hours of SAS treatment offered per week	95.5	99.5	80.5	SAS sessions scheduled	661	955	912	%SAS sessions held	100%	99%+	99%	Individuals enrolled in SAS treatment	777	793	945	Individuals enrolled in AA/NA	701	599	600	Individuals on wait list	0	0	0	Hours of staff training provided	0	8	2	Number of staff trained	0	32	12	Number of staff monitored for	7	3	2
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		<ul style="list-style-type: none"> <li>• Agree</li> </ul>	93%	91%	94%	
		<ul style="list-style-type: none"> <li>• Disagree</li> </ul>	7%	9%	6%	
		Group Leader Respectful				
		<ul style="list-style-type: none"> <li>• Agree</li> </ul>	96%	91%	95%	
		<ul style="list-style-type: none"> <li>• Disagree</li> </ul>	4%	9%	5%	
		<p><b>Recommendation 2, October 2010:</b> Continue to monitor this requirement.</p>				
		<p><b>Findings:</b> Using the DMH Substance Abuse Auditing Form, ASH assessed its compliance with this requirement based on an average sample of 12% of individuals with a current diagnosis of substance abuse (September 2010 - February 2011):</p>				
		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>	99%		
		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 and/or measurable terms.</i>	96%		
		<p>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><b>Other findings:</b> Same as in C.2.f.iv.</p> <p>In addition, the monitor observed the following three groups that offered substance use education:</p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Contemplation 1 (Contemplation): Mirella Ramos and Chuck Watson, Psychiatric Technicians, facilitators</li> <li>2. PSR Mall Group: Self Discovery (Action): Douglas Erb and Chuck Watson, Psychiatric Technicians, facilitators</li> <li>3. PSR Mall Group: Communication 2 (Action): Trina Robbins and Mirella Ramos, Psychiatric Technicians, facilitators</li> </ol> <p>The group observations found general evidence of adequate instruction including relevance and content of topics, knowledge of the facilitators, use of materials and engagement of the individuals.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide process and clinical outcome data for substance abuse services during the review period.</li> <li>2. Continue to monitor this requirement.</li> </ol>
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation,	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Facilitator Observation Monitoring Form. ASH assessed its compliance based on an average sample of 6% of the clinical</p>

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	<p>and receive regular, competent supervision.</p>	<p>facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 305 1885 532"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>99%</td> <td>98.5%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>98%</td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>99%</td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>100%</td> <td>98%</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 items.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form ASH assessed its compliance based on observation of a 6% sample of all facilitators during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 831 1885 1388"> <tbody> <tr> <td>1.</td> <td><i>Session starts and ends on time.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>Facilitator introduces the day's topic and goals.</i></td> <td>96%</td> </tr> <tr> <td>5.</td> <td><i>Facilitator shows familiarity with lesson plan and materials.</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>Facilitator attempts to engage each participant in the session.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Facilitator attempts to keep all participants "on task" during the session.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Facilitator shows a presentation style that keeps some/all participants attentive and interested.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i></td> <td>98%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	99%	98.5%	2.	<i>Course structure</i>	98%	97%	3.	<i>Instructional techniques</i>	99%	99%	4.	<i>Learning process</i>	100%	98%	1.	<i>Session starts and ends on time.</i>	97%	2.	<i>Facilitator greets participants to begin the session.</i>	99%	3.	<i>There is a brief review of work from prior session.</i>	96%	4.	<i>Facilitator introduces the day's topic and goals.</i>	96%	5.	<i>Facilitator shows familiarity with lesson plan and materials.</i>	97%	6.	<i>Facilitator attempts to engage each participant in the session.</i>	99%	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.</i>	99%	9.	<i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i>	98%
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		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	100%
		11.	<i>At conclusion, the facilitator summarizes the work done in the session.</i>	96%
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	96%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	96%
		14.	<i>Lesson plan is available and followed.</i>	93%
	<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 observed six Mall groups. The Substance Abuse groups (Process of Discovery: Self-Discovery, Action Stage; and Relapse Prevention, Action Stage) were well conducted. Attendance was high. Both the primary and co-providers were active, there was material for handouts and reading, individuals were engaged, and the providers walked around assisting individuals during written tasks. It appears that ASH's Substance Abuse Recovery "specialty provider" model is working well. The providers' knowledge and skills, group management strategies and teaching methodologies were up to standards. The other DMH facilities might want to consider this model for their Mall groups, including where possible for the non-Substance Abuse Recovery groups.</p> <p>The "Coping with Life" group is a new group. The group was well attended and participated in by the individuals, given that the individuals were not looking to be discharged into the community anytime soon, if ever. The facilitator handled the questions well and effectively dealt with the emotional states of the individuals. The facilitator was also the only one</p>			

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		<p>observed to provide social attention and feedback while delivering the By Choice cards to the individuals when the group ended. The General Health group had one participant with two providers (a psychiatrist and a nurse practitioner). The providers were actively engaged with the individual and material pertinent to the individual was discussed. The "Medication Education: Depression Management group" was poorly handled. The primary provider was uninvolved with the group, being seated at the table away from where the individuals were watching a video on depression (the back of the television was facing the primary provider). The co-provider was seated among the individual also watching the video. According to the primary provider, the co-provider was new to the group, but he did not know the name of the co-provider. He further indicated that there never was a stable co-provider in his group.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to provide data regarding the number and certification of SAR providers/co-providers and seek to increase the number of certified providers/co-providers.</p> <p><b>Findings:</b> ASH presented the following data regarding the certification of Substance Abuse facilitators:</p>

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		<table border="1" data-bbox="993 228 1896 380"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>12</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>8</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>67%</td> </tr> </table> <p data-bbox="993 423 1896 711">As the table above shows, two-thirds of ASH's SAR providers are certified, even though all the other non-certified providers were trained in Substance Abuse Recovery through the ASH SAR curriculum. This is an increase from the 50% of certified providers during the last review period. ASH is working to certify all of its SAR providers. According to the Mall Director, the data showed that a greater number of individuals have advanced from the pre-contemplation since certified providers were assigned to the pre-contemplation SAR groups.</p> <p data-bbox="993 755 1896 896">The providers in the two Mall groups observed by this monitor were certified. A review of five records of individuals with Substance Abuse diagnoses (DEC, GR, LCS, PAP and ZDS) found that all five individuals were enrolled in SAR groups.</p> <p data-bbox="993 940 1140 1003"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 1047 1896 1188"><b>Current recommendation:</b> Continue to provide data regarding the number and certification of SAR providers/co-providers and seek to increase the number of certified providers/co-providers.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	12	Number of certified SAR providers/co-providers	8	Percentage of SAR providers/co-providers who are certified	67%
Number of Substance Abuse Recovery (SAR) providers/co-providers	12							
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Percentage of SAR providers/co-providers who are certified	67%							
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p data-bbox="993 1239 1577 1268"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1312 1457 1375"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>						

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		<p><b>Findings:</b>  The facility reported that none of the 768 scheduled medical appointments outside the facility during the review period were cancelled.</p> <p>The facility presented data indicating that 13% of scheduled in-house medical appointments were not fulfilled during the review period. Of those, no cancellations were due to staffing or transportation issues. The primary reason for the cancellations was refusals.</p> <p>The total number of cancellations fell during the review period even though the total number of scheduled appointments had increased from the previous review period. Staff interview and documentation review (AD#553, dated 4/12/11) found that ASH has taken a structural approach to address cancellations. Some of the main policy decisions for cancellations documented in the AD are as follows: Unit/Nursing Staff is expected to document cancellations with reasons, physicians are to document adverse outcomes from the individual's refusal, the WRPTs are to document the information in the Present Status section of the individual's WRP and to open a focus of hospitalization with appropriate objectives and interventions should there be a pattern of refusal and the adverse outcome is moderate to high.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b>  Continue to monitor this requirement.</p>

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	<p>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><b>Findings:</b> 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 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 100%. 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 for 11 individuals found that all 11 had assigned the individuals to meaningful groups in line with their diagnoses, cognitive levels, life-goals, and discharge criteria (CRA, LCS, LR, MAS, MB, PAP, PC, RAM, RJ, RO and WEJ).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>
C.2.t	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 96%. Comparative data indicated that ASH maintained a compliance rate of at least</p>

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		<p>90% from the previous review period.</p> <p>A review of the WRPs for six individuals found that five WRPs met the elements of this requirement (CRA, DEC, EWS, GR and PAP) and one did not (LCS). Most WRPTs now review the objectives and document the progress or lack and changes to the objectives and/or interventions if needed in the Present Status section of the individual's WRP.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																									
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Provide data regarding this requirement (Introduction to Wellness and Recovery for newly admitted individuals). Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.</p> <p><b>Findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="991 1117 1898 1385"> <thead> <tr> <th colspan="5">Individuals in need of WRP Education during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Apr-Jun 2010</th> <th>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>437</td> <td>445</td> <td>435</td> <td>424</td> </tr> <tr> <td>Receiving service</td> <td>430</td> <td>439</td> <td>431</td> <td>418</td> </tr> <tr> <td>% receiving service</td> <td>98%</td> <td>98%</td> <td>99%</td> <td>98%</td> </tr> </tbody> </table>	Individuals in need of WRP Education during the current and previous three Mall terms						Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011	With identified need	437	445	435	424	Receiving service	430	439	431	418	% receiving service	98%	98%	99%	98%
Individuals in need of WRP Education during the current and previous three Mall terms																											
	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011																							
With identified need	437	445	435	424																							
Receiving service	430	439	431	418																							
% receiving service	98%	98%	99%	98%																							

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As the table above shows ASH is serving over 98% of the individuals in need of WRP education. This is a significant improvement from the last review period, in which a mean of 52% of the individuals in need of the education were being served.

WRP Education Scheduled and Attended							
2010/2011	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Sessions scheduled	100	135	122	82	129	111	113
Sessions held	87	126	109	76	111	101	102
% held	87	93	89	93	86	91	90
Individuals scheduled	348	357	335	343	342	332	343
Attending at least 1 grp/mo	148	184	156	131	152	148	153
% attended	43	52	47	38	44	45	45

As the table above indicates, ASH scheduled an average of 113 groups per month, and completed a mean of 90% of the WRP education groups scheduled. However, attendance is low (mean 45%). ASH should work towards improving individuals' attendance at WRP education groups.

This monitor reviewed records of seven individuals and found that six individuals were enrolled in Wellness and Recovery groups (CRA, DEC, EWS, JAB, LCS and PAP) and one was not (GR).

**Compliance:**  
Substantial.

**Current recommendation:**  
Continue to monitor this requirement

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<p>C.2.v</p>	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide data regarding the number of groups scheduled and the percentage held compared to the previous review period.</li> <li>• Provide data regarding the number of individuals in need for medication education, the number scheduled and the number receiving this education.</li> </ul> <p><b>Findings:</b> The following table shows further increase in the number of medication education groups scheduled and held since the previous review period.</p> <table border="1" data-bbox="991 672 1808 826"> <thead> <tr> <th colspan="2">Medication Education Groups Provided Sep 2010 to Feb 2011</th> </tr> </thead> <tbody> <tr> <td>Sessions scheduled</td> <td>333</td> </tr> <tr> <td>Sessions provided</td> <td>300</td> </tr> <tr> <td>%C</td> <td>90%</td> </tr> </tbody> </table> <p>The data regarding the number of individuals needing and receiving medication education groups are outlined below:</p> <table border="1" data-bbox="991 976 1883 1317"> <thead> <tr> <th colspan="4">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>July-Sep 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>658</td> <td>897</td> <td>940</td> </tr> <tr> <td># of individuals scheduled for service</td> <td>656</td> <td>889</td> <td>932</td> </tr> <tr> <td># of individuals receiving service</td> <td>496</td> <td>685</td> <td>743</td> </tr> </tbody> </table> <p><b>Other findings:</b> ASH recently streamlined its Medication Education Assessment tool,</p>	Medication Education Groups Provided Sep 2010 to Feb 2011		Sessions scheduled	333	Sessions provided	300	%C	90%	Individuals Needing and Provided Medication Education Groups					July-Sep 2010	Oct-Dec 2010	Jan-Mar 2011	# of individuals needing service	658	897	940	# of individuals scheduled for service	656	889	932	# of individuals receiving service	496	685	743
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		<p>which is completed by the attending psychiatrists within three to five business days post admission. Review of the revised tool found that the facility has continued to use an adequate system to identify individuals in need of substance use education.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide data regarding the number of groups scheduled and the percentage held compared to the previous review period.</li> <li>2. Continue to provide data regarding the number of individuals in need for medication education, the number scheduled and the number receiving this education.</li> </ol>																																								
C.2.w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor and provide data on all the elements for this requirement.</p> <p><b>Findings:</b> The table below showing the mean census and the mean number of individuals meeting the non-adherence criteria is a summary of the facility's data:</p> <table border="1" data-bbox="991 1154 1885 1421"> <thead> <tr> <th colspan="8">Number of Individuals Non-Adherent to WRP</th> </tr> <tr> <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>Average Monthly Census</td> <td>1156</td> <td>1171</td> <td>1168</td> <td>1166</td> <td>1162</td> <td>1141</td> <td>1161</td> </tr> <tr> <td>Zero Attendance</td> <td>123</td> <td>85</td> <td>118</td> <td>112</td> <td>92</td> <td>109</td> <td>107</td> </tr> <tr> <td>%C</td> <td>10%</td> <td>7%</td> <td>10%</td> <td>9%</td> <td>7%</td> <td>9%</td> <td>9%</td> </tr> </tbody> </table>	Number of Individuals Non-Adherent to WRP									Sep	Oct	Nov	Dec	Jan	Feb	Mean	Average Monthly Census	1156	1171	1168	1166	1162	1141	1161	Zero Attendance	123	85	118	112	92	109	107	%C	10%	7%	10%	9%	7%	9%	9%
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		<p>ASH defines non-adherence as failure to attend any active treatment after having been at the facility for at least 14 days. Based on that definition, as shown in the table above, the mean non-adherence rate is 9% for this review period. This is a significant decrease from a mean of 26% during the previous review period.</p> <p>ASH has put forth good effort to address non-adherence. ASH developed a comprehensive survey instrument and conducted an extensive survey of individuals who were non-adherent to PSR Mall services to identify individual reasons for non-adherence. The individual survey showed that the three main reasons were:</p> <ol style="list-style-type: none"> <li>1. "I do not feel well enough or I am too tired to attend classes" (21%);</li> <li>2. "I do not believe the classes will be of any benefit to me" (17.5%); and</li> <li>3. "The classes are too boring" (14.9%).</li> </ol> <p>However, the data analysis had lumped 46.5% of the responses under "Other". Lumping nearly half of the responses under "Other" is not very helpful for individual or group intervention. There must be ways to cluster the responses to some common categories.</p> <p>The three main reasons staff gave for individuals were not participating in Mall groups were:</p> <ol style="list-style-type: none"> <li>1. "Psychiatric instability" (57.5%);</li> <li>2. "Lack of motivation" (54%); and</li> <li>3. "The individual does not believe he/she has a problem".</li> </ol> <p>Here too the category "lack of motivation" is not very helpful. Lack of motivation is not the underlying reason. Rather it usually is the result of some other phenomenon (e.g. "the group is boring" or "I get anxious in</p>
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		<p>groups," etc). The staff should be given better directions to give a more specific response by answering <u>why</u> the individual is not motivated.</p> <p>ASH has staff submit weekly data on non-adherence to the WRPTs. As of March 2011, ASH has established a four-hour class to certify staff in Motivational Interviewing, so that staff can counsel individuals who are non-adherent to Mall groups. Nine-hundred and thirty of the 1200 staff at the facility had undergone the first day's training, with 918 the second day, 776 the third day, and 426 the fourth day; thus 36% have completed the full course, with the remaining at various stages of training.</p> <p>The facility has used a variety of strategies to address non-adherence including Motivational Interviewing, Narrative Restructuring Therapy (NRT), By Choice modification, modification of the individuals' Mall groups, medication adjustments, and other individual therapies. The facility presented data on 32 individuals who underwent NRT.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p><b>Summary of Progress on Psychiatric Assessments and Diagnoses:</b>            ASH has achieved substantial compliance with the requirement regarding the admission psychiatric assessments and maintained substantial compliance with all other requirements in Section D.1.</p> <p><i>Areas of need include:</i></p> <ol style="list-style-type: none"> <li>1. <i>In order to maintain substantial compliance with all requirements in this section, ASH must improve the documentation of an individualized analysis of the risks and benefits of regular treatment, particularly for individuals who have developed adverse effects of treatment and are at risk of further complications.</i></li> <li>2. <i>Ensure that the inter-unit transfer assessments properly address the plan of care.</i></li> </ol> <p><b>Summary of Progress on Psychological Assessments:</b>            ASH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Nursing Assessments:</b>            ASH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b></p> <ol style="list-style-type: none"> <li>1. ASH has maintained substantial compliance with the requirements of</li> </ol>

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		<p>Section D.4, and should continue to enhance and improve current practice.</p> <ol style="list-style-type: none"><li>2. Current RT focused assessments should be updated to improve their clinical utility and meaningfulness, while ensuring that they continue to meet EP requirements.</li><li>3. ASH has made progress, but should continue work to ensure that individuals are referred for appropriate and timely POST assessments and services through RT participation on risk management committees, interdisciplinary collaboration on risk assessments, POST referral usage, and review of daily SIRs.</li></ol> <p><b>Summary of Progress on Nutrition Assessments:</b> ASH has maintained substantial compliance with all requirements of Section D.5 with the exception of the sub-item of timeliness of lower-acuity annual assessments.</p> <p><b>Summary of Progress on Social History Assessments:</b> ASH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Court Assessments:</b> As of the tour conducted in October 2010, ASH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Joshua Deane, MD, Acting Chief of Psychiatry</li> <li>2. Veronica Quezada, MD, Staff Psychiatrist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 37 individuals: AAA, AMD, AM, AMS, AN, AW, DAP, DEC, DH, EM, EN, FAWR, FN, GC, GBT, JJS, JS, JVW, JWB, KJB, LLH, LMR, MC, MDB, MK, MP, MTG, NG, RCP, RD, RJ, RR, RSO, RWW, SMB, TDB and WLF</li> <li>2. Monthly Psychiatric Progress Note for the following 41 individuals: AA, ADD, AE, AR, AS, BE, BJB, DA, DH, DPT, DS, EM, EO, FA, FAR, FR, GB, HH, HSH, JB, JC-1, JC-2, JF-1, JF-2, JHD, JV, KH, LG, LJ, ME, MR, PC, RC, RG, RM, RS, SE, TG, VO, WC and WWW</li> <li>3. ASH Admission Psychiatric Assessment Audit summary data (September 2010 - February 2011)</li> <li>4. ASH Integrated Psychiatric Assessment Audit summary data (September 2010 - February 2011)</li> <li>5. ASH Monthly PPN Audit summary data (September 2010 - February 2011)</li> <li>6. ASH Weekly Physician Progress Note Audit summary data (September 2010 - February 2011)</li> <li>7. ASH Medical Initial Admission Assessment Audit summary data (September 2010 - February 2011)</li> <li>8. ASH Physician Inter-Unit Transfer Note Audit summary data (September 2010 - February 2011)</li> <li>9. Memorandum from ASH Acting Medical Director (April 20, 2011) regarding reduction of psychiatric working hours during this reporting period</li> </ol>

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<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders (“DSM”) for reaching the most accurate psychiatric diagnoses.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (September 2010 - February 2011). The average samples were 22% of admission assessments, 22% of integrated assessments and 24% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 711 1887 786"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 935 1887 1164"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.</td> <td><i>Psychiatric history, including review of present and past history</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that 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 1313 1887 1421"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.b</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i></td> <td>99%</td> </tr> </tbody> </table>	Admission Assessment			4.	<i>Admission diagnosis is documented</i>	100%	Integrated Assessment			2.	<i>Psychiatric history, including review of present and past history</i>	100%	7.	<i>Diagnostic formulation</i>	100%	8.	<i>Differential diagnosis</i>	100%	9.	<i>Current psychiatric diagnoses</i>	100%	Monthly PPN			3.b	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i>	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 for all items.</p> <p><b>Other findings:</b>            During this review period, ASH began implementation of a new streamlined template for a Comprehensive Psychiatric Assessment that combines the Admission and Integrated Assessments and is to be completed within 24 hours of admission. If properly implemented, the consolidated assessment meets the requirements of the EP for both admission and integrated assessments.</p> <p><b>Compliance:</b>            Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Proceed with full implementation of the Comprehensive Psychiatric Assessment and report monitoring data based on this assessment.</li> </ol>
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b>            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>

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		<p><b>Findings:</b> The facility's report on the number and type of positions is summarized below:</p> <table border="1" data-bbox="991 337 1848 621"> <thead> <tr> <th>FTE Psychiatric positions (filled)</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Direct care</td> <td>60.85</td> <td>53.5</td> </tr> <tr> <td>Total, including supervisory</td> <td>76.79 (including second positions)</td> <td>61.04 (including second positions)</td> </tr> <tr> <td>Board-certified</td> <td>51</td> <td>49</td> </tr> <tr> <td>Board-eligible</td> <td>23</td> <td>21</td> </tr> </tbody> </table> <p>The current configuration of psychiatrists consists of 32.92 contracted and 25.5 civil service FTEs.</p> <p><b>Other findings:</b> The following factors have contributed to the decrease in total psychiatrists' working hours during this review period:</p> <ol style="list-style-type: none"> <li>1. The facility has decreased its need for psychiatry additional hours (second positions) due to the decreased psychiatric turn over during this period. The stability of staffing has improved efficiency in completing work requirements without the use of extra time.</li> <li>2. The number of psychiatrists working exclusively in administrative positions was reduced and these FTEs were redirected to direct care.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to provide data regarding average number of direct care and supervisory FTE psychiatric positions (filled) and number of board-</p>	FTE Psychiatric positions (filled)	Previous Period	Current Period	Direct care	60.85	53.5	Total, including supervisory	76.79 (including second positions)	61.04 (including second positions)	Board-certified	51	49	Board-eligible	23	21
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		certified and board-eligible psychiatrists, with comparisons to the last review period.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide information regarding the number and percentage of all psychiatrists at the facility who have been repriviledged for continued appointment using information from the practitioner quality profile (as one of the tools for reprivileging).</li> <li>• Provide summary of any corrective actions to address group and/or practitioner trends/patterns.</li> </ul> <p><b>Findings:</b> During this review period, all psychiatrists who were scheduled for reprivileging according to the facility's policy (#24) were repriviledged based on criteria including the current practitioner quality profile. The facility did not report corrective actions to address group and/or practitioner trends/patterns.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide information regarding the number (and percentage) of psychiatrists at the facility who have been repriviledged for continued appointment using information from the practitioner quality profile (as one of the tools for reprivileging).</li> <li>2. Continue to provide summary of any corrective actions to address group and/or practitioner trends/patterns, as indicated.</li> </ol>
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.

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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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Admission Medical Assessment Monitoring Form, ASH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.i.5 based on an average sample of 20% of admissions each month during the review period (September 2010 - February 2011). The facility reported a mean compliance rate of 100% with the 24-hour requirement. The compliance rates for the indicators in D.1.c.i.1 to D.1.c.i.5 ranged from 99% (D.1.c.i.1) to 100% (all other cells). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of 13 individuals admitted during the review period found substantial compliance in all cases (AMD, DAP, DEC, EN, FAWR, FN, KJB, LLH, MTG, RD, RSO, RWW and TDB).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	Same as above.
D.1.c.i.2	medical history;	Same as above.
D.1.c.i.3	physical examination;	Same as above.

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D.1.c.i.4	diagnostic impressions; and	Same as above.
D.1.c.i.5	management of acute medical conditions	Same as above.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Implement corrective action to ensure that the admission mental status examinations include specific information regarding abnormalities of thought content.</li> <li>• Continue to monitor this requirement and ensure accuracy of self-assessment data regarding the content of the mental status examination.</li> </ul> <p><b>Findings:</b> Using the DMH Admission Psychiatric Assessment Audit, ASH reported compliance rates of 100% for all the requirements in D.1.c.ii based on an average sample of 22% of admissions each month during the review period (September 2010 - February 2011). The data were based on the admission psychiatric assessments through November 2010 and the comprehensive psychiatric assessments for December 2010 through February 2011. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> As mentioned earlier, during this review period, ASH began implementation of the Comprehensive Psychiatric Assessment (11/22/10). This assessment combines the Admission and Integrated Psychiatric Assessments and is to be completed within 24 hours of admission. If properly implemented, this template meets the requirements in both D.1.c.ii and D.1.c.iii.</p> <p>A review of the charts of eight individuals whose assessments were</p>

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		<p>completed using the older Admission Psychiatric Assessment (AMD, DAP, DEC, EN, FAWR, FN, KJB and RSO) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Fully implement the Comprehensive Psychiatric Assessment and present monitoring data for D.1.c.ii and D.1.c.iii based on the new assessment.</p>
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	Same as above.
D.1.c.ii.2	complete mental status examination;	Same as above.
D.1.c.ii.3	admission diagnoses;	Same as above.
D.1.c.ii.4	completed AIMS;	Same as above.
D.1.c.ii.5	laboratory tests ordered;	Same as above.
D.1.c.ii.6	consultations ordered; and	Same as above.
D.1.c.ii.7	plan of care.	Same as above.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure that the mental status examinations include specific information regarding abnormalities of thought content.</li> </ul>

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		<p><b>Findings:</b></p> <p>Using the DMH Integrated Assessment Psychiatry Section Audit, ASH reported a mean compliance rate of 98% based on an average sample of 22% of Integrated Assessments due each month during the review period (September 2010 - February 2011). Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility reported mean compliance rates of 100% for all of the remaining requirements in D.1.c.iii. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all of these items.</p> <p>The facility's data were based on the integrated assessments through November 2010 and the comprehensive psychiatric assessments for December 2010 through February 2011.</p> <p><b>Other findings:</b></p> <p>This monitor reviewed the charts of eight individuals whose assessments were completed using the older Integrated Psychiatric Assessment (AMD, DAP, DEC, EN, FAWR, FN, KJB and RSO) and five individuals whose assessments were completed using the new Comprehensive Psychiatric Assessments (LLH, MTG, RD, RWW and TDB). The review found substantial compliance in all of the integrated assessments. There was evidence of substantial compliance in two comprehensive assessments (MTG and TDB). The comprehensive assessments of LLH, RD and RWW were in partial compliance due to the discrepancy within the violence risk assessment between the documented circumstances of past violent behavior and the current rating of the degree of risk.</p> <p><b>Compliance:</b> Substantial.</p>
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Section D: Integrated Assessments

		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Fully implement the <i>Comprehensive Psychiatric Assessment</i> and present monitoring data for D.1.c.ii and D.1.c.iii based on the new assessment.</li> <li>2. Ensure that the rating of the violence risk is properly matched to the circumstances of past violence.</li> </ol>
D.1.c.iii.1	psychiatric history, including a review of present and past history;	Same as above.
D.1.c.iii.2	psychosocial history;	Same as above.
D.1.c.iii.3	mental status examination;	Same as above.
D.1.c.iii.4	strengths;	Same as above.
D.1.c.iii.5	psychiatric risk factors;	Same as above.
D.1.c.iii.6	diagnostic formulation;	Same as above.
D.1.c.iii.7	differential diagnosis;	Same as above.
D.1.c.iii.8	current psychiatric diagnoses;	Same as above.
D.1.c.iii.9	psychopharmacology treatment plan; and	Same as above.
D.1.c.iii.10	management of identified risks.	Same as above.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are	<b>Current findings on previous recommendations:</b>

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	<p>discontinued no later than the next review;</p>	<p><b>Recommendation 1, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The following table outlines the educational activities that were provided at ASH during this review period and were relevant to EP requirements in this and other sections (forensic topics are addressed in section D.7).</p> <table border="1" data-bbox="989 487 1900 1424"> <thead> <tr> <th data-bbox="989 487 1142 565">Date</th> <th data-bbox="1142 487 1476 565">Title</th> <th data-bbox="1476 487 1740 565">Speaker/ affiliations</th> <th data-bbox="1740 487 1900 565">MD Attendees</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 565 1142 638">9/7/10</td> <td data-bbox="1142 565 1476 638">ADR Case Presentations: Severe EPS</td> <td data-bbox="1476 565 1740 638">S. Mohaupt, MD, ASH</td> <td data-bbox="1740 565 1900 638">26</td> </tr> <tr> <td data-bbox="989 638 1142 824">9/14/10</td> <td data-bbox="1142 638 1476 824">ADR Case Presentations: Atypical NMS and Angioedema from ACE inhibitor: delayed reaction</td> <td data-bbox="1476 638 1740 824">S. Mohaupt, MD, ASH</td> <td data-bbox="1740 638 1900 824">26</td> </tr> <tr> <td data-bbox="989 824 1142 898">9/22/10</td> <td data-bbox="1142 824 1476 898">Anhedonia in Depression and Schizophrenia</td> <td data-bbox="1476 824 1740 898">K. Challakere, MD, UCLA</td> <td data-bbox="1740 824 1900 898">33</td> </tr> <tr> <td data-bbox="989 898 1142 1011">10/21/10</td> <td data-bbox="1142 898 1476 1011">ADR Neuroleptic Malignant Syndrome: Case Review</td> <td data-bbox="1476 898 1740 1011">S. Mohaupt, MD, ASH</td> <td data-bbox="1740 898 1900 1011">25</td> </tr> <tr> <td data-bbox="989 1011 1142 1084">10/19/10</td> <td data-bbox="1142 1011 1476 1084">Treatment of Aggression-Overview</td> <td data-bbox="1476 1011 1740 1084">K. Challakere, MD, UCLA</td> <td data-bbox="1740 1011 1900 1084">30</td> </tr> <tr> <td data-bbox="989 1084 1142 1198">11/10/10</td> <td data-bbox="1142 1084 1476 1198">Involuntary Medication Basic Elements &amp; Criteria</td> <td data-bbox="1476 1084 1740 1198">D. Fennel, MD, H. Osran, MD and G. Gaines, MD, ASH</td> <td data-bbox="1740 1084 1900 1198">30</td> </tr> <tr> <td data-bbox="989 1198 1142 1271">11/9/10</td> <td data-bbox="1142 1198 1476 1271">Adverse Drug Reaction: Biannual Report</td> <td data-bbox="1476 1198 1740 1271">S. Mohaupt, MD, ASH</td> <td data-bbox="1740 1198 1900 1271">26</td> </tr> <tr> <td data-bbox="989 1271 1142 1344">11/16/10</td> <td data-bbox="1142 1271 1476 1344">Psychogenic Polydipsia and Hyponatremia</td> <td data-bbox="1476 1271 1740 1344">K. Challakere, MD, UCLA</td> <td data-bbox="1740 1271 1900 1344">30</td> </tr> <tr> <td data-bbox="989 1344 1142 1424">11/17/10</td> <td data-bbox="1142 1344 1476 1424">Informed Consent</td> <td data-bbox="1476 1344 1740 1424">S. Mohaupt, MD, ASH</td> <td data-bbox="1740 1344 1900 1424">27</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	MD Attendees	9/7/10	ADR Case Presentations: Severe EPS	S. Mohaupt, MD, ASH	26	9/14/10	ADR Case Presentations: Atypical NMS and Angioedema from ACE inhibitor: delayed reaction	S. Mohaupt, MD, ASH	26	9/22/10	Anhedonia in Depression and Schizophrenia	K. Challakere, MD, UCLA	33	10/21/10	ADR Neuroleptic Malignant Syndrome: Case Review	S. Mohaupt, MD, ASH	25	10/19/10	Treatment of Aggression-Overview	K. Challakere, MD, UCLA	30	11/10/10	Involuntary Medication Basic Elements & Criteria	D. Fennel, MD, H. Osran, MD and G. Gaines, MD, ASH	30	11/9/10	Adverse Drug Reaction: Biannual Report	S. Mohaupt, MD, ASH	26	11/16/10	Psychogenic Polydipsia and Hyponatremia	K. Challakere, MD, UCLA	30	11/17/10	Informed Consent	S. Mohaupt, MD, ASH	27
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		12/7/10	ADR Case Review and Management of Constipation	S. Mohaupt, MD, ASH	19
		12/14/10	ADR Medication Variance review of incomplete orders and Rational Polypharmacy	S. Mohaupt, MD, ASH	21
		12/21/10	Reward System Dynamics: Implications for Pharmacological and Non-Pharmacological Treatment Planning	K Challakere MD (UCLA)	21
		1/4/11	ADR	S. Mohaupt, MD, ASH	22
		1/18/11	ADR	S. Mohaupt, MD, ASH	28
		2/8/11	ADR	S. Mohaupt, MD, ASH	27
		2/22/11	Movement Disorders	K Challakere MD (UCLA)	23
		<p>In addition, the following neuropsychology seminars were provided (MD attendance was limited):</p> <ol style="list-style-type: none"> <li>1. Thalamic Memory Deficits; Report Feedback by C. Mathiesen, PsyD</li> <li>2. Neuroanatomy Review by K. Wild, PhD</li> <li>3. Cognitive Assessment of Psychiatric Patients by C. Duke, PsyD</li> <li>4. Integrity Cog Neuropsych Assessment by L. Bolin, PhD, M. Ono, PhD and C. Mathiesen, PsyD</li> <li>5. Pediatric Neuropsychology by M. Ono, PhD</li> <li>6. Grey Matter Loss in Schizophrenia by L. Bolin, PhD</li> <li>7. Neuroanatomy Review by C. Mathiesen, PsyD</li> <li>8. Clinical Neuropsychology Chapter by C. Duke, PsyD</li> </ol>			

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		<p>9. Neuroanatomy Review by M. Ono, PhD            10. Anatomy Review: Thalamus by K. Wild, PhD            11. Spina Bifida by L. Bolin, PhD            12. Psychology Assessment by C. Duke, PhD            13. Anatomy Review by C. Duke, PhD            14. Pediatric Epilepsy by M Ono, PhD</p> <p>The above programs were comprehensive in range, appropriate in content and well-aligned with the needs of the facility. Psychiatrists are encouraged to attend neuropsychology seminars that are relevant to the understanding and diagnosis of individuals with neuropsychiatric impairments.</p> <p><b>Recommendation 2, October 2010</b>            Ensure timely and adequate follow-up to update diagnosis based on results of neuropsychological testing, as clinically appropriate</p> <p><b>Findings:</b>            ASH reported the comparative number of individuals receiving NOS, Deferred and Rule Out Diagnoses for more than 60 days. At the time of this review, no individuals received NOS diagnoses for more than 60 days of Psychotic Disorder, Mood Disorder, Mental Disorder or Impulse Control Disorder.</p> <p>The data showed that the facility has maintained adequate practice in the finalization of diagnoses as clinically appropriate since the last review. The following is a summary of the data:</p> <table border="1" data-bbox="989 1187 1887 1391"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2">Number of individuals in category</td> </tr> <tr> <td>Rule Out</td> <td>6</td> <td>3</td> </tr> <tr> <td>Deferred</td> <td>4</td> <td>1</td> </tr> <tr> <td>NOS</td> <td>21</td> <td>45</td> </tr> </tbody> </table>	Diagnostic category	Previous Period	Current Period		Number of individuals in category		Rule Out	6	3	Deferred	4	1	NOS	21	45
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		<p><b>Other findings:</b>                  The monitor reviewed the charts of the following 10 individuals who have received diagnoses listed as NOS for three or more months:</p> <table border="1" data-bbox="991 375 1879 797"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>AAA</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>AM</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>AN</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>GC</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>JJS</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>JVW</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>LMR</td> <td>Dementia NOS</td> </tr> <tr> <td>NG</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>RCP</td> <td>Dementia NOS</td> </tr> <tr> <td>RJ</td> <td>Cognitive Disorder NOS</td> </tr> </tbody> </table> <p>The review found substantial compliance in all cases, with evidence that the facility has improved diagnostic updates including timely attention to results of neuropsychological testing.</p> <p><b>Compliance:</b>                  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol>	Initials	Diagnosis (NOS)	AAA	Cognitive Disorder NOS	AM	Cognitive Disorder NOS	AN	Cognitive Disorder NOS	GC	Cognitive Disorder NOS	JJS	Cognitive Disorder NOS	JVW	Cognitive Disorder NOS	LMR	Dementia NOS	NG	Cognitive Disorder NOS	RCP	Dementia NOS	RJ	Cognitive Disorder NOS
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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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Findings:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Findings:</b> Same as in D.1.a and D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification</p>

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		<p>numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.</p> <p><b>Findings:</b> ASH reported that five individuals received "no diagnosis" on Axis I during this review period. These diagnoses were resolved at various intervals during hospital stay for three individuals and on the day of discharge for the fourth individual. One individual continues to receive "no diagnosis" on Axis I and reviews by the facility's Chief of Psychiatry found that the primary diagnosis for this individual was an Axis II disorder.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Weekly Physician Progress Note (PPN) Audit, ASH reported a compliance rate of 100% based on an average sample of 100% of individuals with length of stay less than 60 days during the review period (September 2010 - February 2011). 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>ASH also used the DMH Monthly PPN Audit to assess compliance, reporting a compliance rate of 100% based on an average sample of 24% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> The charts of 13 individuals who were admitted during this reporting period were reviewed (AMD, DAP, DEC, EN, FAWR, FN, KJB, LLH, MTG, RD, RSO, RWW and TDB). The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, there was evidence of substantial compliance in 11 charts and partial compliance in two (DCC and EN). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• In order to maintain substantial compliance, the current DMH template for documentation of the monthly reassessments should be streamlined to improve clinical flow of data and to optimize time spent in documentation. This task must be led by the Medical Directors of all four facilities with direct and adequate input from practitioners.</li> </ul>

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		<p><b>Findings:</b>            ASH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 24% 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><b>Other findings:</b>            This monitor reviewed recent Monthly Psychiatric Progress Notes for the following 41 individuals: AA, ADD, AE, AR, AS, BE, BJB, DA, DH, DPT, DS, EM, EO, FA, FAR, FR, GB, HH, HSH, JB, JC-1, JC-2, JF-1, JF-2, JHD, JV, KH, LG, LJ, ME, MR, PC, RC, RG, RM, RS, SE, TG, VO, WC, and WWW. In general, the review found evidence of substantial compliance with the requirements in this subsection. However, there was general evidence of inadequate documentation of an individualized analysis of the specific risks and benefits of treatment. In one case (ME), the failure to document such analysis can be viewed as an inexplicable delay in the adjustment of regular treatment and thus as a contributing factor to an adverse clinical outcome for the individual.</p> <p>This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period to assess the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The following table outlines the reviews:</p> <table border="1" data-bbox="991 1188 1885 1416"> <thead> <tr> <th>Initials</th> <th>Date of seclusion/restraints</th> <th>PRN/Stat (with date of administration)</th> </tr> </thead> <tbody> <tr> <td>AMS</td> <td>12/15/10</td> <td>Lorazepam (12/8/10) and chlorpromazine and lorazepam (12/12/10)</td> </tr> <tr> <td>AW</td> <td>4/3/11</td> <td>Olanzapine (3/27/11 and 3/25/11)</td> </tr> <tr> <td>GBT</td> <td>3/6/11</td> <td>Olanzapine (PRN:3/3/11 0800 and</td> </tr> </tbody> </table>	Initials	Date of seclusion/restraints	PRN/Stat (with date of administration)	AMS	12/15/10	Lorazepam (12/8/10) and chlorpromazine and lorazepam (12/12/10)	AW	4/3/11	Olanzapine (3/27/11 and 3/25/11)	GBT	3/6/11	Olanzapine (PRN:3/3/11 0800 and
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D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	100%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.												
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.												
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1"> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,</i></td> <td>99%</td> </tr> </table>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines,</i>	99%									
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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 that ASH has maintained a compliance rate of at least 90% from 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"> <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>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>	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>	99%
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>	99%			
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	99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall	96%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.			

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	<p>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>																			
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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 to 3, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• In order to maintain substantial compliance, the facility needs to ensure that all assessments include a plan to ensure continuity of care.</li> <li>• Streamline the template for this assessment to minimize duplication of data with the WRPs. This task should be led by the Medical Directors with direct input from practitioners.</li> </ul> <p><b>Findings:</b> ASH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 33% of the individuals who experienced inter-unit transfer per month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1190 1890 1421"> <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>99%</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>	1.	<i>Psychiatric course of hospitalization,</i>	100%	2.	<i>Medical course of hospitalization,</i>	100%	3.	<i>Current target symptoms,</i>	99%	4.	<i>Psychiatric risk assessment,</i>	100%	5.	<i>Current barriers to discharge,</i>	100%	6.	<i>Anticipated benefits of transfer.</i>	100%
1.	<i>Psychiatric course of hospitalization,</i>	100%																		
2.	<i>Medical course of hospitalization,</i>	100%																		
3.	<i>Current target symptoms,</i>	99%																		
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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		<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><b>Other findings:</b> The following table outlines chart reviews by the monitor of eight individuals who experienced inter-unit transfers during the review period:</p> <table border="1" data-bbox="991 488 1476 834"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>DH</td> <td>2/28/11</td> </tr> <tr> <td>EM</td> <td>2/10/11</td> </tr> <tr> <td>JS</td> <td>2/11/11</td> </tr> <tr> <td>JWB</td> <td>11/8/10</td> </tr> <tr> <td>MC</td> <td>2/23/11</td> </tr> <tr> <td>MDB</td> <td>2/24/11</td> </tr> <tr> <td>MK</td> <td>3/8/11</td> </tr> <tr> <td>RR</td> <td>2/10/11</td> </tr> </tbody> </table> <p>This review found substantial compliance in six charts (DH, EM, JS, MC, MDB and MK) and partial compliance in the charts of JWB (inadequate description of hospital course and no plan of care) and RR (no specifics of target symptoms).</p> <p>In April 2011, the facility modified its template for inter-unit transfer assessments. Based on limited reviews, the monitor found general evidence of adequate implementation of this template. However, the assessments reviewed did not properly address the plan of care section of the assessment. This is a significant shortcoming that needs to be corrected prior to full implementation.</p> <p><b>Compliance:</b> Substantial.</p>	Initials	Date of transfer	DH	2/28/11	EM	2/10/11	JS	2/11/11	JWB	11/8/10	MC	2/23/11	MDB	2/24/11	MK	3/8/11	RR	2/10/11
Initials	Date of transfer																			
DH	2/28/11																			
EM	2/10/11																			
JS	2/11/11																			
JWB	11/8/10																			
MC	2/23/11																			
MDB	2/24/11																			
MK	3/8/11																			
RR	2/10/11																			

Section D: Integrated Assessments

		<b>Current recommendation:</b> Continue to monitor this requirement.
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2. Psychological Assessments	
	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charles Broderick, PhD, DMH HOM Team Psychology Expert</li> <li>2. Charlie Joslin, Clinical Administrator</li> <li>3. Christine Mathiesen, PhD, C-PAS Director</li> <li>4. Diane Imrem, PsyD, Chief of Psychology</li> <li>5. Donna Nelson, Director, Standards Compliance Department</li> <li>6. Jessica Mosich, PhD, Senior Psychologist Supervisor</li> <li>7. Teresa M. George, PhD, Senior Psychologist Supervisor</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following 50 individuals: AB, AS, AVM, BNP, DBP, DC, DDP, DFW, DIB, DR, DWB, ERS, FB, GR, JAB, JCK, JJ, JLD, JML, JMR, JRA, JS, JVW, KJC, KQ, LS, MA, MB, MCB, MD, MVB, MW, OCG, OM, PC, PLD, QJAJ, RC, RD, RE, RH, RM, RP, SG, SJL, TDB, TEC, VV, WLF and ZA</li> <li>2. Psychology Assessment Monitoring Form summary data, September 2010 - February 2011</li> <li>3. List of individuals under 23 years of age during this review period</li> <li>4. List of Neuropsychology referrals</li> <li>5. List of individuals whose primary language is not English (September 2010 through February 2011)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit 11) for quarterly review of MAS</li> <li>2. WRPC (Program I, unit 26) for monthly review of WEJ</li> <li>3. WRPC (Program III, unit 17) for quarterly review of CRA</li> <li>4. Mall Group: Substance Abuse Recovery, Contemplation stage</li> <li>5. Mall Group: Substance Abuse Recovery, Relapse Prevention, Preparation/Action stage</li> <li>6. Mall Group: Substance Abuse Recovery, Relapse Prevention, Action</li> </ol>

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		<p>Stage</p> <p>7. Mall Group: Coping with Life Sentence</p> <p>8. Mall Group: Medication Education: Depression Management:</p> <p>9. Mall Group: General Health</p>
D.2.a	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility did not produce any new tools during this review period. The existing tools were deemed adequate to conduct comprehensive psychological assessments.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.2.b	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> This monitor's documentation review found that ASH cared for a total of 11 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 a 100% sample of individuals below 23 years of age</p>

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		<p>during this review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 264 1887 526"> <tr> <td data-bbox="993 264 1087 526">1.</td> <td data-bbox="1087 264 1793 526"><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., 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></td> <td data-bbox="1793 264 1887 526">100%</td> </tr> </table> <p>ASH's compliance rate was 100% in the previous review period.</p> <p>A review of the charts of six individuals under 23 years of age (AS, DC, ERS, JCK, SJL and TDB) found that the facility had addressed the requirements for eligibility and completion of the necessary assessments for all six individuals. Two of the individuals (JCK and TDB) were high school graduates and did not require further assessment. Assessments for the remaining four had been completed in a timely manner, as evidenced by the documents shown by the senior psychologists in charge of this section. However, the reports and documents were not in the charts of two individuals (ERS and SJL).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	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., 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>	100%
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., 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>	100%			
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue current practice.</p>			

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**Findings:**

The following table describes ASH's psychology staffing pattern as of March 29, 2011:

	Filled positions	Vacant positions
Unit psychologist	48	6
Senior psychologist	5	0
Neuropsychologist	4	0

The facility had hired seven new psychologists during this review period. There are expected to be more vacancies in the coming months due to a number of staff slated to retire and a number of staff taking maternity leave.

**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:

1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	81
1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	81
2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	24
2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	24

**Compliance:**

Substantial.

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		<p><b>Current recommendation:</b> Continue to monitor this requirement</p>			
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p><b>Compliance:</b> Substantial.</p>			
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="991 896 1887 972"> <tr> <td>3.</td> <td><i>Expressly state the clinical question(s) for the assessment.</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> <p>A review of the Focused Psychology Assessments for 10 individuals found that all ten contained clear and concise statements with a rationale for the referral (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	99%
3.	<i>Expressly state the clinical question(s) for the assessment.</i>	99%			

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D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">4.</td> <td data-bbox="1087 597 1793 711"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 597 1887 711">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 10 individuals found that all 10 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 (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="993 414 1887 527"> <tr> <td data-bbox="993 414 1087 527">5.</td> <td data-bbox="1087 414 1793 527"><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td data-bbox="1793 414 1887 527">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 10 individuals found that all 10 indicated if the individual would benefit from individual and/or group therapy (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%
5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	100%			
D.2.d.iv	be based on current, accurate, and complete data;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="993 1339 1887 1388"> <tr> <td data-bbox="993 1339 1087 1388">6.</td> <td data-bbox="1087 1339 1793 1388"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 1339 1887 1388">100%</td> </tr> </table>	6.	<i>Be based on current, accurate, and complete data.</i>	100%
6.	<i>Be based on current, accurate, and complete data.</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 Focused Psychology Assessments for 10 individuals found that all 10 included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.d.v	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="991 1044 1887 1193"> <tr> <td data-bbox="991 1044 1087 1193">7.</td> <td data-bbox="1087 1044 1793 1193"><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 1044 1887 1193">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 10 individuals found that all 10 indicated whether the individual would benefit from behavioral</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%			

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		<p>guidelines or required Positive Behavioral Support (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.d.vi	include the implications of the findings for interventions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="991 821 1887 898"> <tr> <td data-bbox="991 821 1087 898">8.</td> <td data-bbox="1087 821 1793 898"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 821 1887 898">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 10 individuals found that all 10 contained documentation of the implications of the findings for PSR mall groups and other interventions (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC). The quality of the assessments with appropriate PSR and therapy recommendations has improved significantly.</p> <p><b>Current recommendation:</b> 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%			

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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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1887 784"> <tr> <td data-bbox="991 597 1081 784">9.</td> <td data-bbox="1081 597 1793 784"><i>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.</i></td> <td data-bbox="1793 597 1887 784">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 10 individuals found that all 10 contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>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.</i>	100%
9.	<i>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.</i>	100%			
D.2.d.viii	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> 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 2010 - February 2011):</p> <table border="1" data-bbox="993 415 1887 565"> <tr> <td data-bbox="993 415 1087 565">10.</td> <td data-bbox="1087 415 1793 565"><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="1793 415 1887 565">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 10 individuals found that all 10 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 (AB, DC, JJ, JS, MA, PLD, RC, RH, SG and TEC).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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%
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%			
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	<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><b>Compliance:</b> Substantial.</p>			

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D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	<p><b>Compliance:</b> Substantial.</p>			
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 34% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1044 1887 1156"> <tr> <td data-bbox="991 1044 1087 1156">12.</td> <td data-bbox="1087 1044 1793 1156"><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 1044 1887 1156">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 15 individuals found that all 15 were conducted in a timely manner (BNP, DBP, DFW, DIB, DWB, GR, JAB, JLD, JML, KJC, MCB, MVB, QJAJ, WLF and ZA).</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%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (September 2010 - February 2011):</p> <table border="1"> <tr> <td>13.</td> <td><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</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> <p>A review of the IAPs for 15 individuals found that all 15 documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (BNP, DBP, DFW, DIB, DWB, GR, JAB, JLD, JML, KJC, MCB, MVB, QJAJ, WLF and ZA).</p> <p><b>Current recommendation:</b> 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	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service</p>	<p><b>Current findings on previous recommendations:</b></p>			

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	<p>planning process;</p>	<p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 21% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 524 1887 638"> <tr> <td data-bbox="993 524 1087 638">14.</td> <td data-bbox="1087 524 1793 638"><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 524 1887 638">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 IAPs for 15 individuals found that all 15 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 (BNP, DBP, DFW, DIB, DWB, GR, JAB, JLD, JML, KJC, MCB, MVB, QJAJ, WLF and ZA).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	98%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	98%			
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue practice in place as of April 2010.</p> <p><b>Findings:</b> ASH continues to ensure that behavioral interventions are developed and</p>			

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		<p>implemented using data derived from structural and functional assessments. All behavioral intervention plans reviewed indicated that the hypotheses and functions of the target behaviors were developed following the completion of structural and functional assessments.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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) with differential diagnoses due each month during the review period (September 2010 - February 2011). 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 1003 1887 1198"> <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.</p> <p>This monitor reviewed the charts of 11 individuals whose diagnoses needed clarification due to insufficient information to form a firm</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%															

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		<p>diagnosis. The review found that all of the Integrated Assessments in the charts (10) had requested and/or conducted additional psychological assessments (DDP, DR, JRA, JVW, LS, MB, MD, PC, RE and RP) to clarify the diagnoses. One individual (RM) continues to refuse to participate in the assessment, and the examiner continues to approach the individual to complete the assessment. Diagnostic clarifications were arrived at through DSM checklist, Neuropsychological assessments, record reviews, and interviews.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>															
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, June 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported the following data from the DMH Psychology Assessment Monitoring Form for the period September 2010 - February 2011:</p> <table border="1" data-bbox="991 1008 1892 1421"> <tr> <td data-bbox="991 1008 1087 1117">21.a</td> <td data-bbox="1087 1008 1793 1117"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 1008 1892 1117">36</td> </tr> <tr> <td data-bbox="991 1117 1087 1192">21.b</td> <td data-bbox="1087 1117 1793 1192"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 1117 1892 1192">27</td> </tr> <tr> <td data-bbox="991 1192 1087 1266">22.a</td> <td data-bbox="1087 1192 1793 1266"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 1192 1892 1266">9</td> </tr> <tr> <td data-bbox="991 1266 1087 1382">22.b</td> <td data-bbox="1087 1266 1793 1382"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i></td> <td data-bbox="1793 1266 1892 1382">9</td> </tr> <tr> <td data-bbox="991 1382 1087 1421">23.</td> <td data-bbox="1087 1382 1793 1421"><i>Of those in 22.b, number of individuals</i></td> <td data-bbox="1793 1382 1892 1421">9</td> </tr> </table>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	36	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	27	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	9	22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	9	23.	<i>Of those in 22.b, number of individuals</i>	9
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	36															
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	27															
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22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	9															
23.	<i>Of those in 22.b, number of individuals</i>	9															

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		<table border="1" data-bbox="991 191 1887 266"> <tr> <td data-bbox="991 191 1087 266"></td> <td data-bbox="1087 191 1793 266" style="text-align: center;"><i>whose plans for assessment were implemented</i></td> <td data-bbox="1793 191 1887 266"></td> </tr> </table> <p>The overall compliance rate was 100% for the review period.</p> <p>A review of ASH's database on tracking, monitoring, and assessing individuals whose primary language is not English found that the senior psychologist in charge of this section has done a good job of ensuring that individuals with language issues are properly tracked from appropriate sources of information and followed up with the examining psychologist for completion of the assessments in a timely manner.</p> <p>A review of the charts of 10 individuals found that nine assessments in the charts were completed in the individual's primary language by bilingual examiners or with the use of interpreters (AVM, FB, JMR, JRA, KQ, MW, OM, RD and VV). One individual (OCG) was had indicated that Spanish was the preferred language (even though English had been checked off in the form). The interview had been conducted in English without documentation of the proficiency of the individual in English and the validity of the assessment.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>whose plans for assessment were implemented</i>	
	<i>whose plans for assessment were implemented</i>				

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3. Nursing Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donna Hunt, RN, HSS</li> <li>2. Megan Emrich, RN, HSS, Acting Assistant Nurse Administrator</li> <li>3. Rosemary Morrison, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH Nursing Admission Assessment Monitoring Audit summary data, September 2010 - February 2011</li> <li>2. ASH Nursing Integrated Assessment Monitoring Audit summary data, September 2010 - February 2011</li> <li>3. ASH training rosters</li> <li>4. Admission and integrated assessments and WRPs for the following 41 individuals: AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC, MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT</li> </ol>
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><b>Compliance:</b> Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each</p>

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		<p>month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 98%. 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 41 individuals (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that that ASH has maintained the exceptional quality of the assessments and all 41 were found to be in substantial compliance. These findings comport with ASH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 100% sample of admissions each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 820 1887 971"> <tr> <td data-bbox="991 820 1087 971">1.</td> <td data-bbox="1087 820 1793 971"><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 820 1887 971">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 Integrated Nursing Assessments for 41 individuals (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that ASH had maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings comport with ASH's data. Beginning in May 2011, the facility will be using the Comprehensive Nursing Assessment tool in place of the Integrated Nursing Assessment</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>	100%
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>	100%			

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		<p>tool.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>2.</td> <td><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>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>2.</td> <td><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>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 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 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 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> <p>ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>						

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		<p>90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 97%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.iv	allergies;	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.v	pain;	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.ix	conditions needing immediate nursing interventions.	<p><u>Admission Assessments</u>            ASH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u>            ASH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>

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		90% from the previous review period.
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> 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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH's training rosters verified that all of the existing RNs and PTs that were required to complete competency-based training regarding Nursing Assessments completed and passed the training and all had current California licenses. Of 17 newly hired RNs, 16 completed the required training.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue current practice.</p>
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 100% mean sample of admissions each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 98%. 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 (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that that all were timely completed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>D.3.d.ii</p>	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 100% mean sample of admissions each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 93%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 41 individuals (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that 40 were timely completed and one was not (JHF). .</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>D.3.d.iii</p>	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on a mean sample of 10% of WRPCs observed each</p>

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		<p>month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 264 1915 418"> <thead> <tr> <th data-bbox="991 264 1610 342"></th> <th data-bbox="1610 264 1761 342">Previous period</th> <th data-bbox="1761 264 1915 342">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 342 1610 378"><i>Registered Nurse attendance at WRPC</i></td> <td data-bbox="1610 342 1761 378">100%</td> <td data-bbox="1761 342 1915 378">97%</td> </tr> <tr> <td data-bbox="991 378 1610 418"><i>Psychiatric Technician attendance at WRPC</i></td> <td data-bbox="1610 378 1761 418">88%</td> <td data-bbox="1761 378 1915 418">79%</td> </tr> </tbody> </table> <p data-bbox="991 459 1915 527">Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 568 1915 747">A review of the charts of 41 individuals (AR, BER, BGC, BM, BNP, BPN, CBD, CLC, DBP, DDB, DFW, DLL, DLR, GMB, GR, JAB, JAH, JED, JHF, JLD, JRA, KRI, LE, LRS, MC,MSG, RC, RE, RH, RKH, RLS, RR, RUC, RW, SDF, TR, TSR, WLF, WLF, WLW and WPT) found that in 39 cases an RN attended the WRPC and in 37 cases a PT attended the WRPC.</p> <p data-bbox="991 792 1140 860"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 906 1457 974"><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	100%	97%	<i>Psychiatric Technician attendance at WRPC</i>	88%	79%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	100%	97%									
<i>Psychiatric Technician attendance at WRPC</i>	88%	79%									

4. Rehabilitation Therapy Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Kathy Runge, Occupational Therapist</li> <li>2. Ladonna Decou, Chief of Rehabilitation</li> <li>3. Rachelle Rianda, Acting Senior Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. List of individuals who had IA:RTS assessments from September 2010 - February 2011</li> <li>2. Records of the following 12 individuals who had IA:RTS assessments from September 2010 - February 2011: AG, AW, GDH, HAS, JO, LMR, NDL, NLG, RP, SDF, TSC and WK</li> <li>3. List of individuals who had Occupational Therapy assessments from September 2010 - February 2011</li> <li>4. Records of the following seven individuals who had Occupational Therapy assessments from September 2010 - February 2011: ADH, AM, IH, JD, JMO, RAM and WK</li> <li>5. List of individuals who had Physical Therapy assessments from September 2010 - February 2011</li> <li>6. Records of the following five individuals who had Physical Therapy assessments from September 2010 - February 2011: BTH, BWB, EBS, TLA and WC</li> <li>7. List of individuals who had Speech Therapy assessments from September 2010 - February 2011</li> <li>8. Records of the following six individuals who had Speech Therapy assessments from September 2010 - February 2011: DR, GI, JM, MMR, RV and TMP</li> <li>9. List of individuals who had Vocational Rehabilitation assessments from September 2010 - February 2011</li> <li>10. Records of the following 10 individuals who had Vocational Rehabilitation assessments from September 2010 - February 2011:</li> </ol>

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		<p>BB, CEM, EBS, GI, JMF, LB, MGD, SDM, WMH and WPP</p> <p>11. List of individuals who had CIPRTA assessments from September 2010 - February 2011</p>
<p>D.4.a</p>	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Review of revised IA:RTS found that the new format supported continued comprehensive findings yet in a more concise and clinically useful structure. Focused assessment tools should be revised, updated, and streamlined based on review and analysis of audit data, clinician recommendations for improving clinical utility, and changes in systemic needs and evolving standards of practice.</p> <p>Supervising Rehabilitation Therapists currently attend weekly PRC meetings as well as FRC meetings, and an occupational therapist reviews daily SIR reports. These efforts will facilitate timely identification of need for POST focused assessments due to triggers, change in function, or change in high-risk status. In addition, an occupational therapist has collaborated with HSS staff and the Director of Nursing as part of the Fall Review Committee in order to make revisions to the current fall risk assessment that will trigger a referral for OT or PT focused assessment if an individual has difficulties with gait, balance and ambulation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>

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<p>D.4.b</p>	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness (seven calendar days from admission) based on an average sample of 13% of IA:RTSs due each month for the review period September 2010 - February 2011 (total of 86 out of 688) and reported a mean compliance rate of 100%. 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 12 individuals to assess compliance of IA:RTSs with timeliness found 11 records in compliance (AG, AW, GDH, HAS, JO, LMR, NDL, NLG, RP, SDF and WK) and one record not in compliance (TSC).</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness (fourteen days from referral) based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 23) and reported a mean compliance rate of 100%. 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 to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness (14 days from referral)</p>
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		<p>based on an average sample of 50% of Physical Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 66 out of 131) and reported a mean compliance rate of 100%. 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 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 (14 days from referral) based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 24) and reported a mean compliance rate of 100%. 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 to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness (30 days from referral) based on an average sample of 23% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2010 - February 2011 (total of 63 out of 280) and reported a mean compliance rate of 100%. 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 10 individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all</p>
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		<p>records in compliance.</p> <p>ASH reported that no individuals were referred for CIPRTA assessments during the review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 13% of IA:RTSs due each month for the review period September 2010 - February 2011 (total of 86 out of 703) and reported a mean compliance rate of 100%. 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 12 individuals to assess compliance of IA:RTSs with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, 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 2010 - February 2011 (total of 23) and reported a mean compliance rate of 100%. Comparative</p>

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		<p>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 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 50% of Physical Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 66 out of 131) and reported a mean compliance rate of 100%. 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 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 2010 - February 2011 (total of 24) and reported a mean compliance rate of 100%. 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 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</p>
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		<p>average sample of 23% of Vocational Rehabilitation Focused Assessments due each month for the review period September 2010 - February 2011 (total of 63 out of 280) and reported a mean compliance rate of 100%. 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 10 individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>ASH reported that no individuals were referred for CIPRTA assessments during the review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 13% of IA:RTSs due each month for the review period September 2010 - February 2011 (total of 86 out of 703):</p> <table border="1" data-bbox="989 1300 1892 1409"> <tr> <td data-bbox="989 1300 1087 1377">3.</td> <td data-bbox="1087 1300 1793 1377"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1300 1892 1377">100%</td> </tr> <tr> <td data-bbox="989 1377 1087 1409">4.</td> <td data-bbox="1087 1377 1793 1409"><i>The skills and supports needed to facilitate transfer</i></td> <td data-bbox="1793 1377 1892 1409">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%						
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		<table border="1" data-bbox="989 191 1892 232"> <tr> <td data-bbox="989 191 1087 232"></td> <td data-bbox="1087 191 1793 232"><i>to the next level of care;</i></td> <td data-bbox="1793 191 1892 232"></td> </tr> </table> <p data-bbox="989 272 1892 342">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p data-bbox="989 383 1892 453">A review of the records of 12 individuals to assess compliance of IA:RTSs with D.4.b.ii criteria found all records in substantial compliance.</p> <p data-bbox="989 493 1892 675">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 2010 - February 2011 (total of 23):</p> <table border="1" data-bbox="989 711 1892 862"> <tr> <td data-bbox="989 711 1087 786">3.</td> <td data-bbox="1087 711 1793 786"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 711 1892 786">100%</td> </tr> <tr> <td data-bbox="989 786 1087 862">4.</td> <td data-bbox="1087 786 1793 862"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 786 1892 862">100%</td> </tr> </table> <p data-bbox="989 902 1892 972">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p data-bbox="989 1013 1892 1118">A review of the records of seven individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p data-bbox="989 1159 1892 1341">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 50% of Physical Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 66 out of 131):</p> <table border="1" data-bbox="989 1377 1892 1417"> <tr> <td data-bbox="989 1377 1087 1417">3.</td> <td data-bbox="1087 1377 1793 1417"><i>Identifies the individual's current functional status,</i></td> <td data-bbox="1793 1377 1892 1417">100%</td> </tr> </table>		<i>to the next level of care;</i>		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,</i>	100%
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3.	<i>Identifies the individual's current functional status, and</i>	100%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%						
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p data-bbox="991 1013 1577 1044"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1084 1457 1153"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1193 1906 1377"><b>Findings:</b> 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 13% of IA:RTSs due each month for the review period September 2010 - February 2011 (total of 86 out of 688):</p>						

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		<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>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 for all three items.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTSs with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, 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 2010 - February 2011 (total of 23):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <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 for all three items.</p> <p>A review of the records of seven 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 50% of Physical Therapy Focused Assessments due each month for the review period September 2010 - February 2011 (total of 66 out of 131):</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>	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 data-bbox="993 943 1577 976"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1021 1457 1086"><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p data-bbox="993 1131 1839 1310"><b>Findings:</b> The facility reported that five out of five Rehabilitation Therapists and/or RT interns requiring training were trained on the IA:RTS on 10/04/10, 11/29/10 and 2/06/11. One (out of one) Rehabilitation Therapist requiring training on the V-RAT was trained on 11/04/10.</p> <p data-bbox="993 1356 1140 1421"><b>Compliance:</b> Substantial.</p>									

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue to enhance current practice.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of the April 2009 tour.</p> <p><b>Compliance:</b> 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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Dawn Hartman, Assistant Director of Dietetics</li> <li>2. Erin Dengate, Assistant Director of Dietetics</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Nutrition Care Monitoring audit data for September 2010 - February 2011 for each assessment type</li> <li>2. Lists of individuals with Nutrition Care Assessments due from September 2010 - February 2011 for each assessment type</li> <li>3. Records of the following two individuals with type D.5.a assessments from September 2010 - February 2011: DMH and GDH</li> <li>4. Records of the following two individuals with type D.5.b assessments from September 2010 - February 2011: KJF and TL</li> <li>5. Records of the following six individuals with type D.5.d assessments from September 2010 - February 2011: AA, AY, CET, DDD, MBB and MC</li> <li>6. Records of the following four individuals with type D.5.e assessments from September 2010 - February 2011: AAG, KQ, RFH and WMH</li> <li>7. Records of the following four individuals with type D.5.f assessments from September 2010 - February 2011: FA, LG, NER and RC</li> <li>8. Records of the following six individuals with type D.5.g assessments from September 2010 - February 2011: IM, JC, JSL-E, LRS, PR and ZME</li> <li>9. Records of the following six individuals with type D.5.i assessments from September 2010 - February 2011: DC, DH, JAD, RLC, SM and WKK</li> <li>10. Records of the following six individuals with type D.5.j.i assessments from September 2010 - February 2011: DDC, KH, LJ, MA, ME and RJS</li> <li>11. Records of the following five individuals with type D.5.j.ii</li> </ol>

Section D: Integrated Assessments

		assessments from September 2010 - February 2011: BMO, DN, JW, MJC and SDH																																				
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011 (total of six):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	100%
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			<i>date of next review. Include NST in comment</i>													
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		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 items that were not N/A in either period except items 1 and 15 (item 9 was N/A in the previous period as well). Compliance for items 1 and 15 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>1.</td> <td>50%</td> <td>100%</td> </tr> <tr> <td>15.</td> <td>50%</td> <td>100%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	50%	100%	15.	50%	100%
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		<p>A review of the records of two individuals to assess compliance with Nutrition type D.5.a criteria found both records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>														

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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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011 (total of three):</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>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and 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>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and 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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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	<p data-bbox="991 1167 1577 1198"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1242 1457 1310"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1354 1803 1414"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its</p>															

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	<p>comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>compliance based on an average sample of 43% of Nutrition Type D.5.d assessments due each month for the review period September 2010 - February 2011 (total of 60 out of 139):</p> <table border="1"> <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>98%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>98%</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>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>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>N/A</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>98%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>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>	98%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	98%	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>	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>	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>	N/A	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	98%	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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Section D: Integrated Assessments

<p>D.5.f</p>	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> 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 2010 - February 2011 (total of 31):</p> <table border="1" data-bbox="989 597 1885 1422"> <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>93%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and 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>	100%	2.	<i>All required subjective concerns are addressed</i>	93%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

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D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p data-bbox="993 946 1577 979"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1019 1455 1084"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1133 1864 1312"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 12% of Nutrition Type D.5.g assessments due each month for the review period September 2010 - February 2011 (total of 60 out of 502):</p> <table border="1" data-bbox="993 1349 1885 1416"> <tr> <td data-bbox="993 1349 1087 1390">1.</td> <td data-bbox="1087 1349 1793 1390"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1349 1885 1390">100%</td> </tr> <tr> <td data-bbox="993 1390 1087 1416">2.</td> <td data-bbox="1087 1390 1793 1416"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1390 1885 1416">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%									
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Section D: Integrated Assessments

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Section D: Integrated Assessments

		<p>Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.5.h	<p>Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 20% of Nutrition assessments (all types) due each month of the review period September 2010 - February 2011 (349 out of 1748). The facility reports that a weighted mean of 99% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 41 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST.</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>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><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 10% of Nutrition Type D.5.i assessments due each month for the review period September 2010 - February 2011 (total of 64 out of 638):</p> <table border="1" data-bbox="991 524 1892 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>78%</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>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>	78%	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>	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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D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p data-bbox="993 950 1577 982"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1026 1455 1091"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1135 1892 1313"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 35% of Nutrition Type D.5.j.i assessments due each month for the review period September 2010 - February 2011 (total of 60 out of 173):</p> <table border="1" data-bbox="993 1349 1892 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>90%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	90%	2.	<i>All required subjective concerns are addressed</i>	100%									
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D.5.j.ii	Every individual will be assessed annually.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 24% of Nutrition Type D.5.j.ii assessments due each month for the review period September 2010 - February 2011 (total of 60 out of 250):</p> <table border="1" data-bbox="991 894 1892 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>53%</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>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> </table>	1.	<i>Assessment is completed on time per policy</i>	53%	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>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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		<table border="1"> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>98%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table>	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	98%	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 items that were not N/A in either period except item 1, which was 27% in the previous period.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
9.	<i>Progress is monitored, measured, and evaluated</i>	100%																															
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%																															
11.	<i>Recommendations are appropriate and complete</i>	100%																															
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%																															
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%																															
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A																															
15.	<i>Assessment utilizes approved abbreviations</i>	98%																															
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17.	<i>Assessment is legible</i>	100%																															
18.	<i>Each page of the assessment is signed</i>	100%																															

Section D: Integrated Assessments

6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Amy Lee Consolati, LCSW, Acting Supervising Social Worker</li> <li>2. Charles Broderick, PhD, DMH HOM Team Psychology Expert</li> <li>3. Donna Nelson, Director, Standards Compliance Department</li> <li>4. Janet Bouffard, LCSW, Chief of Social Work</li> <li>5. Ramiro Zeron, LCSW, Acting Supervising Social Worker</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following eight individuals: DAS, DFW, JA, JL, ML, MW, RC and WLF</li> <li>2. DMH Integrated Assessments: Social Work Section</li> <li>3. DMH 30-Day Psychosocial Assessments</li> <li>4. ASH's Social History Progress Report for this review period</li> <li>5. Family Therapy Assessment data</li> </ol>									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 13% of the Integrated Assessments: Social Work Section due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 1268 1892 1416"> <tbody> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate</i></td> <td style="width: 15%;">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 least the minimum information required in the</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%									
2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the</i>	100%									

Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1890 267"> <tr> <td data-bbox="993 191 1087 267"></td> <td data-bbox="1087 191 1795 267"><i>instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1795 191 1890 267"></td> </tr> </table> <p data-bbox="993 310 1890 378">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="993 423 1890 561">A review of the records of eight individuals to evaluate the Integrated Assessments: Social Work Sections found that all eight assessments were current and comprehensive (DAS, DFW, JA, JL, ML, MW, RC and WLF).</p> <p data-bbox="993 607 1890 748">Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 12% of the 30-Day Psychosocial Assessments due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 786 1890 1013"> <tr> <td data-bbox="993 786 1087 824">1.</td> <td data-bbox="1087 786 1795 824"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1795 786 1890 824">100%</td> </tr> <tr> <td data-bbox="993 824 1087 863">2.</td> <td data-bbox="1087 824 1795 863"><i>Current, and</i></td> <td data-bbox="1795 824 1890 863">100%</td> </tr> <tr> <td data-bbox="993 863 1087 1013">3.</td> <td data-bbox="1087 863 1795 1013"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1795 863 1890 1013">100%</td> </tr> </table> <p data-bbox="993 1057 1890 1125">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 1170 1890 1271">A review of the records of eight individuals to evaluate the 30-Day Psychosocial Assessments found that all eight assessments were current and comprehensive (DAS, DFW, JA, JL, ML, MW, RC and WLF).</p> <p data-bbox="993 1317 1140 1385"><b>Compliance:</b> Substantial.</p>		<i>instructions as applicable or indicate why the information is not available.</i>		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 least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
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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 least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%												

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 12% of the 30-Day Psychosocial Assessments due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 711 1887 862"> <tr> <td data-bbox="993 711 1087 784">4.</td> <td data-bbox="1087 711 1793 784"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1793 711 1887 784">100%</td> </tr> <tr> <td data-bbox="993 784 1087 824">5.</td> <td data-bbox="1087 784 1793 824"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1793 784 1887 824">100%</td> </tr> <tr> <td data-bbox="993 824 1087 862">6.</td> <td data-bbox="1087 824 1793 862"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1793 824 1887 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>A review of the records of eight individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that seven assessments identified and resolved factual inconsistencies (DAS, DFW, JA, JL, ML, MW and WLF) and one did not (RC).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

Section D: Integrated Assessments

<p>D.6.c</p>	<p>Is included in the 7-day integrated assessment and fully documented by the 30<sup>th</sup> day of an individual's admission; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 13% of Integrated Assessments: Social Work Section due each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1890 638"> <tr> <td data-bbox="991 597 1087 638">7.</td> <td data-bbox="1087 597 1793 638"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 597 1890 638">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>A review of the records of eight individuals to evaluate timeliness of the Social Work Integrated Assessment found that all eight assessments were timely (DAS, DFW, JA, JL, ML, MW, RC and WLF). .</p> <p>Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 12% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="991 1081 1890 1122"> <tr> <td data-bbox="991 1081 1087 1122">8.</td> <td data-bbox="1087 1081 1793 1122"><i>Fully documented by 30<sup>th</sup> day of admission</i></td> <td data-bbox="1793 1081 1890 1122">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 eight individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that all eight assessments were timely (DAS, DFW, JA, JL, ML, MW, RC and WLF).</p>	7.	<i>Is included in the 7-day integrated assessment</i>	97%	8.	<i>Fully documented by 30<sup>th</sup> day of admission</i>	96%
7.	<i>Is included in the 7-day integrated assessment</i>	97%						
8.	<i>Fully documented by 30<sup>th</sup> day of admission</i>	96%						

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 13% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 821 1887 1011"> <tr> <td data-bbox="993 821 1087 898">9.</td> <td data-bbox="1087 821 1793 898"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1793 821 1887 898">100%</td> </tr> <tr> <td data-bbox="993 898 1087 1011">10.</td> <td data-bbox="1087 898 1793 1011"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1793 898 1887 1011">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>A review of the records of eight individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all eight assessments included this information (DAS, DFW, JA, JL, ML, MW, RC and WLF).</p> <p>Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 12% of 30-Day</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%						

Section D: Integrated Assessments

		<p>Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 264 1890 451"> <tr> <td data-bbox="993 264 1087 337">9.</td> <td data-bbox="1087 264 1795 337"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1795 264 1890 337">100%</td> </tr> <tr> <td data-bbox="993 337 1087 451">10.</td> <td data-bbox="1087 337 1795 451"><i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i></td> <td data-bbox="1795 337 1890 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 for both items.</p> <p>A review of the records of eight individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that all eight assessments included this information (DAS, DFW, JA, JL, ML, MW, RC and WLF).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%						

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p><b>Summary of Progress:</b> ASH has maintained substantial compliance with all EP requirements in this section.</p>
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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Amy Lee Consolati, LCSW, Acting Supervising Social Worker</li> <li>2. Charles Broderick, PhD, DMH HOM Team Psychology Expert</li> <li>3. Charlie Joslin, Clinical Administrator</li> <li>4. Donna Nelson, Director, Standards Compliance Department</li> <li>5. Janet Bouffard, LCSW, Chief of Social Work</li> <li>6. Ramiro Zeron, LCSW, Acting Supervising Social Worker</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following 20 individuals: AM, AN, BT, CB, CRA, DEC, EN, EWS, GC, GR, JAB, LCS, LR, MB, MW, PAP, PC, RAM, RJ, RO</li> <li>2. List of individuals who have met discharge criteria in the last six months</li> <li>3. List of individuals who have met discharge criteria and are still hospitalized</li> <li>4. Summary data on SW progress notes for individuals in the facility during this review</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit 11) for quarterly review of MAS</li> <li>2. WRPC (Program I, unit 26) for monthly review of WEJ</li> <li>3. WRPC (Program III, unit 17) for quarterly review of CRA</li> </ol>
E.1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning</p>	<p>Please see sub-cells for compliance findings.</p>

Section E: Discharge Planning and Community Integration

	<p>conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	
<p>E.1.a</p>	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 99%. 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 (AN, BT, EN, GC, LR, MB, PC, RJ and RO). Strengths and preferences were defined under a sub-section in the Present Status of the WRP. Eight WRPs had translated the individual's life goals into appropriate foci, objective and interventions under various foci (e.g., foci 3, 5, 10, and 11); one individual (LR) did not have a meaningful life goal and the individual's mental illness was addressed under the Present Status section.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

E.1.b	the individual's level of psychosocial functioning;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and 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 records of nine individuals found that all nine WRPs included the individual's psychosocial functioning in the Present Status section (AN, BT, EN, GC, LR, MB, PC, RJ and RO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate</p>

Section E: Discharge Planning and Community Integration

		<p>of 99%. 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 seven WRPs contained documentation that discharge barriers were discussed with the individual (AN, BT, EN, GC, MB, RJ and RO). The remaining two WRPs did not (LR and PC). All WRPs contained good documentation on the individual's discharge status with a review of the discharge-related objectives and their status.</p> <p>Discharge status, readiness, and barriers were discussed within the team during the "update" in Phase A of the WRPC and with the individual when the individual was in attendance in Phase B.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and 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>

Section E: Discharge Planning and Community Integration

		<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 (AN, BT, EN, GC, LR, MB, PC, RJ and RO). These individuals were deemed to require a number of supports, skills, and resources to enable them to transition to the community upon discharge (e.g., housing, transportation, SSI, and community treatment).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and 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 records of nine individuals found that eight WRPs contained documentation indicating that the individual was an active participant in the discharge process (AN, BT, EN, GC, LR, MB, RJ and RO). The remaining one WRP contained no documentation that the individual participated in the discussion (PC).</p>

Section E: Discharge Planning and Community Integration

		<p>This monitor observed three WRPCs (CRA, MAS and WEJ). The individuals in all three WRPCs were engaged with the WRPT on matters related to discharge. However, the WRPTs could have elicited information on the individual's understanding on the requirements and where he stands on achieving each of the discharge objectives, and not limit the discussion to just telling the individual his/her discharge issues and status thereof.</p> <p>A review of the records of six individuals found that all six WRPs contained measurable objectives and interventions to address the individual's discharge criteria (CRA, DEC, EWS, GR, LCS and PAP). All six WRPs also prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall service. The WRPTs of the WRPs reviewed had given priority to developing objectives and interventions that arise from the individual's discharge criteria, followed by secondary issues that will assist the individual's discharge, and then followed by other pertinent issues and personal interests.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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 subcells for compliance findings.</p>

Section E: Discharge Planning and Community Integration

E.3.a	measurable interventions regarding these discharge considerations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and 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 WRPs of nine individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all nine WRPs (AN, BT, EN, GC, LR, MB, PC, RJ and RO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate</p>

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		<p>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 records of nine individuals found that all nine WRPs identified the staff member responsible for the interventions (AN, BT, EN, GC, LR, MB, PC, RJ and RO), except when numerous staff is involved, for example on the units, in which case the discipline, usually Nursing, was listed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3.c	The time frames for completion of the interventions.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (September 2010 - February 2011) and 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 records of seven individuals found that all seven WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (CRA, DEC, EWS, GC, GR, JAB and PAP).</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																
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><b>Compliance:</b> Substantial.</p>																																
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Documentation review found that seven civilly committed individuals referred for discharge are still hospitalized, and all had been referred for discharge within the last six months.</p> <table border="1"> <thead> <tr> <th>ID</th> <th>Referral Date</th> <th>Current Status</th> <th>SW efforts to overcome barrier</th> </tr> </thead> <tbody> <tr> <td>PC</td> <td>12/22/10</td> <td>Potential step-down hospital via CONREP</td> <td>Superior Court hearing continued to 5/9/11</td> </tr> <tr> <td>CB</td> <td>12/23/10</td> <td>CONREP</td> <td>Medication change 1/31/11 - requires 90 days post change.</td> </tr> <tr> <td>AR</td> <td>12/29/10</td> <td>CONREP</td> <td>Pending CONREP decision</td> </tr> <tr> <td>MW</td> <td>2/1/11</td> <td>CONREP</td> <td>Accepted 3/21 - court order and placement pending</td> </tr> <tr> <td>VT</td> <td>2/9/11</td> <td>CONREP</td> <td>CONREP decision pending</td> </tr> <tr> <td>ML</td> <td>2/9/11</td> <td></td> <td>Denied CONREP</td> </tr> <tr> <td>LW</td> <td>2/24/11</td> <td></td> <td>Denied CONREP due to non-</td> </tr> </tbody> </table>	ID	Referral Date	Current Status	SW efforts to overcome barrier	PC	12/22/10	Potential step-down hospital via CONREP	Superior Court hearing continued to 5/9/11	CB	12/23/10	CONREP	Medication change 1/31/11 - requires 90 days post change.	AR	12/29/10	CONREP	Pending CONREP decision	MW	2/1/11	CONREP	Accepted 3/21 - court order and placement pending	VT	2/9/11	CONREP	CONREP decision pending	ML	2/9/11		Denied CONREP	LW	2/24/11		Denied CONREP due to non-
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			revocable parole															
		<p>Further document review and interview of the Chief of Social Work found that the facility had discharged a total of 612 individuals during this review period (September 1, 2010 to February 28, 2011): 271 individuals (PC 1370) to County Jail; 170 individuals (PC 2684) to CDC-R; 151 individuals to the community (their terms had expired or their legal criteria was not met; 19 individuals to CONREP; and 21 individuals from other custodial types (new charges, dual commitment court, etc.). These numbers do not include the number of individuals transferred to other state hospitals.</p> <p>Additional analysis of individuals discharged during this review period revealed the data presented in the table below:</p> <table border="1"> <thead> <tr> <th data-bbox="989 748 1209 898">Legal Code (# discharged)</th> <th data-bbox="1209 748 1425 898">Mean days from admission to referral (range)</th> <th data-bbox="1425 748 1642 898">Mean days from referral to discharge (range)</th> <th data-bbox="1642 748 1858 898">Length of stay at ASH (range)</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 898 1209 974">PC - 2684 (12)</td> <td data-bbox="1209 898 1425 974">239 (47-420)</td> <td data-bbox="1425 898 1642 974">4 (2-7)</td> <td data-bbox="1642 898 1858 974">243 (45-423)</td> </tr> <tr> <td data-bbox="989 974 1209 1050">PC - 1370 (12)</td> <td data-bbox="1209 974 1425 1050">72 (18 - 155)</td> <td data-bbox="1425 974 1642 1050">8 (0-10)</td> <td data-bbox="1642 974 1858 1050">90 (28 - 185)</td> </tr> <tr> <td data-bbox="989 1050 1209 1127">CONREP (19)</td> <td data-bbox="1209 1050 1425 1127">1yr 19d (52d - 3yr 3d)</td> <td data-bbox="1425 1050 1642 1127">71d (12d -132d)</td> <td data-bbox="1642 1050 1858 1127">1.5y 176d (84d -3y 346d)</td> </tr> </tbody> </table> <p>According to the Chief of Social Work, the discharge dates are significantly affected in CONREP cases due to CONREP criteria and requirements, court approval and bed availability.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Legal Code (# discharged)	Mean days from admission to referral (range)	Mean days from referral to discharge (range)	Length of stay at ASH (range)	PC - 2684 (12)	239 (47-420)	4 (2-7)	243 (45-423)	PC - 1370 (12)	72 (18 - 155)	8 (0-10)	90 (28 - 185)	CONREP (19)	1yr 19d (52d - 3yr 3d)	71d (12d -132d)	1.5y 176d (84d -3y 346d)
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E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs of individuals who have met their discharge criteria due each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 92%. 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 five individuals found that all five WRPs contained documentation of the assistance needed by the individual in the new setting (AM, CB, EN, MW and RAM). ASH's assistance to these individuals included arrangement for transportation, ID card, and making contact with the families.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to 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 individualized action plan for each such child or	

Section E: Discharge Planning and Community Integration

	adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	
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<b>F. Specific Therapeutic and Rehabilitation Services</b>	
	<p><b>Summary of Progress on Psychiatric Services:</b></p> <ol style="list-style-type: none"><li>1. ASH has maintained substantial compliance with all of the requirements in this section.</li><li>2. ASH has strengthened its system of medication management including reporting, analysis and performance improvement actions regarding adverse drug reactions and medication variances as well as drug utilization evaluations. This system appears to be sufficient to maintain progress in this area in the future.</li></ol> <p><b>Summary of Progress on Psychological Services:</b></p> <ol style="list-style-type: none"><li>1. ASH has maintained substantial compliance with all EP requirements in this section.</li><li>2. ASH has significantly increased its production of Behavioral Guidelines and Positive Behavior Support plans.</li><li>3. ASH's By Choice incentive program has expanded by adding new activities, and is working collaboratively with other divisions to enhance the quality of life of the individuals in the facility.</li><li>4. ASH has taken a comprehensive approach to violence reduction, first by conducting a violence study assessing staff's and individuals' perceptions of the problem, and has put forth numerous proposals based on analysis of the study data. Meanwhile the facility has improved its practice by adding new groups and supports targeting violence.</li></ol> <p><b>Summary of Progress on Nursing Services:</b> ASH has maintained substantial compliance in the area of documentation of PRN and Stat medications.</p> <p><b><i>Areas of need include:</i></b> <i>ASH needs to implement effective strategies that address the problematic nursing issues regarding changes in status to ensure</i></p>

*that the nursing assessments and nursing documentation are clinically adequate, complete and consistent.*

**Summary of Progress on Rehabilitation Therapy Services:**

1. ASH has maintained substantial compliance with the requirements of Section F.4.
2. The quality and detail of 24-hour support plans has improved from the last review period. However, the positioning and ADL sections were often either not completed or completed superficially. The POST team should continue to develop these plans and include interdisciplinary input (e.g., from psychologist, behavioral specialist) as clinically indicated.
3. Currently, most objectives are focused on verbalizing rather than demonstrating or applying a learned behavior or skill. Objectives are not consistently aligned with individuals' cognitive, social, and communication skills.

**Summary of Progress on Nutrition Services:**

1. ASH has maintained substantial compliance with the requirements of Section F.5 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
2. ASH does not currently have a process to ensure that level of care staff and/or relevant treatment team members receive training on Nutrition Care Assessment recommendations as clinically indicated.

**Summary of Progress on Pharmacy Services:**

As of the tour conducted in October 2010, ASH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH

Section F: Specific Therapeutic and Rehabilitation Services

	<p>to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on General Medical Services:</b> ASH has maintained substantial compliance with all the requirements in this section.</p> <p><b>Summary of Progress on Infection Control:</b> ASH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Dental Services</b> ASH's Dental Department has continued to maintain substantial compliance in all areas of the Enhancement Plan except for refusals, which are the responsibility of the WRPTs.</p> <p><b><i>Areas of need include:</i></b> <i>The WRPTs need to develop, regularly review, and revise adequate and appropriate WRPs in alignment with the risk levels of the dental refusals in order for this area to come into substantial compliance.</i></p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Jarrod Macha, Psychiatric Technician, Standards Compliance</li> <li>2. Joshua Deane, MD, Acting Chief of Psychiatry</li> <li>3. Stephen Mohaupt, MD, Chair of the Medication Management EP Performance Improvement Committee</li> <li>4. Veronica Quezada, MD, Staff Psychiatrist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following 39 individuals: AAA, AB, BCS, BPN, BRT, CE, CTSJ, DKM, DWH, DWC, ER, GCR, GGL, IC, JBW, JDS, JEC, JG, JJA, JN, JV, KT, LCR, LHE, MAC, MM, MPS, NJG, OWV, RAD, RAZ, RDC, RDP, RJS, RM, TH, VLG, WLD, and ZW</li> <li>2. ASH Admission Psychiatric Assessment Audit summary data (September 2010 - February 2011)</li> <li>3. ASH Integrated Assessment: Psychiatry Section Audit summary data (September 2010 - February 2011)</li> <li>4. ASH Monthly PPN Audit summary data (September 2010 - February 2011)</li> <li>5. ASH PRN and Stat monitoring summary data (September 2010 - February 2011)</li> <li>6. ASH Movement Disorder Monitoring summary data (September 2010 - February 2011)</li> <li>7. Last 11 ADRs for this reporting period</li> <li>8. ASH aggregated data regarding ADRs (September 2010 - February 2011)</li> <li>9. Ten Intensive Case Analyses (ICAs) completed during this review period</li> <li>10. Last ten MVRs for this reporting period</li> <li>11. ASH aggregated data regarding medication variances (September 2010 - February 2011)</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> <li>12. Pharmacy and Therapeutics Committee Minutes during the review period</li> <li>13. Drug Utilization Evaluations (DUEs) completed by ASH during this review period:             <ol style="list-style-type: none"> <li>a. Lithium</li> <li>b. Long-Acting Antipsychotics,</li> <li>c. SSRIs</li> <li>d. Anticholinergics</li> <li>e. Benzodiazepines</li> </ol> </li> <li>14. ASH Psychiatric Clinical Outcome summary data (previous and current reporting period)             <ol style="list-style-type: none"> <li>a. Any aggression to self resulting in major injury</li> <li>b. Any peer-to-peer aggression resulting in major injury</li> <li>c. Any aggression to staff resulting in major injury</li> <li>d. Individuals having alleged abuse/neglect/exploitation</li> <li>e. Individuals having confirmed abuse/neglect/exploitation</li> <li>f. Individuals with two or more intra-class psychotropic medications for psychiatric reasons</li> <li>g. Individuals with four or more inter-class psychotropic medications for psychiatric reasons</li> <li>h. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder</li> <li>i. Unique count of individuals in restraint</li> <li>j. Unique count of restraint events</li> <li>k. Unique count of individuals in seclusion</li> <li>l. Unique count of seclusion events</li> <li>m. Individuals on benzodiazepines who are diagnosed with substance use</li> <li>n. Individuals on benzodiazepines diagnosed with cognitive disorder</li> <li>o. Elderly on anticholinergics (age &gt;65)</li> <li>p. Individuals diagnosed with cognitive disorder on anticholinergics</li> <li>q. Individuals diagnosed with TD prescribed anticholinergics</li> <li>r. Count of severe ADRs</li> </ol> </li> </ol>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>s. Number of individuals advanced at least one stage of change or sustained in maintenance</p>
<p>F.1.a</p>	<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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> 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><b>Findings:</b> The following summarizes the updates to the DMH medication guidelines during this review period:</p> <ol style="list-style-type: none"> <li>1. Loading dose strategy for haloperidol decanoate was changed from "300 mg IM every two weeks times two to three doses" to "300 mg IM every one to two weeks times two to three doses." This change was based on discussion of the weekly dosing approach currently in use in the admission units at Patton State Hospital. It was noted that weekly dosing has resulted in achievement of a desirable plasma concentration within two to three weeks without need for an oral crossover and has largely not produced problematic adverse events, e.g. excessive sedation, symptomatic hyperprolactinemia, extra-pyramidal symptoms, etc.</li> <li>2. Clarification that the information regarding dosing and initiation of long-acting antipsychotics is informational and does not obligate prescribers to use the initiation strategies.</li> <li>3. The language regarding lamotrigine side effects was changed from "headaches" to "headaches, including due to aseptic meningitis."</li> <li>4. A guideline that Drug Utilization Evaluation (DUE) should include all individuals taking the medication if it was taken by fewer than 20 individuals.</li> <li>5. The DUE audit forms were deleted from the policy. This was</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>replaced with descriptive language of requirements for DUEs.</p> <p>ASH has adopted these updates. In addition, the following outlines the updates that were implemented in the facility's local formulary:</p> <ol style="list-style-type: none"><li>1. Initial orders for benzodiazepines, anticholinergics, and psychiatric PRNs are no longer limited to 14 days and will now be included with the regular monthly unit medication reviews. Orders for benzodiazepines must include a taper schedule to eliminate ongoing use unless clear rationale for continued use is present in the monthly progress note and MRC approval is obtained.</li><li>2. All orders for benzodiazepines, quetiapine and bupropion will continue to require crush but no longer require crush and float.</li><li>3. All orders for acetaminophen and hydrocodone (norco) and tramadol will require crush.</li><li>4. Atomoxetine, buspirone, quetiapine, clonazepam, and bupropion remain on restricted formulary. Initial use of these medications requires non-formulary medication request approval prior to dispensing from pharmacy.</li><li>5. Divalproex sprinkles and valproic acid liquid will require non-formulary approval prior to dispensing.</li><li>6. Initial titration of propranolol and clonidine pre-administration blood pressure and pulse checks should continue. Once vital signs have been stable for 30 days and no further medication adjustments are anticipated, pre-administration vital signs are no longer necessary in the absence of hypertension. However, if a dosage change occurs, vital signs should be re-initiated until clinical stability is demonstrated (7-14 days).</li><li>7. Regular and NPH insulin were removed from the formulary and individuals receiving these forms were converted to insulin aspart and insulin glargine, respectively.</li></ol>
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		<p><b>Recommendation 2, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 22%, 22% and 24%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	The facility reported 100% compliance rates for all of the corresponding indicators in the admission and integrated assessments since the last review. The rates for the two indicators in the Monthly Progress Notes (PPN) audit were 100% and 99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for these items.
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	The Monthly PPN audit reported a rate of 100%, the same as reported during the previous review.
F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.ii.
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Same as in F.1.a.ii.
F.1.a.v	monitored appropriately for side effects;	The rates for the two indicators in the Monthly Progress Notes audit were 100% and 99%. Comparative data indicated that ASH has

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		maintained a compliance rate of at least 90% from the previous review period for both items.									
F.1.a.vi	modified based on clinical rationales;	Same as in F.1.a.ii.									
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.ii.									
F.1.a.viii	Properly documented.	<table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>100%</td> </tr> <tr> <td>Monthly PPN</td> <td>2, 3 and 5</td> <td>100%</td> </tr> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2, 3 and 5	100%
Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%									
Integrated Assessment (Psychiatry)	7 and 10	100%									
Monthly PPN	2, 3 and 5	100%									
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> ASH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 24% of individuals who have been hospitalized for 90 or more days during the review period (September 2010 - February 2011). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 56% and 49% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p> <table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>6.</td> <td><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td>99%</td> </tr> </tbody> </table>	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>	99%			
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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>	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> <table border="1"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication.</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring PRN medication.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to PRN medication.</i></td> <td>97%</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 items.</p> <table border="1"> <thead> <tr> <th colspan="3">Nursing Services Stat</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of Stat medication.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring Stat medication.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to Stat medication.</i></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 items.</p> <p><b>Other findings:</b> Same as in D.1.f.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Nursing Services PRN			1.	<i>Safe administration of PRN medication.</i>	98%	2.	<i>Documentation of the circumstances requiring PRN medication.</i>	100%	3.	<i>Documentation of the individual's response to PRN medication.</i>	97%	Nursing Services Stat			1.	<i>Safe administration of Stat medication.</i>	97%	2.	<i>Documentation of the circumstances requiring Stat medication.</i>	98%	3.	<i>Documentation of the individual's response to Stat medication.</i>	95%
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<p>F.1.c</p>	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Provide CME update regarding the relative risks of various benzodiazepine agents in individuals with substance use disorders.</li> </ul> <p><b>Findings:</b></p> <p>ASH used the standardized DMH Monthly PPN Audit Form to assess compliance (September 2010 - February 2011). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 711 1885 1013"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines</i></td> <td>98%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics</i></td> <td>95%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy</i></td> <td>99%</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 items.</p> <p>Additionally, ASH reported the following comparative data:</p> <table border="1" data-bbox="991 1235 1894 1421"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Total number of individuals receiving benzodiazepines for 60 days or more</i></td> <td>102</td> <td>99</td> </tr> <tr> <td>2.</td> <td><i>Total number of individuals receiving</i></td> <td>91</td> <td>88</td> </tr> </tbody> </table>		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>	98%	5.d.ii.	<i>Anticholinergics</i>	95%	5.d.iii.	<i>Polypharmacy</i>	99%		Indicators	Previous period	Current period	1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	102	99	2.	<i>Total number of individuals receiving</i>	91	88
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			<i>benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i>		
		3.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more</i>	79	79
		4.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning) for 60 days or more</i>	20	18
		5.	<i>Total number receiving anticholinergics for 60 days or more</i>	147	96
		6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above, for 60 days or more</i>	30	19
		7.	<i>Total number with intra-class polypharmacy</i>	433	398
		8.	<i>Total number with inter-class polypharmacy</i>	188	205
		<p>The above data showed that ASH has maintained appropriate caution in the use of these classes of medications.</p> <p>On March 8, 2011, CME was provided, by S. Mohaupt, MD, ASH, regarding the relative risks of benzodiazepines in patients with severe mental illness and substance abuse disorders.</p> <p><b>Other findings:</b> This monitor reviewed the facility's databases regarding individuals</p>			

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		<p>receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> <li>1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders;</li> <li>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</li> <li>3. Anticholinergic medications for elderly individuals; and</li> <li>4. Various forms of polypharmacy.</li> </ol> <p>The following outlines reviews by this monitor of the charts of individuals receiving the above types of medication regimens. Diagnoses are listed only if they signified high-risk conditions:</p> <p><b><u>Benzodiazepine use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AAA</td> <td>Lorazepam and benztropine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>AB</td> <td>Lorazepam</td> <td>Alcohol Abuse, Cannabis Abuse and Borderline Intellectual Functioning</td> </tr> <tr> <td>BRT</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>DWH</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JV</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>LCR</td> <td>Lorazepam</td> <td>Alcohol Dependence</td> </tr> <tr> <td>MAC</td> <td>Lorazepam</td> <td>Alcohol Abuse</td> </tr> <tr> <td>RM</td> <td>Lorazepam</td> <td>Opioid Dependence, Alcohol Abuse and Cannabis Abuse</td> </tr> <tr> <td>VLG</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>WLD</td> <td>Zolpidem</td> <td>Polysubstance Dependence and Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>This review found substantial compliance in seven charts (BRT, DWH, JV,</p>	Individual	Medication(s)	Diagnosis	AAA	Lorazepam and benztropine	Cognitive Disorder NOS	AB	Lorazepam	Alcohol Abuse, Cannabis Abuse and Borderline Intellectual Functioning	BRT	Clonazepam	Polysubstance Dependence	DWH	Lorazepam	Polysubstance Dependence	JV	Lorazepam	Polysubstance Dependence	LCR	Lorazepam	Alcohol Dependence	MAC	Lorazepam	Alcohol Abuse	RM	Lorazepam	Opioid Dependence, Alcohol Abuse and Cannabis Abuse	VLG	Clonazepam	Polysubstance Dependence	WLD	Zolpidem	Polysubstance Dependence and Borderline Intellectual Functioning
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LCR, MAC, RM and VLG) and partial compliance in three (AAA, AB and WLD). The charts of AAA and WLD included inadequate review/analysis of the individualized risk of treatment given the individuals' underlying conditions.

**Anticholinergic use**

Individual	Medication(s)	Diagnosis
BCS	Benztropine	Borderline Intellectual Functioning Partial: no documentation of individualized risks regarding cognitive decline
DKM	Benztropine	Borderline Intellectual Functioning
IC	Benztropine	Tardive Dyskinesia and Borderline Intellectual Functioning
RAD	Benztropine	Borderline Intellectual Functioning incomplete monitoring using MMSE
RDC	Benztropine	Borderline Intellectual Functioning
VLG	Diphenhydramine	Tardive Dyskinesia partial

This review found substantial compliance in all cases.

**Anticholinergic use for individuals age 65 or above:**

Individual	Medication(s)	Diagnosis
JDS	Diphenhydramine	

At the time of the review, only one individual age 65 or above (JDS) received long-term treatment with anticholinergics. There was evidence of substantial compliance in this chart.

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<u>Polypharmacy use</u>		
Individual	Medication(s)	Diagnosis
BPN	Risperidone, mirtazapine, lithium and benztropine	
CTSJ	Citalopram, divalproex, trifluoperazine and olanzapine	
DKM	Fluphenazine, risperidone, divalproex and benztropine	
DWC	Haloperidol decanoate, olanzapine, citalopram, chlorpromazine and benztropine	
JBW	Olanzapine, risperidone, clonazepam, divalproex and lithium	
JJA	Haloperidol, quetiapine, mirtazapine, divalproex, benztropine and zolpidem	
LHE	Haloperidol decanoate, olanzapine, lamotrigine and lithium	
NJG	Paliperidone, chlorpromazine, divalproex, naltrexone and zolpidem	Polysubstance Dependence and Mild Mental Retardation
RDC	Clozapine, haloperidol, clonazepam, benztropine and divalproex	
ZW	Haloperidol decanoate, lamotrigine, olanzapine, fluoxetine, and propranolol	

This review found substantial compliance in seven charts and partial compliance in the chart of JJA and ZW (inadequate justification for treatment with mirtazapine and fluoxetine, respectively given the individuals' conditions) and NJG (inadequate monitoring of the risks for an individual with cognitive impairment).

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:             <ol style="list-style-type: none"> <li>a. Benzodiazepines;</li> <li>b. Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>c. Benzodiazepines and have any diagnosis of cognitive impairment;</li> <li>d. Anticholinergics;</li> <li>e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>f. Intra-class polypharmacy; and</li> <li>g. Inter-class polypharmacy.</li> </ol> <p>The data for items a to e should continue to be limited to the use of the medication (s) for 60 or more days.</p> </li> </ol>						
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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Monthly PPN Auditing Form, ASH assessed its compliance based on an average sample of 24% of individuals receiving these medications during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="989 1339 1887 1412"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5</td> <td><i>Responses to and side effects of prescribed</i></td> <td>98%</td> </tr> </tbody> </table>	Monthly PPN			5	<i>Responses to and side effects of prescribed</i>	98%
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CE	Risperidone and aripiprazole	Diabetes Mellitus, Hyperlipidemia , Obesity and Hypertension												
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		GCR	Risperidone	Diabetes Mellitus and Hypertension
		JEC	Olanzapine and aripiprazole	Diabetes Mellitus
		JG	Clozapine	Diabetes Mellitus
		JN	Olanzapine and risperidone	Diabetes Mellitus
		KT	Risperidone	Diabetes Mellitus, Obesity and Hypertension
		MM	Quetiapine	Diabetes Mellitus, Obesity and Dyslipidemia
		OWV	Clozapine	Diabetes Mellitus, Hyperlipidemia , Obesity and Hypertension
		RAZ	Olanzapine and trifluoperazine	Diabetes Mellitus, Obesity and Hypertension
		RDP	Olanzapine and haloperidol	Diabetes Mellitus and Hypertension
<p>This review found general evidence of timely and adequate laboratory monitoring for the metabolic risks of treatment.</p> <p>As mentioned in D.1.f, chart reviews found that the documentation of individualized analysis of the risks of treatment was generic in too many cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Implement a nursing instruction to ensure proper identification by nursing (and physician notification) of changes that may suggest early development of myocarditis.</li> </ol>				

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<p>F.1.e</p>	<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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Movement Disorders Auditing Form, ASH assessed its compliance based on average samples ranging from 22% to 24% of individuals relevant to each indicator during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1890 1312"> <tr> <td>1.</td> <td><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>All individuals with movement disorders are appropriately treated.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td>100%</td> </tr> <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> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	99%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	99%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	100%	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	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><b>Other findings:</b>  This monitor reviewed the charts of six individuals (AB, GGL, IC, MPS, RJS and TH) who were diagnosed with tardive dyskinesia</p> <p>The review found that ASH has maintained progress in the following areas:</p> <ol style="list-style-type: none"> <li>1. Timely completion of admission and quarterly AIMS tests (all cases);</li> <li>2. Tracking of results of AIMS tests by the treating psychiatrists and documentation of the scores in the psychiatric progress notes at a reasonable frequency (all cases);</li> <li>3. Development of foci and corresponding objectives and interventions related to TD in the WRPs (all cases);</li> <li>4. Use of appropriate learning outcomes in the WRP objectives related to TD (AB and MPS);</li> <li>5. Caution in the long term use of anticholinergic agents (all cases); and</li> <li>6. Use of safer antipsychotic medication interventions, as clinically indicated (RJS and TH).</li> </ol> <p>In a few charts, the WRPs included objective statements related to the management of TD that were either not attainable for the individual (TH) or clinically inappropriate for the individual (or the practitioner) (GGL),</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  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	<b>Current findings on previous recommendations:</b>

	<p>reactions ("ADR").</p>	<p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to increase reporting of ADRs.</li> <li>• Continue review and analysis of ADRs and present summary of aggregated data to address the following:             <ul style="list-style-type: none"> <li>○ The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> <li>○ Classification of probability and severity of ADRs;</li> <li>○ Any negative outcomes for individuals who were involved in serious reactions;</li> <li>○ Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</li> <li>○ 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).</li> </ul> </li> </ul> <p><b>Findings:</b> The following summarizes the facility's data:</p> <table border="1" data-bbox="991 930 1890 1390"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>71</td> <td>81</td> </tr> <tr> <td colspan="3"><b>Classification of Probability of ADRs</b></td> </tr> <tr> <td>Doubtful</td> <td>9</td> <td>6</td> </tr> <tr> <td>Possible</td> <td>34</td> <td>51</td> </tr> <tr> <td>Probable</td> <td>27</td> <td>22</td> </tr> <tr> <td>Definite</td> <td>1</td> <td>2</td> </tr> <tr> <td colspan="3"><b>Classification of Severity of ADRS</b></td> </tr> <tr> <td>Mild</td> <td>18</td> <td>19</td> </tr> <tr> <td>Moderate</td> <td>45</td> <td>52</td> </tr> <tr> <td>Severe</td> <td>8</td> <td>10</td> </tr> </tbody> </table>		Previous period	Current period	Total ADRs	71	81	<b>Classification of Probability of ADRs</b>			Doubtful	9	6	Possible	34	51	Probable	27	22	Definite	1	2	<b>Classification of Severity of ADRS</b>			Mild	18	19	Moderate	45	52	Severe	8	10
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Total ADRs	71	81																																	
<b>Classification of Probability of ADRs</b>																																			
Doubtful	9	6																																	
Possible	34	51																																	
Probable	27	22																																	
Definite	1	2																																	
<b>Classification of Severity of ADRS</b>																																			
Mild	18	19																																	
Moderate	45	52																																	
Severe	8	10																																	

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		<p>Of the 10 severe ADRs, none reportedly resulted in permanent harm to the individual involved.</p> <p>ASH conducted intensive case analyses (ICAs) on all severe ADRs reported during this review period. The following is an outline of these reactions with the suspected agents listed in parentheses:</p> <ol style="list-style-type: none"> <li>1. Neuroleptic malignant syndrome (risperidone);</li> <li>2. Systemic allergic reaction (norvasc);</li> <li>3. Gastrointestinal allergic reaction (naprosyn);</li> <li>4. Constipation with partial small bowel obstruction (risperidone, benztropine and quetiapine);</li> <li>5. Allergic reaction in the tongue (Septocaine, lisinopril and Robaxin);</li> <li>6. Lithium toxicity and hepatic encephalopathy (lithium);</li> <li>7. Priapism (quetiapine);</li> <li>8. Urinary retention (haloperidol);</li> <li>9. Cerebrovascular accident (olanzapine); and</li> <li>10. Lithium toxicity (lithium).</li> </ol> <p>The ICAs utilized appropriate methodology and the recommendations for systemic corrective/educational actions and actions taken were generally adequate.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to increase reporting of ADRs.</li> <li>2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:             <ul style="list-style-type: none"> <li>• The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> </ul> </li> </ol>
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		<ul style="list-style-type: none"> <li>• Classification of probability and severity of ADRs;</li> <li>• Any negative outcomes for individuals who were involved in serious reactions;</li> <li>• Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</li> <li>• 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).</li> </ul>
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p><b>Findings:</b> During this review period, ASH conducted five DUEs, which addressed the use of the following medications:</p> <ol style="list-style-type: none"> <li>1. Lithium (indications and laboratory monitoring);</li> <li>2. Long-acting antipsychotic medications (combined use with oral agents);</li> <li>3. Serotonin-specific reuptake inhibitors (SSRIs) (indications and documentation of risks);</li> <li>4. Anticholinergic agents (indications and documentation of risks); and</li> <li>5. Benzodiazepines (indications and documentation of risks).</li> </ol> <p>The DUEs utilized appropriate methodology and the recommendations for systemic corrective/educational actions and actions taken were generally adequate.</p> <p><b>Compliance:</b></p>

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		<p>Substantial.</p> <p><b>Current recommendation:</b> Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>			
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Present data to address the following: <ul style="list-style-type: none"> <li>○ Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;</li> <li>○ Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>○ Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);</li> <li>○ Number of critical breakdown points by outcome;</li> <li>○ Clinical information regarding each variance (category E or above) and the outcome to the individual involved;</li> <li>○ Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and</li> <li>○ Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ul> </li> <li>• Continue to provide results of analysis of patterns and trends, with corrective/educational actions related to MVRs.</li> </ul> <p><b>Findings:</b> The following is a summary of ASH data regarding MVRs:</p> <table border="1" data-bbox="1003 1339 1747 1414"> <tr> <td data-bbox="1003 1339 1444 1414">Number of Medication Variances</td> <td data-bbox="1444 1339 1598 1414">Previous Period</td> <td data-bbox="1598 1339 1747 1414">Current Period</td> </tr> </table>	Number of Medication Variances	Previous Period	Current Period
Number of Medication Variances	Previous Period	Current Period			

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		Prescribing	507	1032
		Transcribing	247	275
		Ordering/Procurement	2	2
		Dispensing	29	62
		Administration	373	351
		Drug Security	232	158
		Documentation	1260	988
		Total variances	2650	2868
			Previous Period	Current Period
		Total Critical Breakdown Points	2451	2625
		Potential MVRs	2091	2273
		Actual MVRs	360	352
		# Prescribing	499	1022
		# Transcribing	214	230
		#Ordering/Procurement	2	0
		# Dispensing	21	21
		# Administration	280	251
		# Drug Security	222	156
		# Documentation	1213	945
		Outcome A	0	0
		Outcome B	2091	2273
		Outcome C	347	339
		Outcome D	13	12
		Outcome E	0	1
		Outcome F	0	0
		Outcome G	0	0
		Outcome H	0	0
		Outcome I	0	0
		During this review period, one variance reached severity level for an ICA.		

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		<p>The variance involved the administration of the wrong dose of insulin to a newly admitted individual. The facility analyzed this event and traced it to a misreading of the transfer medication form from the referring facility. No permanent harm occurred to the individual and ASH implemented adequate corrective action based on this analysis.</p> <p>ASH conducted adequate review and analysis of contributing factors regarding patterns and trends of variances during this review period. The most significant pattern/trend involved an increase in prescribing variances. The facility reported that the primary reasons for the significant increase were: an illegible addressograph, incomplete duration of the order and missing "do not exceed" and 14-day limits on the orders for PRN medications. The facility's data indicated that 98% of the prescribing variances did not reach the individuals and were identified due to improved scrutiny of the process (increased nursing audits and additional training of pharmacy technicians). The facility reported adequate corrective actions to address this pattern/trend.</p> <p>The majority of ASH's drug security variances were missed initials on the controlled drug log at change of shift and the majority of documentation variances were missed initials on the MAR. Due to the decrease in these numbers, it was interpreted that the staff are performing better with fewer incidents of missed initials during this review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Present data to address the following:             <ol style="list-style-type: none"> <li>a. Total number of variances and total number of critical breakdown points during the previous review period;</li> <li>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous</li> </ol> </li> </ol>
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		<p>period;</p> <ol style="list-style-type: none"> <li>c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);</li> <li>d. Number of critical breakdown points by outcome;</li> <li>e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;</li> <li>f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and</li> <li>g. Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ol> <p>2. Continue to provide results of analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.a through F.1.h.</li> <li>• Continue to present data regarding outcomes of mental health services.</li> </ul> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p>The facility presented additional data regarding outcomes of its clinical services. The data addressed the rate per 1000 days of the following indicators (the monitor's comments in parentheses were based on overall estimate of the trend in the data):</p> <ol style="list-style-type: none"> <li>1. Any aggression to self resulting in major injury (increase-very small number);</li> <li>2. Any peer-to-peer aggression resulting in major injury (decrease);</li> <li>3. Any aggression to staff resulting in major injury (decrease);</li> <li>4. Individuals having alleged abuse/neglect/exploitation (increase);</li> </ol>

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		<ol style="list-style-type: none"> <li>5. Individuals having confirmed abuse/neglect/exploitation (decrease);</li> <li>6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons (mild increase);</li> <li>7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons (decrease);</li> <li>8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder (increase from zero to one);</li> <li>9. Unique count of individuals in restraint (mild increase);</li> <li>10. Unique count of restraint events (increase);</li> <li>11. Unique count of individuals in seclusion (no significant change);</li> <li>12. Unique count of seclusion events (increase);</li> <li>13. Individuals on benzodiazepines who are diagnosed with substance use (no significant change);</li> <li>14. Individuals on benzodiazepine diagnosed with cognitive disorder (no significant change);</li> <li>15. Elderly on anticholinergic medications (age &gt;65) (increase-very small number);</li> <li>16. Individuals diagnosed with cognitive disorder on anticholinergics (increase);</li> <li>17. Individuals diagnosed with TD prescribed anticholinergics (increase-small number);</li> <li>18. Count of severe ADRs (increase);</li> <li>19. Count of severe medication variances (increase-very small number); and</li> <li>20. Percentage of individuals receiving substance abuse services who advanced at least one stage of change or sustained in maintenance stage (decrease).</li> </ol> <p>These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance.</p>
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Same as in F.1.a through F.1.h.</li> <li>2. Continue to present data regarding outcomes of mental health services.</li> </ol>
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in F.1.b and F.1.i.</p> <p><b>Findings:</b> Same as in F.1.b and F.1.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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 Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in F.1.b and F.1.i.</p> <p><b>Findings:</b> Same as in F.1.b and F.1.i.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Same as in F.1.b and F.1.i.</p>
F.1.l	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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	<p>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>	<p><b>Compliance:</b> Substantial.</p>
F.1.m.i	<p>all individuals prescribed continuous anticholinergic treatment for more than two months;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> 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><b>Findings:</b> 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><b>Current recommendation:</b> 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>

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

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F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as F.1.e.</p> <p><b>Findings:</b> Same as F.1.e.</p> <p><b>Current recommendations:</b> Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Findings:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Current recommendations:</b> Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Findings:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendations:</b> Same as in C.2.n, C.2.o and F.1.c.</p>
F.1.o	<p>Atascadero 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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Adam Brotman, PsyD, PBS Team Leader</li> <li>2. Bettina Hodel, PhD</li> <li>3. Brooke Hatcher, RT, Supplemental Activities Coordinator</li> <li>4. Charles Joslin, Clinical Administrator</li> <li>5. Christine Mathiesen, PhD, C-PAS Director</li> <li>6. Deborah Hewitt, PhD</li> <li>7. Diane Imrem, PsyD, Chief of Psychology</li> <li>8. Donna Nelson, Standards Compliance Director</li> <li>9. Edward Bischoff, PhD, Senior Supervising Psychologist</li> <li>10. John De Morales, Executive Director</li> <li>11. Joseph Morrow, PsyD, Acting PBS Team Leader</li> <li>12. Killorin Riddell, PhD, Coordinator Psychology Specialty Services</li> <li>13. Mary Marble, PT, Assistant to By Choice Coordinator</li> <li>14. Matt Hennessey, PhD, Psychologist, Mall Director</li> <li>15. Michaela Hienze, PhD, Staff Psychologist</li> <li>16. Mike Tandy, PhD, Senior Psychologist</li> <li>17. Rafael Romero, US, By Choice Coordinator</li> <li>18. Teresa M. George, PhD, Senior Psychologist Supervisor</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following 60 individuals: AA, AS, AT, AZ, BB, BM, CB, CC, CJ, CRA, CS, DC, DD, DEC, DH, DJW, DM, DP, DR, DW, ED, EJD, ES, ET, EWS, FR, GM, GR, GT, HH, HFH, JC, JH, JKS, JR, LCS, LP, LR, LS, MAM, MAS, MC, MG, ML, MR, MT, PAP, RAL, RD, RE, REM, RG, RR, RS, SB, TR, VC, WEJ, WF and ZS</li> <li>2. List of PBS staff training topics</li> <li>3. PBS staff training material</li> <li>4. New Employee Orientation PBS training material</li> <li>5. Psychology Specialty Services Committee Meeting Minutes</li> </ol>

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		<p>6. Completed Psychology Testing Observation Forms</p> <p>7. Structural and functional assessments completed during this review period</p> <p>8. PBS plans implemented during this review period</p> <p>9. Behavior guidelines implemented during this review period</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit 11) for quarterly review of MAS</li> <li>2. WRPC (Program I, unit 26) for monthly review of WEJ</li> <li>3. WRPC (Program III, unit 17) for quarterly review of CRA</li> </ol>
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH has three PBS teams, and meets the requirement for a 1:300 ratio. In addition, the facility also has a DCAT team that supports the PBS teams.</p> <p>The PBS and DCAT team members have continued with their professional development. Training was conducted on November 4 and 13, 2010. Topics covered during training included the following: chart documentation of behavioral intervention plans; creating milieu interventions for PBS plans/behavioral guidelines and documenting them in the individual's WRP; behavior chaining; and creating and printing PSR Mall notes. In addition, team members attend group supervision once every two weeks.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue current practice.</p>
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH has provided continuing training and education to PBS team members and has continued to train newly hired staff and existing staff on PBS-related matters. Documentation review found that training on a variety of PBS-related topics had been presented on November 4, 2010 and January 14, 2011. In addition, the PBS team members have group supervision on Functional Assessment on a bi-weekly basis (on Thursdays).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Monitoring-By Choice Form, ASH assessed its compliance based on an average sample of 10% of the quarterly and annual WRPs due each month of this review period (September 2010 - February 2011):</p>

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		<table border="1"> <tr> <td data-bbox="978 183 1073 266">2.</td> <td data-bbox="1073 183 1793 266"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 183 1921 266">100%</td> </tr> </table>	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%						
<p>Comparative data indicated that ASH maintained a compliance rate of least 90% since the previous review period.</p> <p>A review of the records of 13 individuals found that all 13 WRPs reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (CC, CJ, CRA, DC, DEC, DH, EWS, GR, GT, LCS, LP, LR and PAP). All of the WRPs also contained documentation indicating if the individual was given an opportunity to reallocate his By Choice points, and what the individual's response was. It appears that the WRPTs have not gotten used to allocating the 50% of the By Choice points under their control. By Choice staff should review this with the WRPTs to ensure that this becomes part of the practice so that the staff can re-allocate their portion of the points when individuals are unable or unwilling to re-allocate their points. In addition, WRP staff might want to prepare and review By Choice point data and reallocation point issues with the individual prior to the conference, as this discussion could take some time and very often WRPTs do not seem to have the time for a proper discussion of By Choice point issues with the individual during the conference.</p> <p>This monitor observed three WRPCs (CRA, MAS and WEJ). The three WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, ASH assessed its compliance based on a mean sample of 14% of the Level of Care staff:</p>								
<table border="1"> <tr> <td data-bbox="978 1339 1073 1380">1.</td> <td data-bbox="1073 1339 1774 1380"><i>Staff understands the goal of the By Choice system</i></td> <td data-bbox="1774 1339 1921 1380">100%</td> </tr> <tr> <td data-bbox="978 1380 1073 1421">2.</td> <td data-bbox="1073 1380 1774 1421"><i>Staff can state the current point cycle</i></td> <td data-bbox="1774 1380 1921 1421">99%</td> </tr> </table>			1.	<i>Staff understands the goal of the By Choice system</i>	100%	2.	<i>Staff can state the current point cycle</i>	99%
1.	<i>Staff understands the goal of the By Choice system</i>	100%						
2.	<i>Staff can state the current point cycle</i>	99%						

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		<table border="1"> <tr> <td data-bbox="989 191 1066 267">3.</td> <td data-bbox="1066 191 1774 267"><i>Staff can state the procedure for assigning participation points on an individual's point card.</i></td> <td data-bbox="1774 191 1871 267">100%</td> </tr> <tr> <td data-bbox="989 267 1066 380">4.</td> <td data-bbox="1066 267 1774 380"><i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i></td> <td data-bbox="1774 267 1871 380">100%</td> </tr> <tr> <td data-bbox="989 380 1066 456">5.</td> <td data-bbox="1066 380 1774 456"><i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i></td> <td data-bbox="1774 380 1871 456">100%</td> </tr> <tr> <td data-bbox="989 456 1066 568">6.</td> <td data-bbox="1066 456 1774 568"><i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i></td> <td data-bbox="1774 456 1871 568">99%</td> </tr> <tr> <td data-bbox="989 568 1066 644">7.</td> <td data-bbox="1066 568 1774 644"><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td data-bbox="1774 568 1871 644">99%</td> </tr> <tr> <td data-bbox="989 644 1066 756">8.</td> <td data-bbox="1066 644 1774 756"><i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i></td> <td data-bbox="1774 644 1871 756">99%</td> </tr> <tr> <td data-bbox="989 756 1066 833">9.</td> <td data-bbox="1066 756 1774 833"><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td data-bbox="1774 756 1871 833">100%</td> </tr> <tr> <td data-bbox="989 833 1066 906">10.</td> <td data-bbox="1066 833 1774 906"><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td data-bbox="1774 833 1871 906">99%</td> </tr> </table>	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>	100%	6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	99%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	99%	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>	99%	9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	100%	10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</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><b>Other findings:</b> Using the Fidelity of Implementation by Individuals Form, ASH also assessed fidelity of By Choice implementation based on a mean sample of 21% of individuals in the facility:</p>																											
1.	<i>The individual understands the goal of the By Choice system.</i>	99%																									
2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	98%																									
3.	<i>The individual can state, to the best of his/her ability</i>	99%																									

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			<i>how they earn points throughout the day.</i>		
		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>	99%	
		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>	97%	
		8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	98%	
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	99%	
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% since the previous review period.</p> <p>Using the By Choice Monitoring Form: Satisfaction Check, ASH surveyed a mean sample of 20% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>			
				Previous period	Current period
		1.	<i>By Choice motivates me to participate in treatment</i>	100%	98%
		2.	<i>The point system motivates me to improve my behavior</i>	100%	98%
		3.	<i>The point system motivates me to learn new skills</i>	99%	97%
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	100%	97%

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		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	100%	99%		
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	100%	98%		
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	100%	99%		
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	100%	98%		
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	100%	99%		
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	100%	98%		
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	100%	99%		
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	99%	97%		
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	100%	97%		
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	99%	98%		
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	100%	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%	

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		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 reference.</i>	100%
		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% since the previous review period for all items.</p>				
<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, 21% 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		99%		
Individuals		99%		

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		By Choice Program Staff	100%
		<p>The By Choice coordinator has continued to provide the oversight and training necessary to maintain the integrity of the program. A number of new activities have been introduced and steps to improve existing activities had been conducted. A new "Unit Incentive Bingo" has been implemented with the view of reinforcing individuals to keep their units safe without any violence. This is an excellent concept and needs to be refined based on feedback from the individuals and the staff. In addition, training has been conducted for new employees; newly admitted individuals are given a "New Admit Orientation to BY-CHOICE" by the BY-CHOICE staff; ongoing education is continued during store hours to increase the individual's knowledge and as a means of socialization; a section of the wall in the By Choice store is set up for "Art Wall" to give release to the individuals' creative spirits; and service is provided at the courtyard "Kiosk" store.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> 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>	

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>															
F.2.c	Each State Hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>															
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (September 2010 - February 2011):</p> <table border="1"> <tr> <td>1.</td> <td><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>100%</td> </tr> <tr> <td>2.</td> <td><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering</i></td> <td>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</i>	100%
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5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering</i>	100%															

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			<i>events and consequences.</i>	
		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 based on the structural and functional assessments.</i>	100%
		<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 12 PBS plans (AA, AT, ED, ES, ET, JC, JH, JR, LS, ML, RS and VC) found that all 12 had been developed and implemented based on data derived from structural and functional assessments. ASH has made the completion of structural and functional assessments prior to developing behavioral intervention plans a standard practice, and this was evidenced in all of the behavioral interventions, including the emergency and medical behavioral intervention plans, reviewed by this monitor. The quality of the assessments ranged from fair to good. A good assessment across shifts and locations can be found in the structural and functional assessment completed for AA. The function and hypotheses stated in a number of assessments and intervention plans are not clear and are non-specific (AT, BB, BM, GM, LS and MG). For example, many of these plans state "to get attention" as one of the functions, without clarifying what</p>		

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		<p>the nature/type of the attention is, from whom, and when; another function given is "due to internal stimuli...consequence is the relief from his internal stimuli," again without stating the nature of the internal stimuli, under what conditions and settings; yet another function given as "...as a result of hearing voices" without clarifying the nature of the voices, and the circumstances and situations. Better examples can be found in a number of other assessments and intervention plans (ES, HH, JR, MC and RS). Stating hypothesized functions with clarity and specificity should lead to a function-specific intervention and deliver positive outcomes.</p> <p>The quality of structural and functional assessments can be further enhanced by incorporating mental illness and physical/medical indicators and signs and symptoms when conducting functional assessments. This will help identify if the signs and symptoms of the mental/physical illness are present during episodes of maladaptive behaviors. This is one way to differentiate "illness"-precipitated and -maintained behaviors from environmental factors.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (September 2010 - February 2011):</p>

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">5.</td> <td style="width: 85%;"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td style="width: 10%; text-align: center;">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 10 PBS plans (AT, ED, ES, ET, JH, JR, LS, ML, RS and VC) found that the hypotheses in all 10 were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%
5.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%			
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (September 2010 - February 2011):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">5.</td> <td style="width: 85%;"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td style="width: 10%; text-align: center;">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 10 PBS plans (AT, ED, ES, ET, JH, JR, LS, ML, RS and VC)</p>	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			

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		<p>found that all 10 documented and discussed previous behavioral interventions and their effects, as documented in the respective structural and functional assessment reports.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans and behavior guidelines during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 857 1890 971"> <tr> <td data-bbox="991 857 1087 971">17.</td> <td data-bbox="1087 857 1795 971"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1795 857 1890 971">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 22 behavioral intervention plans (AT, BM, CC, CJ, DC, DH, DP, ED, ES, ET, GM, GT, JC, JH, JR, LP, LR, LS, MG, ML, RS and VC) found that all 22 plans were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>The following deficiencies were noted in a number of PBS plans:</p> <p>1. Poor operational definitions of target behaviors as in DP, ET and JC</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

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		<p>(e.g. "smearing feces" or "inappropriate sexual behavior" in ET; or "harming or threatening to harm himself" . . . how is this done, with what, where, and when? The plan should clarify the specific ways this particular individual harms himself; instead, the way it is written it can be anyone and everyone who 'harm' themselves); a better example can be found in the chart of LS.</p> <ol style="list-style-type: none"> <li>2. Functions are not clearly stated as in ES (the narrative here has lots of unnecessary historical and assessment elements, and the functions are real clear). A better example can be found in JR.</li> <li>3. Prevention strategies are generic and do not utilize elements of the setting events and antecedents, teaching/training alternate/ replacement behaviors and coping skills.(e.g., the prevention strategies for ES and ET are not specific preventative strategies designed to eliminate/modify the setting events and precipitating/ antecedent events and to prescribe what staff should do under those situations). Attend to eliminating/modifying the predisposing and precipitating factors instead of dealing with them under the "intervention section", which should apply only if they cannot be dealt with at the preventative level. Better examples can be found under prevention strategies in the charts of MC and iRS (item #1). Ensure that actionable steps are prescribed for staff to act on and not simply state "be aware" (e.g. RS); state what staff should be doing once they are "aware" of the situation. Staff orientation, training, and other general administrative matters should not be placed under "prevention' strategies" (e.g. JC).</li> <li>4. Reactive strategies are not prescriptive and not written clearly in simple language that direct care staff can read, comprehend, and act on them without difficulty as in ET and LS (e.g. it is difficult to understand what is meant by "...model the behaviors necessary to regulate emotions in general and especially in social interactions;" "help him to resume his baseline behavior;" or "...staff are to assist him without emotion and in a calm way to help him resume his baseline behaviors. Staff's responses to his target behaviors should be</li> </ol>
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		<p>businesslike and direct”).</p> <ol style="list-style-type: none"> <li>5. Replacement behaviors do not serve the same function to deliver the same or better consequence with little effort as in JC, ET for R2, DP, BM for R1, MG for R1 (e.g. how is deep breathing to deliver attention that the individual seeks through aggression?).</li> <li>6. Interventions do not always include the schedules. Who should implement it, and when, where, and how many/how much/how long (e.g. GM, “staff will provide 1:1 counseling”, or “staff will offer Mr. M the opportunity to speak to them in a private non-threatening area”). Discuss with the staff before setting up the schedule and then write the strategies with specifics.</li> </ol> <p>In addition to correcting the deficiencies identified above, the quality of the PBS plans will be further enhanced by paying attention to the following:</p> <ul style="list-style-type: none"> <li>• Align and match prevention and intervention strategies to specific predisposing, precipitating, and predictive variables.</li> <li>• Where possible (in most cases it is possible) arrange situations so the individual comes into contact with naturally occurring reinforcers.</li> <li>• Do not leave the interpretation of the strategies to the imagination and creativity of the direct care staff. Once you have collaborated with them and jointly decided on what strategies to use, be prescriptive, do not write in generalities.</li> <li>• Emphasize preventative indicators (i.e. setting events, antecedents, establishing operations, and precursors) during assessments, AND utilize each one, matching them to appropriate preventions, interventions, and reactive strategy/strategies.</li> <li>• Involve individuals (those with the cognitive and functional capacities) in the choice of interventions, self-monitoring, and self-evaluation of their program. This will lead to better outcome, maintained longer, and serve them well in the long run, especially when in the community.</li> </ul>
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans or behavior guidelines during the review months (September 2010 - February 2011) and reported a mean compliance rate of 100%.</p> <table border="1" data-bbox="991 711 1887 824"> <tr> <td>22.</td> <td><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>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 for the PBS plans and behavior guidelines of 14 individuals (AT, DW, ED, ES, ET, JH, JR, LS, ML, MT, RD, RR, RS and VC) found that ASH had conducted fidelity checks on all 14 of the behavioral intervention plans.</p> <p><b>Current recommendation:</b> 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%			
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>			

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psychiatric PRN and Stat medication for behavior control;

**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							
2010	Jun	Jul	Aug	Sep	Oct	Nov	Mean
Restraint	26	26	36	31	38	42	33
%C	100	100	100	100	100	100	100
Seclusion	41	22	33	42	47	38	37
%C	100	100	100	100	100	100	100
1:1	32	20	32	30	38	28	30
%C	100	100	100	100	100	100	100
Aggression to peers	34	25	33	41	50	46	38
%C	100	100	100	100	100	100	100
Aggression to self	8	7	9	7	11	8	8
%C	100	100	100	100	100	100	100

As seen in the table above, the PSSC had reviewed 100% of individuals who had met trigger thresholds on a number of key indicators including: restraint, seclusion, enhanced observation (1:1/2:1), aggression to peers, and aggression to self. Document analysis and staff interview found that the PSSC also had reviewed aggression triggers for aggression to staff (e.g. BS had aggressed against staff and his case was reviewed at the PSSC).

ASH has taken a number of steps to address violence at a facility level. The PSSC and the Psychology Department in collaboration with other departments have made significant contributions to this project. Document review found that the facility had conducted a comprehensive assessment to identify individual and group-based violence in the facility.

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		<p>The violence study data have provided some preliminary useful information for the facility to work on. For example, the study results showed that most aggressive events were perpetrated by individuals at the Supported Level of cognitive functioning, and by individuals diagnosed with Borderline Personality Disorder. Patient response showed that their aggression in the "impulsive" was triggered through frustration, the "organized" through feeling threatened, and the "psychotic" through hearing voices; they had indicated signs and symptoms towards aggression such as irritation (impulsive), resisting direction (organized), and irritation (psychotic); they would like to be provided with quiet time (impulsive and organized) and PRN (psychotic); and all three groups (impulsive, organized, and psychotic) wanted to talk to staff when they showing signs and symptoms towards aggression.</p> <p>The facility is also addressing violence reduction through Mall groups (e.g. the newly developed and implemented "1370 Mall group") and milieu interventions (e.g. the Therapeutic Milieu Enhancement Team [TMET]). The TMET is providing services at many levels including training staff at the unit level, mentoring unit staff upon referrals and providing Motivational Interviewing training to staff who have not had the training (79% of the staff at the facility have completed the training).</p> <p>ASH is pondering other ways to address violence reduction. In this light, the Quality Council has made the following proposals:</p> <ul style="list-style-type: none"> <li>• Enhanced Treatment Unit (ETU) (to provide a 24-hour locked treatment unit with enhanced clinical staffing and enhanced police presence; the individuals are to return to a regular unit when they attain behavioral stability;</li> <li>• DBT unit (this will serve for the most part as a step-down unit for individuals coming out of the ETU); and</li> <li>• A Social Learning Unit (SLU) (for lower-functioning individuals to have a safe milieu directed to their needs).</li> </ul>
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This monitor reviewed records of 19 individual documented to have met a trigger threshold (AS, AT, AZ, CB, CS, DD, DM, DR, DW, ED, FR, GT, JKS, MAM, MR, RE, RG, SB and WF). The PSSC had reviewed all of the cases and had taken appropriate action based on the information available at that time. In some cases, counseling had decreased the individual's maladaptive behaviors (GT) and a formal behavioral intervention was not required. In another (AZ), the individual was found to be unstable due to mental illness and the team decided to follow through with a Behavior Guideline, and meanwhile the individual is receiving support through the newly implemented "1370" Mall group.

**Other findings:**

Trigger trend data showed a significant reduction in triggers (from SIRs) since implementation of behavioral intervention plans (Behavior Guidelines, and Positive Behavior Support Plans) on aggression to self, aggression to peers and aggression to staff (September, 210 to February, 2011). A summary of the data is as follows:

Plan Type	Behaviors	Total incidents at plan start dates	Total incidents in February 2011
PBS plans	Total Aggression	15	9
	Aggression to Peers	11	8
	Aggression to Staff	4	1
BGs	Total Aggression	33	16
	Aggression to Peers	19	12
	Aggression to Staff	14	4

As the table above shows, there was a significant reduction in the total numbers of maladaptive behaviors since the implementation of behavioral intervention plans. The reduction cannot be ascribed solely to the behavioral intervention plans. The individuals simultaneously receive a

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		<p>variety of education, training, and intervention from different sources (e.g., Mall groups, individual therapies, medication). However, it speaks to the effectiveness of the bio-psycho-social intervention paradigm with behavioral intervention as an integral component.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (September 2010 - February 2011) and reported a mean compliance rate of 100%. 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 nine individuals with behavioral intervention plans (CC, CJ, DC, DH, GR, LP, LR, SB and ZS) found that the psychologists had interacted with other disciplines, primarily with the psychiatry staff, to integrate treatment modalities into their behavioral intervention plans. Consultation with other disciplines also takes place during the ETRC/PSSC meetings where trigger cases are reviewed, and at WRPCs where the PBS/DCAT psychologists attend the conferences to present data and to assist with documentation in the Present Status section of the individual's WRP. This monitor observed such collaboration while observing MAS' WRPC, in which the PBS team members were in attendance. Further evidence of the high level of psychology collaboration with other disciplines was evidenced through verbal</p>

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		<p>feedback from staff of other disciplines during the Risk Management review conducted by the Court Monitor and his experts on 4/20/2011.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (September 2010 - February 2011) and reported a mean compliance rate of 99%. 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 10 individuals with PBS plans or PBS assessments (AA, DJW, EJD, HFH, MG, PAP, RAL, REM, RS and TR) found that all 10 WRPs in the charts had properly specified in the objectives and interventions sections of the individual's WRP.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 415 1887 492"> <tr> <td data-bbox="993 415 1087 492">24.</td> <td data-bbox="1087 415 1793 492"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 415 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 records of 10 individuals with PBS plans or PBS assessments (AA, DJW, EJD, HFH, MG, PAP, RAL, REM, RS and TR) found that all 10 WRPs in the charts had properly discussed the PBS plans in the Present Status section of the individuals' WRPs. The documentation of these behavioral intervention plans in the WRPs has improved significantly. The PBS staff attends the WRPCs to assist with the documentation.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (September 2010 - February 2011):</p>			

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		<table border="1" data-bbox="991 191 1887 266"> <tr> <td data-bbox="991 191 1087 266">21.</td> <td data-bbox="1087 191 1793 266"><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 191 1887 266">100%</td> </tr> </table> <p data-bbox="991 310 1896 378">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 420 1896 488">A review of 10 PBS plans (AT, ED, ES, ET, JH, JR, LS, ML, RS and VC) found that all 10 plans included data on staff training and fidelity checks.</p> <p data-bbox="991 531 1457 599"><b>Current recommendation:</b> Continue to monitor this requirement.</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%			
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p data-bbox="991 644 1577 673"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 716 1457 784"><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="991 826 1881 1005"><b>Findings:</b> 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 data-bbox="991 1047 1457 1115"><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p data-bbox="991 1161 1577 1190"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 1232 1415 1300"><b>Recommendation, October 2010:</b> See F.2.a.ii.</p> <p data-bbox="991 1343 1136 1411"><b>Findings:</b> See F.2.a.ii.</p>			

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		<p><b>Current recommendations:</b> See F.2.a.ii.</p>
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH has a Diagnostic and Cognitive Assessment Team (DCAT). The team has been very active conducting assessments, providing Mall group services, and assisting PBS teams with conducting structural and functional assessments and developing and implementing behavioral intervention plans. According to the data presented to this monitor, the DCAT received 53 referrals during this review period. The team addressed these referrals through record reviews, structural and functional assessments and direct observations, and developed and implemented behavioral guidelines and Positive Behavior Support plans. In addition, the team members attended WRPCs to review assessment and outcome data with the WRPTs. The CAT is also involved in the Mentoring Project that counsels individuals regarding their PSR Rehabilitation Services.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>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><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Staff interview and documentation reviews (list of individuals reviewed at PSSC meetings, PSSC meeting minutes) found that the PSSC has met regularly and that attendance of the standing members of the Committee at these meetings has been high. Documentation indicated that 20 meetings were held during this review period (9/1/2010 through 2/29/2011) with 100% attendance. 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.). In addition, the PSSC meets separately to review cases in depth and provide feedback to the WRPTs and unit psychologists.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> 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 2010 - February 2011):</p>

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		<table border="1"> <thead> <tr> <th></th> <th>2010/2011</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>36</td> <td>55</td> <td>30</td> <td>41</td> <td>23</td> <td>45</td> <td>38</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>31</td> <td>54</td> <td>34</td> <td>39</td> <td>37</td> <td>32</td> <td>38</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>34</td> </tr> </tbody> </table> <p>ASH is currently staffed with four neuropsychologists. According to the Chief of Neuropsychological Services, the length of time taken to complete assessments is often a function of refusals by individuals that cause delays in completing the assessments.</p> <p>ASH also evaluated a total of 124 individuals to determine the individual's needs and the appropriate cognitive remediation group for that individual. ASH has 11 cognitive remediation groups at present, including a Spanish language group for one of the three "Get With It" groups.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		2010/2011	Sep	Oct	Nov	Dec	Jan	Feb	Mean	18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	36	55	30	41	23	45	38	18.a. ii	<i>Of those in 18.a.i, number completed</i>	31	54	34	39	37	32	38	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							34
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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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p>																																				

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		<p><b>Findings:</b> 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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donna Hunt, RN, HSS</li> <li>2. Megan Emrich, RN, HSS, Acting Assistant Nurse Administrator</li> <li>3. Rosemary Morrison, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH Nursing Services Monitoring PRN Audit summary data, September 2010 - February 2011</li> <li>2. ASH Nursing Services Monitoring Stat Audit summary data, September 2010 - February 2011</li> <li>3. ASH Nursing Staff Familiarity Monitoring Audit summary data, September 2010 - February 2011</li> <li>4. ASH Medical Transfer Audit summary data, September 2010 - February 2011</li> <li>5. ASH Nursing Services Audit summary data, September 2010 - February 2011</li> <li>6. ASH Medication Administration Monitoring Audit summary data, September 2010 - February 2011</li> <li>7. Medication Administration Monitoring audit for medication observation conducted on site</li> <li>8. ASH's training rosters data</li> <li>9. ASH's policy on documentation of medication and treatments</li> <li>10. RN Physical Assessment Tracking Tool description and form</li> <li>11. ASH Central Nursing Services Practice Development Series curriculum</li> <li>12. Administrative Directive 537: Change of Shift Report Hand-Off Communication</li> <li>13. Nursing Policy 218: Change of Shift Report Hand-Off Communication</li> <li>14. Medical records for the following 60 individuals: ADB, AFC, ALP, BGC, BLH, BYR, CD, CJE, DAC, DCT, DD, DEC, DJH, DJM, DLW, DP,</li> </ol>

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		<p>DRR, DRS, ECD, EME, ER, FK, GI, HAC, ISW, JAA, JAW, JC, JCM, JDS, JL, JLR, JR, KM, LC, LCR, LJ, LW, MB, MDN, ME, MIM, MLS, MM, MT, MWT, NT, OR, PAA, PD, PRS, RBC, RD, RDP, RGP, RH, SCK, TAK, TT and ZE</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Shift report on unit 1</li> <li>2. Medication administration on Program VI, unit 22</li> <li>3. WRPC (Program III, unit 32) for monthly review of MD</li> <li>4. WRPC (Program VI, unit 7) for quarterly review of KVK</li> <li>5. WRPC (Program VII, unit 23) for 14-day review of DLL</li> </ol>
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p><b>Compliance:</b> Substantial.</p>
F.3.a.i	safe administration of PRN medications and Stat medications;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Include the key for the numbers used for injection sites on the PRN/Stat Emergency Medication Notes.</p> <p><b>Findings:</b> In January 2011, the PRN/Stat Emergency Medication Interdisciplinary Note was revised to include a key reflecting the sites for injections.</p> <p><b>Recommendation 2, October 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b></p> <p>Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 56% mean sample of PRNs administered each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 98%. 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 also assessed its compliance based on a 49% mean sample of Stat medications administered each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 97%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 250 PRN and Stat orders (200 PRN and 50 Stat) for 47 individuals (ADB, ALP, BGC, BLH, BYR, CD, CJE, DAC, DCT, DD, DEC, DJH, DJM, DLW, DRR, DRS, ECD, EME, GI, HAC, ISW, JAA, JAW, JC, JCM, JDS, JL, JLR, LC, LCR, LJ, LW, MB, MDN, MLS, MT, MWT, PAA, PD, PRS, RBC, RDP, RGP, RH, TAK, TT and ZE) found that 247 included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all notes.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 56% mean sample of PRNs administered each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 376 1887 527"> <tr> <td data-bbox="991 376 1087 527">3.</td> <td data-bbox="1087 376 1793 527"><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 376 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>A review of 200 incidents of PRN medications for 25 individuals (ADB, BLH, BYR, CJE, DAC, DCT, DD, DJM, DLW, ECD, JAA, JAW, JDS, JLR, LJ, LW, MDN, MLS, MT, MWT, PAA, PRS, RBC, RDP and RH) found adequate documentation in the IDNs of the circumstances requiring the PRN in 193 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, ASH also assessed its compliance based on a 49% mean sample of Stat medications administered each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1081 1887 1232"> <tr> <td data-bbox="991 1081 1087 1232">4.</td> <td data-bbox="1087 1081 1793 1232"><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 1081 1887 1232">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>A review of 50 incidents of Stat medications for 24 individuals (ALP,</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>	100%	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>	98%
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>	100%						
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>	98%						

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		<p>BGC, BLH, CD, DEC, DJH, DRR, DRS, EME, GI, HAC, ISW, JC, JCM, JL, LC, LCR, MB, MDN, PD, RGP, TAK, TT and ZE) found adequate documentation in the IDNs of the circumstances requiring the Stat in 49 incidents.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 56% mean sample of PRNs administered each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 857 1887 971"> <tr> <td data-bbox="991 857 1087 971">5.</td> <td data-bbox="1087 857 1793 971"><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 857 1887 971">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>A review of 200 incidents of PRN medications for 25 individuals (ADB, BLH, BYR, CJE, DAC, DCT, DD, DJM, DLW, ECD, JAA, JAW, JDS, JLR, LJ, LW, MDN, MLS, MT, MWT, PAA, PRS, RBC, RDP and RH) found a timely comprehensive assessment in the IDNs of the individual's response in 197 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, ASH also assessed its compliance based on a 49% mean sample of Stat medications</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	97%
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		<p>administered each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 305 1887 415"> <tr> <td data-bbox="993 305 1087 415">6.</td> <td data-bbox="1087 305 1793 415"><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 305 1887 415">95%</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 50 incidents of Stat medications for 24 individuals (ALP, BGC, BLH, CD, DEC, DJH, DRR, DRS, EME, GI, HAC, ISW, JC, JCM, JL, LC, LCR, MB, MDN, PD, RGP, TAK, TT and ZE) found a timely comprehensive assessment in the IDNs of the individual's response in 49 incidents.</p> <p><b>Current recommendation:</b> 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	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, ASH continued to follow the same process for MVRs, which included the following steps:</p> <ol style="list-style-type: none"> <li>1. MVR generated after variance discovered</li> <li>2. Review by Program HSS - maintains original MVR</li> <li>3. Review by Program Unit Supervisor - all MVRs</li> <li>4. Review by Program Director, as applicable (all actual MVRs)</li> <li>5. Review by Standards Compliance MVR Team - all MVRs for</li> </ol>			

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		<p>review/data agreement and identification of serious potential variances</p> <p>6. Review by Pharmacy (all actual MVRs) - for ORYX benchmarking</p> <p>The Programs immediately contact Standards Compliance regarding any MVR suspected to be actually or potentially serious. The information is forwarded to the Medical Director, Central Nursing Services, the 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>A review of 50 MVRs found that ASH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> 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><b>Compliance:</b> Substantial.</p>

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	<p>service plan, in terms of the current DSM criteria, are required.</p>	<p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Staff Familiarity Monitoring Audit, ASH assessed its compliance based on an average sample of 15% of the nursing staff:</p> <table border="1" data-bbox="991 711 1887 860"> <tr> <td data-bbox="991 711 1087 860">8.</td> <td data-bbox="1087 711 1793 860"><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 711 1887 860">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>In three WRPCs observed, all team members were familiar with the individual and his 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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</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>	100%
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>	100%			

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<p>F.3.e</p>	<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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that audits regarding nursing documentation for change in status address the quality of the documentation.</li> <li>• Audit change of status requirement by first reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool.</li> </ul> <p><b>Findings:</b> Nursing administrators at ASH indicated that they were aware of the following deficits in the nursing documentation addressing changes in status:</p> <ul style="list-style-type: none"> <li>• Lapses of time between reassessments when an individual is identified as having a change in physical status;</li> <li>• Documentation of complete and adequate assessments that reflect clinical understanding of an individual's medical condition;</li> <li>• Clear and consistent documentation of physician notification; and</li> <li>• An effective tool for RNs to communicate assessments required from shift to shift.</li> </ul> <p>Since the last review, the Statewide Nursing Group met to address these issues and developed a new audit tool for changes in status that includes the process of reviewing the clinical "story". The new audit process will include a review of the documentation four weeks prior to the transfer out of the facility to a community ER/hospital and one week post return to the facility. The focus of the review will be on the quality of the nursing documentation. The new audit tool will be finalized by May 2011. The current audit tool only requires review of the nursing documentation at the time of a transfer, which only includes the RN Change in Condition Note and other transfer documents. Since the new audit tool had not</p>
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		<p>been yet been implemented, ASH's data below were reflective of the limited process just described and did not comport with the reviewer's findings. In addition, in March 2011 ASH hosted a Nursing Summit that included discussion and review of best practices and methods for auditing documentation.</p> <p>Since the last review, ASH had implemented the following procedures to begin to address the problematic issues regarding changes in status:</p> <ul style="list-style-type: none"> <li>• November 2010: Program HSSs began reviewing Medical/Psychiatric Appointment Log daily and reviewing those individuals' nursing documentation for quality and providing feedback to the RNs.</li> <li>• November 2010: Nurse on Duty (NOD) HSSs begin real-time reviews of all documentation related to medical transfers, including documentation and assessments when the individuals were transferred out of the facility; upon return; adequate documentation in the WRPs; and the plan of care.</li> <li>• November 2010: "The Loop" website was implemented as a training/communication tool. Each month, new information will be posted on this website for RNs and PTs to review and keep updated regarding changes in procedures. In February 2011, the new RN Physical Assessment Tracking Tool was posted for staff review.</li> <li>• December 2010 through February 2011: A pilot of the RN Physical Assessment Tracking Tool was implemented on two units. Hospital-wide training was completed by CNS in February 2011 and the tool was then implemented hospital-wide on March 1, 2011, replacing the TC/RN Reassessment Tracking Tool.</li> <li>• March 2011: Unit RNs began participating in the Individual Case Review Studies with their HSSs that includes the review of the nursing documentation four weeks prior to and one week after the transfer.</li> <li>• March 1, 2011: Central Nursing Services RN mentors began reviewing Medical/Psychiatric Appointment Logs daily, reviewing entries into</li> </ul>
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		<p>the RN Physical Assessment Tracking Log, and reviewing documentation for quality, providing feedback to the RNs.</p> <ul style="list-style-type: none"> <li>• March 21-22, 2011: The Nursing Summit was held at ASH and revisions were made to the following:             <ul style="list-style-type: none"> <li>▪ RN Change in Physical Status form</li> <li>▪ Provision of Care Policy (to include Psych Tech and LVN responsibilities)</li> <li>▪ Medical Transfer Audit</li> <li>▪ RN Progress Note for Assessment and Evaluation</li> <li>▪ Nursing Weekly Progress Note</li> <li>▪ Presentation of the new RN Physical Assessment Tracking Tool</li> <li>▪ Use of the Change of Shift (DVD) for training</li> </ul> </li> <li>• Beginning April 2011, all newly hired PTs upon completion of the hospital's orientation program will attend an additional three-day training provided by Central Nursing Services staff that includes the following areas:             <ul style="list-style-type: none"> <li>▪ Nursing Weekly Progress Note</li> <li>▪ Input into the WRPC</li> <li>▪ Provision of Care</li> <li>▪ Kardex/Change of Shift/Shift Assignments</li> <li>▪ MOSES</li> <li>▪ Admission and Discharge Paperwork</li> <li>▪ Interviewing Techniques (including for when an individual is in Restraint/Seclusion)</li> <li>▪ Computer orientation (access to databases, nursing procedures, etc)</li> </ul> </li> <li>• May 2010 and ongoing: Individual Case Review Studies implemented by Central Nursing Services following the above-outlined process.</li> </ul> <p><b>Recommendation 3, October 2010:</b> Continue training modules focused on building and improving nursing competency regarding assessments and documentation addressing changes in status.</p>
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		<p><b>Findings:</b> In March 2011, ASH provided training on Focused Physical Assessment Training Module 2 - Integumentary Assessment. In addition to the live classes offered, a videotape of the class will be available for training and will include a practicum to receive credit for the class. The next module training regarding Abdominal Assessment/Constipation will be provided in April 2011, also with live classes as well as the availability of the videotaped training with a practicum.</p> <p><b>Recommendation 4, October 2010:</b> Ensure that audits addressing change of shift report accurately reflect the shift report observed. Continue efforts in mentoring appropriate shift reports.</p> <p><b>Findings:</b> In September 2010, the completion of the Shift Change audits was delegated to the Central Nursing Services HSSs and RN Mentors. Also, in December 2010 through February 2011, a Change of Shift Workgroup was implemented to address the quality of the shift reports and the CNS RN Mentors coordinated with Program Nursing Coordinators to provide the refresher training to the Unit Supervisors and SPTs in February 2011, with ongoing training and mentoring provided to unit staff. In addition, the Nursing Policy 218, and Administrative Directive 537: Change of Shift Report Hand-Off Communication was revised to include mandatory attendance by the Unit Supervisors. Also, it is now required that the Sick Call Log and the RN Physical Assessment Tracking Tool are reviewed at shift change report.</p> <p><b>Recommendation 5, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b></p>
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		<p>Using the DMH Medical Transfer Audit, ASH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 337 1887 565"> <tr> <td data-bbox="991 337 1087 451">1.</td> <td data-bbox="1087 337 1793 451"><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 337 1887 451">96%</td> </tr> <tr> <td data-bbox="991 451 1087 565">7.</td> <td data-bbox="1087 451 1793 565"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 451 1887 565">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>A review of the records of 13 individuals who were transferred to a community hospital/emergency room (AFC, DP, ER, FK, JR, KM, ME, MIM, MM, NT, OR, RD and SCK) found that there continued to be a number of problematic issues with the nursing documentation. Examples of problematic issues included:</p> <p><u>Change in Status</u></p> <ul data-bbox="991 976 1921 1117" style="list-style-type: none"> <li>• Nurses not recognizing symptoms as changes in status that warrant assessments and regular follow up.</li> <li>• Inconsistencies found regarding when the Change of Status forms are to be initiated.</li> </ul> <p><u>Nursing Assessments</u></p> <ul data-bbox="991 1198 1921 1414" style="list-style-type: none"> <li>• No complete nursing assessment conducted for an individual noted to have possible lithium toxicity and placed on a medical 1:1.</li> <li>• No regular nursing assessments documented for an individual demonstrating significant cognitive changes, incontinence, and requiring total care for activities of daily living.</li> <li>• No nursing follow-up assessment documented for an individual</li> </ul>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	100%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	100%						

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		<p>demonstrating signs of dehydration. Also, no consistent documentation of fluid intake.</p> <ul style="list-style-type: none"> <li>• Nursing note indicated that abnormal vital signs would be retaken when individual was calmer. No documentation found that vital signs were rechecked for nine hours.</li> <li>• No assessments of bowel sounds and palpation of the abdomen found when PRNs were given for episodes of constipation.</li> <li>• Incomplete nursing assessments for pain.</li> <li>• Lack of follow up assessments for symptoms of constipation.</li> <li>• No nursing assessment or description of an individual prior to or after administering IV Ativan.</li> <li>• No nursing assessment or complete set of vital signs documented for an individual coughing at intervals, sounding dry and breathing shallow.</li> <li>• No nursing documentation of assessments and procedures post lumbar puncture.</li> <li>• Lack of a complete nursing assessment upon return to the facility specifically addressing the symptoms that precipitated the hospitalization or ER visit.</li> <li>• No consistent nursing assessments of surgical sites.</li> <li>• The lack of neurological checks and mental status documented for individuals with a significant change in cognition.</li> </ul> <p><u>Documentation</u></p> <ul style="list-style-type: none"> <li>• Difficult to determine exactly when an individual was actually transferred to community hospital/emergency room from documentation in progress notes, transfer form, and RN Change of Status form.</li> <li>• A number of Change of Status forms noted assessments were conducted by a check mark; however, there was no documentation of the results of the assessments.</li> <li>• Progress note indicated that an RN had assessed an individual with changes in physical status, however, no findings of the assessment were documented.</li> </ul>
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		<ul style="list-style-type: none"> <li>• PRN medications for pain not appropriately documented in nurses' progress notes.</li> <li>• Illegible progress notes and signatures and titles</li> <li>• A significant number of progress notes that were documented out of order.</li> <li>• Lack of consistent documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline.</li> <li>• Significant gaps in documentation after individuals were identified as experiencing a change in status.</li> <li>• No consistent documentation addressing the monitoring of equipment such as IVs, G-Tubes, or NG Tubes.</li> <li>• Documentation blanks in Intake/Output flow sheets.</li> <li>• No nursing documentation indicating if an individual was actually catheterized at the Urgent Care Room.</li> <li>• The lack of adequate and complete documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room.</li> <li>• No consistent summary documented of treatments provided at the community hospital or ER.</li> <li>• No reference to the use of Neuro checks sheets or flow sheets used for documentation in the nursing progress notes.</li> </ul> <p>As noted above, these findings did not comport with ASH's data. The interventions listed above addressing some of the problematic issues in this area indicated that that the facility and the State were aware of the problems and were making significant efforts to identify more accurately the problematic issues that have been consistently found in this area and implement strategies to address these issues. The facility needs to develop and implement a system for documentation, such as the use of the RANs and/or Nursing Protocols, so that nurses have a structure guiding their documentation to ensure completeness and consistency. The facility recognizes that it has significant work to do in</p>
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		<p>this area so that the individuals are provided timely and appropriate nursing assessments and interventions that are consistently documented, which will ultimately result in substantial compliance with this requirement.</p> <p>Using the DMH Nursing Services Audit, ASH assessed its compliance based on a 97% sample of Change of Shift Reports observed during in the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 522 1887 636"> <tr> <td data-bbox="991 522 1087 636">10.</td> <td data-bbox="1087 522 1793 636"><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 522 1887 636">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>Observation of shift report on unit 1 found that the report was included some good clinical information; however, it was difficult to determine from the shift report why exactly the individuals were on that particular unit. A brief statement for each individual addressing this issue in alignment with the Axis diagnoses would easily clarify this since the UCR is basically ASH's medical unit and individuals transferred there would be being observed for specific issues. This information and specific clinical information indicating if the individuals were doing better or worse regarding their symptoms would make the shift report complete. The facility needs to continue its efforts in training and mentoring appropriate shift reports.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement the revised audit tool regarding nursing documentation for</li> </ol>	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>	97%
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>	97%			

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		<p>change in status to address the quality and completeness of the nursing documentation.</p> <ol style="list-style-type: none"> <li>2. Continue training and strategies focused on building and improving nursing competency regarding assessments and documentation of changes in status.</li> <li>3. Develop and implement a system for documentation, such as the use of the RANs and/or Nursing Protocols, so that nurses have a structure guiding their documentation to ensure completeness and consistency.</li> <li>4. Continue efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis Diagnoses.</li> <li>5. Continue to monitor this requirement.</li> </ol>
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p><b>Compliance:</b> Substantial.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Ensure that auditors for medication administration allow the unit nurse to demonstrate the process in order to accurately assess the procedure to provide adequate medication administration data without becoming a distraction to the process.</p> <p><b>Findings:</b> In December 2010, a mandatory training was provided to all HSSs that included a review of the expectations regarding the Medication Administration Audits without distracting the person administering medications.</p> <p><b>Recommendation 2, October 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 63% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 98%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period. Compliance rates for other items in this audit are reported in the following cells.</p> <p>From observations of medication administration on Unit 22, the medication nurse observed demonstrated consistent interaction with the individuals receiving medications and provided some medication education. All medication administration procedures were appropriately followed. Also, the facility nurse observing the medication administration provided appropriate feedback and correction when appropriate.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.f.ii	education is provided to individuals during medication administration;	The facility reported a mean compliance rate of 93%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	The facility reported a mean compliance rate of 99%. Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Provide retraining to staff addressing the need to document the medication, dosage, route and time administered for PRNs and Stat</p>

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		<p>medications on the front of the Medication Administration Record.</p> <p><b>Findings:</b> In January and February, 2011, training was provided regarding the appropriate documentation of PRN and Stat medications.</p> <p><b>Recommendation 2, October 2010:</b> Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice.</p> <p><b>Findings:</b> ASH's policy Documentation of Medication and Treatments was appropriately revised in February 2011 to reflect the correct procedure for documenting PRN and Stat medications on the medication administration record.</p> <p><b>Recommendation 3, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 63% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 99%. 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 that were found and reported on the MTRs and Narcotic Logs during the review period.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement in the event this issue arises.</p> <p><b>Findings:</b> There were no bed bound individuals during the review period.</p> <p><b>Compliance:</b> Not applicable.</p> <p><b>Current recommendation:</b> Continue current practice.</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><b>Compliance:</b> 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 the individual's status;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH training rosters indicated that over 90% of all existing staff attended and passed the required training.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to	<p><b>Current findings on previous recommendation:</b></p>

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	prevent and de-escalate crises; and	<p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Information provided after the tour indicated that 100% of nursing staff had completed the New Employee Therapeutic Milieu training.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.h.iii	positive behavior support principles.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Information provided after the tour indicated that 90% of nursing staff had completed the New Employee PBS training.</p> <p><b>Current recommendations:</b> See F.3.h.ii.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH's training rosters indicated that 100% of newly hired nursing staff and 94% of existing nursing staff had completed the required training.</p> <p><b>Compliance:</b> Substantial.</p>

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		<b>Current recommendation:</b> Continue current practice.
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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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Kathy Runge, Occupational Therapist</li> <li>2. Ladonna Decou, Chief of Rehabilitation</li> <li>3. Rachelle Rianda, Acting Senior Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 audit data for September 2010 - February 2011</li> <li>2. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review</li> <li>3. Records of the following 24 individuals participating in observed PSR Mall groups: AAP, AB, APS, AV, BAB, CET, DRM, EJD, GTM, JC, JDS, JGF, JMH, KJB, LCS, LE, MAK, MDW, MLH, MNT, PA, RAH, SBH and VA</li> <li>4. List of individuals who received direct physical therapy services from September 2010 - February 2011</li> <li>5. List of individuals who received direct speech therapy services from September 2010 - February 2011</li> <li>6. List of individuals who received direct occupational therapy services from September 2010 - February 2011</li> <li>7. Records of the following 14 individuals who received direct physical therapy, speech therapy, and/or occupational therapy services from September 2010 - February 2011: ADD, DMM, DRS, IM, JAL, JC, JLR, JMR, MAA, MER, MR, RW, SW-1 and SW-2</li> <li>8. List of individuals with a 24-Hour Rehabilitation Support Plan</li> <li>9. Records of the following six individuals with 24-Hour Rehabilitation Support Plans: AM, DRS, GDH, MBB, PSJ and TMP</li> <li>10. List of individuals with INPOP plans</li> <li>11. Record of the following individual with an INPOP plan: PSJ</li> <li>12. List of individuals at high risk for falls</li> <li>13. List of individuals with three or more falls in 30 days and falls</li> </ol>

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		<p>resulting in major injury during the review period</p> <ol style="list-style-type: none"> <li>14. List of individuals at high risk for skin breakdown</li> <li>15. List of individuals with an incident of a decubitus ulcer during the review period</li> <li>16. Records of the following four individuals at high risk for falls: FDS, MBB, SCK and WAC</li> <li>17. Records of the following two individuals who had three or more falls in 30 days or a fall with a major injury during the review period: AT and DTR</li> <li>18. Record of the following individual with an incident of a decubitus ulcer during the review period: GAB</li> <li>19. Record of the following individual at high risk for impaired skin integrity: RR</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Self Discovery through Art PSR Mall group</li> <li>2. Brain Fitness through Music PSR Mall group</li> <li>3. Anger Management (assisted) PSR Mall group</li> <li>4. Interacting through Music PSR Mall group</li> <li>5. Competency through Activities 1 PSR Mall group</li> <li>6. Competency through Activities 2 PSR Mall group</li> <li>7. Improving Balance PSR Mall group</li> <li>8. Brain Fitness (Spanish) PSR Mall group</li> <li>9. Anger Management (Spanish) PSR Mall group</li> <li>10. Exploring Mental Health through Music PSR Mall group</li> <li>11. Mental Health Wellness PSR Mall group</li> <li>12. Mealtime for individual with 24 Hour Support Plan</li> </ol>
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><b>Compliance:</b> Substantial.</p>

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<p>F.4.a.i</p>	<p>the provision of direct services by rehabilitation therapy services staff; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> The table below presents the number of hours scheduled versus number of hours provided in direct OT, PT and SLP treatment during the week of 1/31/11:</p> <table border="1" data-bbox="989 561 1587 716"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>28</td> <td>20</td> </tr> <tr> <td>OT</td> <td>23</td> <td>19</td> </tr> <tr> <td>SLP</td> <td>35</td> <td>31</td> </tr> </tbody> </table> <p>The facility reported that the discrepancy between hours scheduled and provided was due primarily to refusals and illness.</p> <p><b>Other findings:</b> Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 14% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period September 2010 - February 2011, and reported a mean compliance rate of 100%. 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 receiving direct occupational, physical, and/or speech therapy direct treatment to assess compliance with F.4.a.i criteria found all records in substantial compliance. Upon record review, it appears that direct treatment objectives and interventions that were focused on improving functional cognitive skills continue to be listed under Focus 6, rather than under a more appropriate focus of treatment (e.g. Focus 1). Furthermore, while adequate progress</p>		Scheduled	Provided	PT	28	20	OT	23	19	SLP	35	31
	Scheduled	Provided												
PT	28	20												
OT	23	19												
SLP	35	31												

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		<p>was documented in the Present Status section of the WRP, detailed documentation of progress was not consistently noted in the physical therapy progress notes, and physical therapy objectives were measureable but not consistently tied to a functional skill.</p> <p>In terms of individual outcomes, objectives were either met or documentation of progress towards objectives was noted for 10 out of 14 individuals reviewed.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> The facility reported that one individual (DRS) met criteria for an INPOP during the review period. No audit data were provided, though a review of the record found it to be in substantial compliance with criteria for an INPOP, evidence of plan implementation and individual reassessment as clinically indicated.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</p>
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p>

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		<p><b>Findings:</b> The facility reported that all 202 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. Types of training provided included the following: Speech Language Assessment results and recommendations, dysphagia training, POST services and the enduring WRPT, 24-hour support plan, OT clinic infection control policy, POST services, and adapted feeding equipment and dysphagia.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 1, October 2010:</b> During the maintenance period, 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.</p> <p><b>Findings:</b> A review of records of individuals at risk for falls, impaired skin integrity and choking, and who met a fall trigger or had a reported decubitus, choking incident or incident of aspiration pneumonia, found that 24-hour support plans appeared to be clinically indicated for three individuals (DRS, GAB and MBB). One individual (DRS) had a 24-hour support plan developed and implemented, one individual (MBB) had a 24-hour support plan that addressed choking risk but not fall risk, and one individual's record (GAB) showed no evidence of POST assessment or 24-hour support plan.</p>

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		<p>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period September 2010 - February 2011, and reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of six individuals with 24-hour support plans to assess compliance with F.4.c criteria found four records in substantial compliance (AM, GDH, PSJ and TMP), and two records in partial compliance (DRS and MBB), as they did not include all relevant sections related to ADLs and mobility.</p> <p><b>Recommendation 2, October 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 11% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period September 2010 - February 2011, and reported a mean compliance rate of 98%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>The table below presents the number of hours scheduled versus number of hours provided in PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 1/31/11:</p> <table border="1" data-bbox="989 1300 1654 1414"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>258</td> <td>254</td> </tr> <tr> <td>Voc Rehab</td> <td>72</td> <td>72</td> </tr> </tbody> </table>		Scheduled	Provided	RT	258	254	Voc Rehab	72	72
	Scheduled	Provided									
RT	258	254									
Voc Rehab	72	72									

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		<p>A review of the records of 24 individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 22 records in substantial compliance (AAP, AB, APS, AV, BAB, CET, DRM, EJD, GTM, JGF, JMH, KJB, LCS, LE, MAK, MDW, MLH, MNT, PA, RAH, SBH and VA) and two records in partial compliance (JC, JDS).</p> <p>In terms of individual outcomes, objectives were either met, or documentation of progress towards objectives was noted for 18 out of 19 individuals reviewed (individuals recently enrolled in groups not reviewed in terms of progress toward individual outcomes).</p> <p>Observation of 11 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. There seems to have been an increase in the variety of available RT groups, particularly for individuals who require cognitive assistance and supports. There is a good selection of groups that utilize RT modalities to supplement didactic teaching within the various foci. However, currently most objectives are focused on verbalizing, rather than demonstrating or applying a learned behavior or skill. In addition, while they meet criteria of being specific and measurable, objectives are not consistently aligned with individual cognitive, social, and communication skills.</p> <p><b>Other findings:</b></p> <p>A review of two individuals who had three or more falls in 30 days or fall resulting in major injury and four individuals at high risk for falls found that when clinically indicated, four records (AT, DTR, FDS and WAC) had adequate documentation of both therapy services assessment and treatment plan (e.g., 24 hour support plan, direct treatment objective and intervention) to remediate fall risk and/or future occurrence, one record had partial documentation (MBB), and one did not have documentation</p>
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		<p>(SCK). A review of a record of an individual who had recurrent incidents of decubitus (GAB) found no documentation of therapy services assessment and plan to remediate decubitus risk and/or future occurrence.</p> <p>During observation of an individual with a 24-hour support plan during lunch on the unit, it was noted that while his plan appeared to be implemented in terms of required supervision, the milieu did not seem to support the safe mealtime behaviors that the plan was designed to facilitate. A lack of seating during the sack lunch period resulted in many individuals standing, talking while eating, and eating rapidly, which presented modeling of behaviors contraindicated for the individual at risk.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. During the maintenance period, ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan or direct POST services to improve function or decrease risk of harm receive this service.</li> <li>2. Continue to monitor this requirement.</li> </ol>
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> 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</p>

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		<p>2010 - February 2011:</p> <table border="1" data-bbox="989 264 1885 643"> <tr> <td data-bbox="989 264 1087 341">e.</td> <td data-bbox="1087 264 1793 341"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 264 1885 341">100%</td> </tr> <tr> <td data-bbox="989 341 1087 417">f.</td> <td data-bbox="1087 341 1793 417"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 341 1885 417">100%</td> </tr> <tr> <td data-bbox="989 417 1087 493">g.</td> <td data-bbox="1087 417 1793 493"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 417 1885 493">100%</td> </tr> <tr> <td data-bbox="989 493 1087 570">h.</td> <td data-bbox="1087 493 1793 570"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 493 1885 570">100%</td> </tr> <tr> <td data-bbox="989 570 1087 643">i.</td> <td data-bbox="1087 570 1793 643"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 570 1885 643">100%</td> </tr> </table> <p data-bbox="989 683 1822 751">Comparative data indicated that ASH maintained a compliance rate greater than 90% from the previous review period for all items.</p> <p data-bbox="989 797 1140 862"><b>Compliance:</b> Substantial.</p> <p data-bbox="989 907 1457 972"><b>Current recommendation:</b> 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%
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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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Dawn Hartman, Assistant Director of Dietetics</li> <li>2. Erin Dengate, Assistant Director of Dietetics</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from September 2010 - February 2011 for each assessment type</li> <li>2. Records of the following 41 individuals with types a-j.ii assessments from September 2010 - February 2011: AA, AAG, AY, BMO, CET, DC, DDC, DDD, DH, DMH, DN, FA, GDH, IM, JAD, JC, JSL-E, JW, KH, KJF, KQ, LG, LJ, LRS, MA, MBB, MC, ME, MJC, NER, PR, RC, RFH, RJS, RLC, SDH, SM, TL, WKK, WMH and ZME</li> <li>3. Nutrition Care Monitoring Tool audit data from September 2010 - February 2011 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)</li> <li>4. Nutrition Care Monitoring Tool audit data from March-August 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)</li> <li>5. List of individuals with choking and aspiration pneumonia incidents during the review period</li> <li>6. Records of the following two individuals at risk for choking/ aspiration: GP and MBB</li> <li>7. Record of the following individual with an incident of aspiration pneumonia during the review period: DRS</li> <li>8. Records of the following two individuals with an incident of choking during the review period: DAY and JKK</li> <li>9. List of individuals with a new diabetes diagnosis during the review period</li> </ol>

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		<p>10. Records of the following three individuals with a new diagnosis of diabetes during the review period: AGA, AT and JD</p> <p>11. List of individuals at risk for metabolic syndrome</p> <p>12. Records of the following two individuals at high risk for metabolic syndrome: RT and SO</p> <p>13. Records of the following three individuals participating in the Step Up to Wellness PSR mall group: AED, RC and WLB</p> <p>14. New Employee Training materials for Food Service Technicians and Cooks</p> <p>15. Weight Management and BMI Guidelines for WRPTs (revised 3/08/11)</p> <p>16. Step Up to Health Diabetes Prevention Program</p> <p><u>Observed:</u> Step Up to Wellness PSR Mall Group</p> <p><u>Toured:</u> Food Services area/kitchen</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 20% of Nutrition Assessments (all types) due each month from September 2010 - February 2011 (total of 349 out of 1748):</p> <table border="1" data-bbox="989 1300 1887 1412"> <tr> <td data-bbox="989 1300 1073 1341">7.</td> <td data-bbox="1073 1300 1793 1341"><i>Nutrition education is documented.</i></td> <td data-bbox="1793 1300 1887 1341">99%</td> </tr> <tr> <td data-bbox="989 1341 1073 1412">8</td> <td data-bbox="1073 1341 1793 1412"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i></td> <td data-bbox="1793 1341 1887 1412">100%</td> </tr> </table>	7.	<i>Nutrition education is documented.</i>	99%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	100%
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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"><i>identified.</i></td> <td style="width: 50%;"></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 41 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>Upon review of Nutrition Care assessments and updates, it was noted that recommendations are often made for the mealtime milieu, or for provision of dietary and eating supports by level of care staff. However there is not currently a system in place to ensure that recommendations are communicated to the treatment team and/or level of care staff, with training provided as needed.</p> <p>The facility reported that all food service technicians and cooks are provided training on therapeutic diet textures (mechanical soft and NDD diets) upon New Employee Orientation, which was substantiated by review of training checklist and materials. In addition, updates are provided as clinically indicated (e.g., following change to Nutrition Care manual).</p> <p>ASH assessed its compliance with tray accuracy based on an average sample of 10% of average daily census from September 2010 (total of 698 out of 6964) and found that 99% of trays audited were in 100% compliance.</p> <p><b>Other findings:</b> A review of records of five individuals at high risk for metabolic syndrome and with a new diagnosis of diabetes found that four records had evidence of a nutrition assessment and acuity level commensurate with level of risk that addressed either risk factors or appropriate</p>	<i>identified.</i>	
<i>identified.</i>				

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		<p>contributing factors (AT, JD, RT and SO). Four records 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. No referral for nutrition assessment was made for one individual (AGA) following new diabetes diagnosis.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. During the maintenance period, develop a system to ensure that level of care staff and other appropriate WRPT members are trained and informed on nutrition assessment recommendations.</li> </ol>						
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with WRP integration based on an average sample of 20% of Nutrition Assessments (all types) due each month from September 2010 - February 2011 (349 out of 1748):</p> <table border="1" data-bbox="989 1154 1887 1344"> <tr> <td data-bbox="989 1154 1087 1227">19.</td> <td data-bbox="1087 1154 1793 1227"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 1154 1887 1227">99%</td> </tr> <tr> <td data-bbox="989 1227 1087 1344">20.</td> <td data-bbox="1087 1227 1793 1344"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 1227 1887 1344">97%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	99%	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>	97%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	99%						
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>	97%						

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		<p>at least 90% from the previous review period for both items.</p> <p>A review of the records of 13 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><b>Other findings:</b>  A review of records of three individuals participating in the Step Up to Wellness PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found one record in substantial compliance (RC) and two records in partial compliance (AED and WLB). Both of these records had evidence of a completed progress note, but no evidence of documentation of progress in the Present Status section of the WRP.</p> <p>Observation of the Step Up to Wellness 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>BMI guidelines have been updated to reflect revised entrance criteria for the Step Up group. These criteria allow for a more proactive approach to identifying individuals who are at risk for diabetes.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</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	<b>Current findings on previous recommendation:</b>

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	<p>dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p><b>Recommendation, October 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> 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><b>Other findings:</b> A review of the records of two individuals who were at risk for choking and aspiration found evidence in both records that a speech therapy referral or assessment was completed. An individualized plan did not appear to be clinically indicated for GP, but for MBB, a 24-hour support plan was developed and implemented to address choking risk following speech therapy evaluation and was subsequently updated. Review of the records of two individuals with reported choking incidents found that one of two individuals (DAY) did not choke but broke his tooth while eating (incident was inaccurately reported). Review of the record of JKK found that following a choking incident, the individual was assessed by a physician, who observed him swallowing water and a cracker and subsequently found "no evidence of swallowing disorder or dysphagia". No speech therapy evaluation or assessment of the individual eating the item he choked on (peanut butter sandwich), or similar items within his current diet texture was performed. Review of a record of an individual with a reported incident of aspiration pneumonia (DRS) found that he was seen monthly by the speech therapist for reassessment due to dysphagia, and had a 24-hour support plan in place to prevent aspiration and support safety and function during intake. The plan was revised on 2/1/11 based on reassessment findings.</p> <p><b>Compliance:</b> Substantial.</p>
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		<p><b>Current recommendation:</b> Continue to enhance current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Two new dietitians were hired during the review period and were trained to competency on basic issues related to aspiration and dysphagia.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility reported that no individuals currently receive enteral nutrition and are NPO. The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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

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7. General Medical Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ali Akhavan, MD, Physician and Surgeon</li> <li>2. Ana Onglao, MD, Physician and Surgeon</li> <li>3. Art Onglao, MD, Physician and Surgeon</li> <li>4. Bob Taylor, MD, Physician and Surgeon</li> <li>5. Douglas Shelton, MD, Chief Physician and Surgeon</li> <li>6. Emily Luk, MD, Physician and Surgeon</li> <li>7. Hani Boutros, MD, Physician and Surgeon</li> <li>8. Hussein Akhavan, MD, Physician and Surgeon</li> <li>9. Joshua Deane, MD, Acting Chief of Psychiatry</li> <li>10. Phil Wichmann, MD, Physician and Surgeon</li> <li>11. Rosie Morrison, RN, Acting Nurse Administrator</li> <li>12. Thomas Cahil, MD, Acting Medical Director</li> <li>13. Willard Towle, MD, Physician and Surgeon</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 11 individuals: DP, ER, FK, JR, ME, MM-1, MM-2, NT, OR, RD and SK</li> <li>2. List of all individuals admitted to external hospitals and transferred to the hospital's internal medical unit 1 during the review period</li> <li>3. Psychogenic Polydipsia Protocol - revised 12/21/10</li> <li>4. Quarterly Progress Notes on the following 11 individuals: BP, DC, EM, FR, HMK, JD, KT, MC, PD, RJS and RR</li> <li>5. ASH Medical-Surgical Progress Note Audit summary data (September 2010 - February 2011)</li> <li>6. ASH Integration of Medical Conditions into the WRP Audit summary data (September 2010 - February 2011)</li> <li>7. ASH Medical Emergency Response Drill Audit summary data (September 2010 - February 2011)</li> <li>8. Summary information on Medical Emergency Response Drills</li> </ol>

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		<p>conducted during the review period</p> <ol style="list-style-type: none"> <li>9. ASH Medical Transfer Audit summary data (September 2010 - February 2011)</li> <li>10. Hospital Paperwork rec'd within 7 days of patient admitted to ASH summary data (September 2010 - February 2011)</li> <li>11. ASH Diabetes Mellitus Audit summary data (September 2010 - February 2011)</li> <li>12. ASH Hypertension Audit summary data (September 2010 - February 2011)</li> <li>13. ASH Dyslipidemia Audit summary data (September 2010 - February 2011)</li> <li>14. ASH Asthma/COPD Audit summary data (September 2010 - February 2011)</li> <li>15. ASH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: <ul style="list-style-type: none"> <li>• Diabetes Mellitus</li> <li>• Dyslipidemia</li> <li>• Obesity</li> <li>• Hypertension</li> <li>• Bowel Dysfunction</li> <li>• Falls</li> <li>• Aspiration Pneumonia</li> <li>• Seizure Disorder</li> <li>• Unexpected Mortalities</li> </ul> </li> </ol>
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice in medical care.</li> <li>• Implement further corrective actions to address this monitor's findings of process deficiencies in nursing assessments of changes in the status of individuals.</li> <li>• Provide a summary outline of any changes in policies and procedures</li> </ul>

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	<p>monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>regarding medical care to individuals during the review period.</p> <p><b>Findings:</b>                  During this review period, ASH has implemented a variety of corrective actions, including the following:</p> <ol style="list-style-type: none"> <li>1. Real-time reviews of all documentation related to medical transfers to ensure quality documentation;</li> <li>2. Mentoring of RNs regarding adequate documentation in the WRP and the plan of care as well as follow-up assessments upon return transfer;</li> <li>3. Implementation on two units of a pilot of the <i>RN Physical Assessment Tracking Tool</i> (this tool was implemented hospital-wide on March 1, 2011 replacing the <i>TC/RN Reassessment Tracking Tool</i> and hospital-wide training was completed in February 2011);</li> <li>4. Review of Medical/Psychiatric Appointment Logs to assess nursing entries into the RN Physical Assessment Tracking Log; and</li> <li>5. Initiation, in March 2011, of Case Review Studies to assess documentation of nursing reassessments (during four weeks prior to a transfer to a higher level of care and one week following the return to ASH).</li> </ol> <p><b>Findings:</b>                  This monitor reviewed the charts of 13 individuals who were transferred to an outside medical facility during this review period and interviewed the physicians and surgeons who were involved in their care. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 1300 1873 1406"> <thead> <tr> <th data-bbox="991 1300 1157 1377">Individual</th> <th data-bbox="1157 1300 1434 1377">Date/time of MD evaluation</th> <th data-bbox="1434 1300 1873 1377">Reason for transfer</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1377 1157 1406">1</td> <td data-bbox="1157 1377 1434 1406">9/30/10</td> <td data-bbox="1434 1377 1873 1406">S/P Head Injury</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1	9/30/10	S/P Head Injury
Individual	Date/time of MD evaluation	Reason for transfer						
1	9/30/10	S/P Head Injury						

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		2	9/30/10	Attempted suicide
		3	10/6/10	R/O Stroke
		4	10/8/10	R/O Acute Prostatitis
		5	10/17/10	R/O Appendicitis
		6	10/31/10	Status Epilepticus
		7	11/9/10	R/O Gastrointestinal Bleeding
		8	11/11/10	Cluster seizures
		9	12/13/10	Abdominal Pain
		10	12/20/10	Abdominal Pain
		11	1/8/11	New onset seizure
		12	1/23/11	Stroke
		13	2/7/11	Hyponatremia
		<p>The review found that, in general, ASH has maintained timely and adequate medical care of the individuals in its care. The following process deficiencies were identified:</p> <ol style="list-style-type: none"> <li>1. There was no documentation by nursing of receipt of critical laboratory values (of serum sodium levels of 115 and 110) in the case of ER. However, physician notification occurred in a timely manner in this case.</li> <li>2. There was no documentation of temperature in the nursing change of condition form for an individual (AC) who suffered acute abdominal pain on 10/17/10. However, a timely and adequate nursing reassessment at the urgent care room and a medical assessment resulted in timely transfer to an outside hospital, where he was diagnosed with appendicitis.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice in medical care.</li> </ol>		

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		2. Continue implementation of corrective actions to address findings of process deficiencies in nursing reassessments of changes in the status of individuals.									
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring of this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Surgical Progress Notes Auditing Form, ASH assessed its compliance based on an average sample of 10% of all individuals with at least one diagnosis on Axis III during the review period (September 2010 - February 2011):</p> <table border="1"> <tr> <td>1.</td> <td><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td>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>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%	2.	<i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	100%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	100%
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		<p><b>Other findings:</b> This monitor reviewed medical quarterly progress notes on the following 11 individuals: BP, DC, EM, FR, HMK, JD, KT, MC, PD, RJS and RR. The review found general evidence that ASH has maintained substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement (Medical Transfers, Integration of Medical Conditions into the WRP and Medical Emergency Events).</li> <li>• Provide summary of areas of concern that were identified during medical emergency drills and corresponding corrective actions.</li> </ul> <p><b>Findings:</b> Using the DMH Medical Transfer Auditing Form, ASH assessed its compliance based on a review of all medical transfers during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1117 1890 1377"> <tr> <td data-bbox="991 1117 1087 1227">1.</td> <td data-bbox="1087 1117 1793 1227"><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 1117 1890 1227">96%</td> </tr> <tr> <td data-bbox="991 1227 1087 1377">2.</td> <td data-bbox="1087 1227 1793 1377"><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 1227 1890 1377">99%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	99%
1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%						
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		3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	99%
		4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	100%
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	100%
		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>	100%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	100%
	<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items except item 3, which was 88% in the previous period.</p>			
	<p>ASH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 11% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (September 2010 - February 2011). 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>	99%
		2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	98%
		3.	<i>There is an appropriate focus statement for each</i>	98%

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		<table border="1"> <tr> <td data-bbox="991 191 1087 228"></td> <td data-bbox="1087 191 1795 228"><i>medical condition or diagnosis</i></td> <td data-bbox="1795 191 1892 228"></td> </tr> <tr> <td data-bbox="991 228 1087 305">4.</td> <td data-bbox="1087 228 1795 305"><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td data-bbox="1795 228 1892 305">98%</td> </tr> <tr> <td data-bbox="991 305 1087 381">5.</td> <td data-bbox="1087 305 1795 381"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1795 305 1892 381">96%</td> </tr> </table>		<i>medical condition or diagnosis</i>		4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	98%	5.	<i>There are appropriate intervention(s) for each objective</i>	96%	<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>Using the same tool, the facility reviewed a 100% sample of individuals who have refused medical treatment or laboratory tests. This audit reported 92% compliance with the indicator regarding the WRPTs' review, assessment and development of strategies to overcome individuals' refusals of medical procedures. Comparative data indicated a compliance rate of at least 90% since the previous review period. However, a review of records of 15 individuals that were designated as high risk regarding their refusals for treatments/appointments (AA, AS, BJS, DRR, DS, EGM, GMW, JAB, JJP, JKS, JSB, LF, SAJ, SMW and VLK) found that all had documentation of the refusals noted in the Present Status section of the WRPs; however, two individuals were noted to be at moderate risk according to their WRPs (AA and SMW) and six had no risk level identified in the WRP (DS, GMW, JAB, JSB, LF and VLK). Although all WRPs contained an open focus addressing refusals, the quality of the objectives and interventions were not adequate for individuals who were identified as being at high risk regarding their refusals. The interventions found in the high-risk WRPs were basically the same as found in the WRPs for those individuals with lower refusal risk levels. In addition, most of the interventions listed in these WRPs such as "provide education regarding the need for [the refused treatment/appointment]" noted that these would be provided monthly. Providing only monthly interventions for individuals designated at high risk is not adequate in alignment with the risk level. Consequently, the WRPs reviewed were not reflective of a higher level of intensity and were</p>
	<i>medical condition or diagnosis</i>											
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		<p>not adequate for individuals deemed at high risk for treatment/ appointment refusals. The WRPTs need to develop, regularly review, and revise adequate and appropriate WRPs in alignment with the designated risk levels of the refusals in order for this area to be in substantial compliance. These findings do not comport with ASH data.</p> <p>ASH used the Medical Emergency Response Evaluation tool and assessed its compliance based on a review of all actual medical emergencies (#26) during the review period (September 2010 - February 2011):</p> <table border="1"> <tr> <td>1.</td> <td><i>Did the first responder appropriately assess and call for help?</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Did the first responder provide appropriate CPR procedures?</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Did the first responder provide appropriate rescue breathing procedures?</i></td> <td>67%</td> </tr> <tr> <td>4.</td> <td><i>Did the first responder provide Heimlich procedures?</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>Did the first responder provide appropriate BFA procedures?</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Did the RN respond in a timeframe consistent with the emergency?</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Did the MD respond within 15 minutes?</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i></td> <td>96%</td> </tr> <tr> <td>10.</td> <td><i>Was the unit milieu appropriately managed?</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Was all required equipment available?</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>Was all required equipment in working order?</i></td> <td>97%</td> </tr> <tr> <td>13.</td> <td><i>Were all medical supplies available?</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Were all medications available?</i></td> <td>100%</td> </tr> </table>	1.	<i>Did the first responder appropriately assess and call for help?</i>	100%	2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%	3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	67%	4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A	5.	<i>Did the first responder provide appropriate BFA procedures?</i>	100%	6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%	7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%	8.	<i>Did the MD respond within 15 minutes?</i>	100%	9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	96%	10.	<i>Was the unit milieu appropriately managed?</i>	100%	11.	<i>Was all required equipment available?</i>	100%	12.	<i>Was all required equipment in working order?</i>	97%	13.	<i>Were all medical supplies available?</i>	100%	14.	<i>Were all medications available?</i>	100%
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		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%	
		16.	<i>Did all the staff perform according to assigned roles?</i>	99%	
		17.	<i>Was staff competent in operating equipment?</i>	100%	
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	95%	
		19.	<i>Was all required documentation completed?</i>	100%	
		20.	<i>Was EMS able to access the site in a timely manner?</i>	100%	
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%	
		<p>The facility provided detailed information on the areas of concern that were identified during the performance of each actual emergency and corresponding corrective actions. The information was adequate and is summarized as follows:</p> <ol style="list-style-type: none"> <li>1. Unit staff did not bring all rescue breathing equipment: recommendation to standardize location of medical emergency equipment approved by Quality Council.</li> <li>2. Too many staff on scene but unsure on how to handle emergency: remind staff to review quarterly Medical Emergency Drill Information.</li> <li>3. NOD was called instead of calling 2911: standing reminder in quarterly ASHALL announcements.</li> </ol> <p>Using the same monitoring tool, ASH assessed its compliance based on a sample of 5% of emergency drills (mock codes) (total of 150) performed during the review period (September and November 2010 and January and February 2011):</p>			
		1.	<i>Did the first responder appropriately assess and call for help?</i>	75%	
		2.	<i>Did the first responder provide appropriate CPR procedures?</i>	50%	

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		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
		4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A
		5.	<i>Did the first responder provide appropriate BFA procedures?</i>	50%
		6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	50%
		7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
		8.	<i>Did the MD respond within 15 minutes?</i>	100%
		9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	100%
		10.	<i>Was the unit milieu appropriately managed?</i>	75%
		11.	<i>Was all required equipment available?</i>	75%
		12.	<i>Was all required equipment in working order?</i>	75%
		13.	<i>Were all medical supplies available?</i>	100%
		14.	<i>Were all medications available?</i>	100%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	50%
		16.	<i>Did all the staff perform according to assigned roles?</i>	97%
		17.	<i>Was staff competent in operating equipment?</i>	83%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%
		19.	<i>Was all required documentation completed?</i>	100%
		20.	<i>Was EMS able to access the site in a timely manner?</i>	92%
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	N/A
		<p>The facility provided detailed information on the areas of concern that were identified during the performance of each emergency drill and corresponding corrective actions. The information was adequate and is outlined as follows:</p>		

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		<ol style="list-style-type: none"><li>1. Ice packs were used to cool down heat stroke victim in the UCR: recommendation to use a plastic container with a spray nozzle (works equally as well and is less expensive).</li><li>2. Two carts were at the scene with one facing the wrong direction, turning the cart around delayed transport of the injured: staff reminded that the cart is to be turned around upon arrival so it is always facing towards UCR and ready to go.</li><li>3. Staff waved off with the words "This is only a drill," which is not consistent with training. Staff are to treat drills as real and not wave off responding staff.</li><li>4. Compressions should be continuous and rapid (~100/min). Rescue breathing is not necessary if compressions are begun since the facemask and bag are forthcoming: information communicated to all staff.</li><li>5. Facemask needed to be turned around in order to make a good seal: information communicated to all staff.</li><li>6. Not all staff responding wore gloves: information communicated to all staff.</li><li>7. 2911 was not called immediately: information communicated to all staff.</li><li>8. Some prompting was needed to call the code: reminded staff on scene.</li><li>9. Staff slowed down once they were aware it was a drill: discussed with staff on scene.</li><li>10. Staff did not state "this is a drill" when calling 2911: information communicated to all staff.</li><li>11. Dispatch did not state "This is a drill" during radio communication: issue critiqued with those involved and communicated to all others.</li><li>12. Staff standing around observing instead of assisting with CPR: information communicated to all staff.</li><li>13. Backboard was removed from gurney prior to transferring to cart which loses time: written process emailed to NOD staff.</li></ol>
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		<ol style="list-style-type: none"><li>14. Gurney stuck and could not raise, transport delayed: USs to ensure all gurneys in working order.</li><li>15. Victim loaded onto cart from side which has higher potential for injury and delays time: discussed with responsible staff.</li><li>16. Unit 1 2911 line (red phone) had a poor connection and staff could not hear: reviewed with staff.</li><li>17. MOD needs to know if the site is a crime scene: discussed at Department of Medicine meeting.</li><li>18. When crime is involved, need to determine if scene is clear prior to staff leaving and start of clean-up: discussed at Department of Medicine meeting.</li><li>19. Some staff responded and then left scene when a drill was announced: information communicated to all staff.</li><li>20. ASH Policy no longer uses rescue breathing; mouth to mouth: placed on drill announcement.</li><li>21. Medical Emergency Flow Sheet not being utilized: team instructed staff to use sheet for this drill.</li><li>22. Staff appeared confused on how to connect O<sub>2</sub> tubing to O<sub>2</sub> tank nozzle: information communicated to all staff.</li><li>23. Lead person must direct others on what action to take to avoid assumptions.</li><li>24. Ambu bag needed to have the mask extended sooner: information communicated to all staff.</li><li>25. Large O<sub>2</sub> tank used for transport and fell to floor when transferring to cart: reminded staff involved.</li><li>26. Staff confusion with location of emergency equipment; oxygen, ambu bag and other equipment took too long to arrive: assess standardized location for emergency equipment on all units.</li><li>27. O<sub>2</sub> tank low. Central Supply will not refill until PSI is 500 or lower: limit increased to 700 PSI &amp; stickers placed on tanks.</li><li>28. Victim's chest was not checked for expansion: information communicated to all staff.</li><li>29. All the lights in the dayroom were off. Had to ask staff to turn them</li></ol>
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		<p>on before starting the drill: check with clinical administrator.</p> <p>30. Staff was not sure what to do once the emergency was announced. staff member asked the proctors what to do: conduct more training with staff.</p> <p>31. Staff member did not have alarm on. Had to borrow from another staff member: reminders to staff and monitoring.</p> <p>32. Staff didn't stabilize the neck until NOD arrived on scene. The C-collar was applied while the patient was in the prone position, which made it difficult to align: ensure C-collar training includes scenarios where injured is prone, wedged against wall, etc.</p> <p>33. Patient wasn't aligned correctly on back- board. Had to readjust - decision was made to keep patient on backboard. The drill was paused for a quick training session on the KED Sled and Stair Chair: Nursing working with Fire Department to set up annual training for C-collar/stabilization.</p> <p>34. Backboard on Unit 15 missing strap. Patient's hands and fingers were smashed during transport as they were not able to be secured. Stair chair should have been used: Fire Dept to retrain staff on all upstairs units in use of Stair Chair.</p> <p>35. The 2911 call to Unit 1 had a high-pitched sound which made it difficult for staff on Unit 1 to hear the calling party: Unit 1 staff will ask caller to step away from the panel to eliminate the feedback.</p> <p>36. Radio traffic did not clarify "this is a drill": dispatch notified of steps they need to follow regarding 2911 calls during medical emergency drills.</p> <p>37. Status/location checks on the Fire Department were not conducted: dispatch staff instructed that if they don't hear from the Fire Department, they are to radio and check their status.</p> <p>38. NOD called the switchboard to request the ambulance: proper procedure reviewed with specific staff.</p> <p>39. There could have been more probing into the patient's chief complaint: read drill announcement.</p> <p>40. Staff didn't remove the other patient who was observing from the</p>
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		<p>dayroom while the drill was underway: US informed that area must be cleared of residents.</p> <p>41. NOD did not receive requested Fire Department assistance for stabilization and transport: Fire Department to take the initiative.</p> <p>42. Incident not documented as a drill in CAD and confusion over who should enter data: review process with all dispatchers.</p> <p>43. Need additional KED Sleds/Stair Chairs: Quality Council approved purchase of three stair chairs &amp; three KED sleds. Items ordered.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement (Medical Transfers, Integration of Medical Conditions into the WRP and Medical Emergency [actual events and drills]).</li> <li>2. Ensure that WRPs addressing refusals are individualized, and the objectives and interventions are accurately reflective of the refusal risk level rating.</li> <li>3. Provide summary of areas of concern that were identified during medical emergency drills and corresponding corrective actions.</li> </ol>
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility has maintained its practice since the last review.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility has maintained after-hours coverage by a primary care physician and a psychiatrist on-site as confirmed by a review of the on-call schedule during this reporting period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility presented data based on a 100% sample of individuals returning from outside medical treatment during the review period (March-August 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%, the same rate reported during the last review period.</p>

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		<p><b>Other findings:</b>            Chart reviews by this monitor (see F.7.a) found that the discharge assessments from outside hospitals were available in the individuals' records.</p> <p><b>Compliance:</b>            Substantial.</p> <p><b>Current recommendation:</b>            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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b>            Continue to monitor this requirement.</p> <p><b>Findings:</b>            ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 12% (diabetes mellitus), 11% (hypertension), 10% (dyslipidemia) and 11% (COPD/asthma) of individuals diagnosed with these disorders during the review months (September 2010 - February 2011). The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 1192 1890 1421"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>99%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	99%	2.	<i>HgbA1C was ordered quarterly.</i>	99%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	97%	4.	<i>Blood sugar is monitored regularly.</i>	100%	5.	<i>Urinary micro albumin is monitored annually.</i>	99%
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		<table border="1"> <tr> <td data-bbox="991 191 1087 305">6.</td> <td data-bbox="1087 191 1797 305"><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td data-bbox="1797 191 1894 305">100%</td> </tr> <tr> <td data-bbox="991 305 1087 380">7.</td> <td data-bbox="1087 305 1797 380"><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td data-bbox="1797 305 1894 380">100%</td> </tr> <tr> <td data-bbox="991 380 1087 454">8.</td> <td data-bbox="1087 380 1797 454"><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i></td> <td data-bbox="1797 380 1894 454">98%</td> </tr> <tr> <td data-bbox="991 454 1087 496">9.</td> <td data-bbox="1087 454 1797 496"><i>Blood pressure is monitored weekly.</i></td> <td data-bbox="1797 454 1894 496">100%</td> </tr> <tr> <td data-bbox="991 496 1087 610">10.</td> <td data-bbox="1087 496 1797 610"><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td data-bbox="1797 496 1894 610">97%</td> </tr> <tr> <td data-bbox="991 610 1087 685">11.</td> <td data-bbox="1087 610 1797 685"><i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i></td> <td data-bbox="1797 610 1894 685">100%</td> </tr> <tr> <td data-bbox="991 685 1087 760">12.</td> <td data-bbox="1087 685 1797 760"><i>Podiatry care was provided by a podiatrist at least annually.</i></td> <td data-bbox="1797 685 1894 760">100%</td> </tr> <tr> <td data-bbox="991 760 1087 834">13.</td> <td data-bbox="1087 760 1797 834"><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td data-bbox="1797 760 1894 834">99%</td> </tr> <tr> <td data-bbox="991 834 1087 876">14.</td> <td data-bbox="1087 834 1797 876"><i>Diabetes is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1797 834 1894 876">100%</td> </tr> <tr> <td data-bbox="991 876 1087 946">15.</td> <td data-bbox="1087 876 1797 946"><i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1797 876 1894 946">100%</td> </tr> </table>	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 appropriately 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>	97%	11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	100%	12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	100%	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 interventions for this condition.</i>	100%	
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		<table border="1"> <tr> <td data-bbox="991 191 1087 266">4.</td> <td data-bbox="1087 191 1795 266"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1795 191 1894 266">99%</td> </tr> <tr> <td data-bbox="991 266 1087 310">5.</td> <td data-bbox="1087 266 1795 310"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1795 266 1894 310">100%</td> </tr> <tr> <td data-bbox="991 310 1087 384">6.</td> <td data-bbox="1087 310 1795 384"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1795 310 1894 384">100%</td> </tr> <tr> <td data-bbox="991 384 1087 459">7.</td> <td data-bbox="1087 384 1795 459"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1795 384 1894 459">99%</td> </tr> <tr> <td data-bbox="991 459 1087 607">8.</td> <td data-bbox="1087 459 1795 607"><i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i></td> <td data-bbox="1795 459 1894 607">100%</td> </tr> <tr> <td data-bbox="991 607 1087 651">9.</td> <td data-bbox="1087 607 1795 651"><i>An exercise program has been initiated.</i></td> <td data-bbox="1795 607 1894 651">98%</td> </tr> <tr> <td data-bbox="991 651 1087 719">10.</td> <td data-bbox="1087 651 1795 719"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1795 651 1894 719">NA</td> </tr> </table>	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	99%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	100%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	100%	7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	99%	8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	100%	9.	<i>An exercise program has been initiated.</i>	98%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	NA				
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			<i>recommendation followed, as applicable.</i>	
		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>	98%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	99%
		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Asthma/COPD</u></p>		
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	100%
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	100%
		4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	NA
		5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	100%
		6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	100%
		7.	<i>The individual has been assessed for a flu vaccination.</i>	100%
		8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</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 items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue to provide information regarding the facility's review of the performance of Physicians and Surgeons based on objective indicators.</p> <p><b>Findings:</b> ASH reportedly re-privileged all Physicians and Surgeons who were scheduled for re-privileging during this review period (#3) to meet facility requirement of re-privileging every two years following the first year of appointment to the medical staff. Re-privileging was based on performance indicators that are reviewed on a quarterly basis for each Physician and Surgeon. These indicators were addressed in the previous report.</p> <p>The facility reported that the Department of Medicine has continued monthly peer review of Physicians and Surgeons based on a review of the care provided to individuals transferred to acute hospitals for medical care. This review found that all Physicians and Surgeons met generally accepted standards of care during this review period.</p> <p><b>Recommendation 2, October 2010:</b> Continue to provide process and clinical outcomes of medical service with comparison to previous review period.</p>

		<p><b>Findings:</b>            ASH provided process and clinical outcome data for the current reporting period, including comparisons with the previous review period. The following is a summary outline of the data:</p> <ol style="list-style-type: none"> <li>1. Process outcomes:               <ol style="list-style-type: none"> <li>a. Number of individuals newly diagnosed with Diabetes Mellitus;</li> <li>b. Number of new diagnoses of Diabetes Mellitus in individuals receiving new generation antipsychotics;</li> <li>c. Number of individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics;</li> <li>d. Percentage of individuals whose BMI is tracked monthly;</li> <li>e. Presence of WRP objectives and interventions for constipation;</li> <li>f. Number of individuals with 3+ falls in 30 days;</li> <li>g. Total number of falls;</li> <li>h. Timeliness and appropriateness of external consultations;</li> <li>i. Number of unexpected mortalities and</li> <li>j. Review process for unexpected deaths.</li> </ol> </li>   <li>2. Clinical outcomes:               <ol style="list-style-type: none"> <li>a. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus;</li> <li>b. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics;</li> <li>c. Percentage of individuals with dyslipidemia with LDL &lt;130;</li> <li>d. Percentage of individuals with diabetes mellitus with LDL &lt;100;</li> <li>e. Number/percentage of individuals with BMI &gt;25;</li> <li>f. Percentage of individuals with hypertension with blood pressure &lt; 140/90;</li> <li>g. Percentage of individuals with diabetes mellitus and blood pressure &lt;130/80;</li> <li>h. Number of individuals hospitalized for bowel dysfunction;</li> </ol> </li> </ol>
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		<ul style="list-style-type: none"><li>i. Individuals with falls resulting in major injury;</li><li>j. Number of individuals diagnosed with aspiration pneumonia;</li><li>k. Number of individuals with refractory seizures and</li><li>l. Number of individuals with status epilepticus.</li></ul> <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p>Review of the outcome data found that the facility has, in general, maintained positive outcomes of its medical services. The facility reported that its Medical Risk Management Committee has reviewed the process and clinical outcome data to assess overall performance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ul style="list-style-type: none"><li>1. Continue to provide information regarding the facility's review of the performance of Physicians and Surgeons based on objective indicators.</li><li>2. Continue to provide process and clinical outcomes of medical service with comparison to previous review period.</li></ul>
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Section F: Specific Therapeutic and Rehabilitation Services

8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donna Moore, RN</li> <li>2. Gina M. Dusi, PHN II</li> <li>3. Rosemary Morrison, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH IC Admission PPD summary data, September 2010 - February 2011</li> <li>2. ASH IC Annual PPD Audit summary data, September 2010 - February 2011</li> <li>3. ASH IC Hepatitis C Audit summary data, September 2010 - February 2011</li> <li>4. ASH IC HIV Positive Audit summary data, September 2010 - February 2011</li> <li>5. ASH IC Immunization Audit summary data, September 2010 - February 2011</li> <li>6. ASH IC Immunization Refusal Audit summary data, September 2010 - February 2011</li> <li>7. ASH IC MRSA Audit summary data, September 2010 - February 2011</li> <li>8. ASH IC Positive PPD Audit summary data, September 2010 - February 2011</li> <li>9. ASH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, September 2010 - February 2011</li> <li>10. ASH IC Sexually Transmitted Disease (STD) Audit summary data, September 2010 - February 2011</li> <li>11. Infection Control Committee meeting minutes dated 10/28/10, 9/28/10, 11/18/10, 12/16/10 and 1/27/11</li> <li>12. HSS Committee meeting minutes dated 11/15/10, 11/22/10, 12/13/10, 1/3/11, 1/24/11, 2/14/11 and 3/7/11</li> <li>13. Department of Medicine meeting minutes dated 9/21/10, 10/28/10,</li> </ol>

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		<p>11/18/10, 12/16/10 and 2/24/11</p> <p>14. Environment of Care minutes dated 1/20/11 and 2/17/11</p> <p>15. Administrative Directive 553: Assisting Individuals to Adhere to the Plan of Care (Refusals), dated April 12, 2011</p> <p>16. ASH Infection Control Manual Section II-C; Immunizations, dated March 30, 2011</p> <p>17. Medical records of the following 99 individuals: AAJ, AAV, ACCW, ACR, ACT, AD, ADH, ADW, AHS, AJ, AJS, ALS, AND, AOO, BB, BFV, BNE, BP, BWS, CAC, CED, CJE, CM, CSC, DAB, DCT, DDK, DDM, DDP, DE, DH, DLP, DLY, DR, DRF, DRT, ED, FD, GBG, GH, GIH, GL, GTM, HS, IC, JAB, JCC, JCD, JDM, JDS, JH, JHA, JJC, JFF, JKC, JL, JLM, JLP, JM, JMM, JR, JSA, JTP, KJR, KRI, KUS, LLH, LWH, MB, MJA, ML, MPS, MT, MW, PA, RB, RDT, RE, RJB, RLF, RP, RSG, RWW, RYC, SAC, SAE, SBH, SS, SWV, TAN, TJS, TLJ, TRM, TT, VB, VH, WAV, WCH, WMC and WSA</p>
F.8.a	Each State hospital shall establish an effective infection control program that:	<b>Compliance:</b> Substantial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings (by test/disease):</b></p> <p><b><u>Admission PPD</u></b> Using the DMH IC Admission PPD Audit, ASH assessed its compliance based on an average sample of 10% of individuals admitted to the hospital with a negative PPD in the review months (September 2010 - February 2011):</p>

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		<table border="1"> <tr> <td data-bbox="987 191 1081 267">1.</td> <td data-bbox="1081 191 1795 267"><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 191 1890 267">100%</td> </tr> <tr> <td data-bbox="987 267 1081 344">2.</td> <td data-bbox="1081 267 1795 344"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1795 267 1890 344">100%</td> </tr> <tr> <td data-bbox="987 344 1081 420">3.</td> <td data-bbox="1081 344 1795 420"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1795 344 1890 420">100%</td> </tr> <tr> <td data-bbox="987 420 1081 496">4.</td> <td data-bbox="1081 420 1795 496"><i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1795 420 1890 496">100%</td> </tr> <tr> <td data-bbox="987 496 1081 568">5.</td> <td data-bbox="1081 496 1795 568"><i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1795 496 1890 568">N/A</td> </tr> </table>	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>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	N/A	<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (ASH does not utilize the two-step PPDs referred to in item 5).</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> None required.</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 22 individuals admitted during the review period (AHS, BB, BFV, DDM, DRT, GBG, GH, GIH, JAB, JDS, JJF, JLP, JM, JMM, KRI, KUS, MT, MW, RSG, SAC, SWV and TRM) found that all had a physician's order for PPD upon admission and all were timely administered and read.</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>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%																
5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	N/A																

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		<p><b>Annual PPD</b></p> <p>Using the DMH IC Annual PPD Audit, ASH assessed its compliance based on an average sample of 10% of individuals needing an annual PPD during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 375 1887 677"> <tr> <td data-bbox="991 375 1087 451">1.</td> <td data-bbox="1087 375 1793 451"><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 375 1887 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 527">2.</td> <td data-bbox="1087 451 1793 527"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 451 1887 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 604">3.</td> <td data-bbox="1087 527 1793 604"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 527 1887 604">100%</td> </tr> <tr> <td data-bbox="991 604 1087 677">4.</td> <td data-bbox="1087 604 1793 677"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 604 1887 677">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> None required.</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 11 individuals requiring an annual PPD during the review period (AJS, CJE, DH, ED, GTM, HS, MPS, PA, RDT, RP and VH) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</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><b><u>Hepatitis C</u></b>  Using the DMH IC Hepatitis C Audit, ASH assessed its compliance based on an average sample of 47% of individuals admitted to the hospital in the review months (September 2010 - February 2011) who were positive for Hepatitis C:</p> <table border="1"> <tr> <td data-bbox="991 451 1087 561">1.</td> <td data-bbox="1087 451 1793 561"><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 451 1887 561">100%</td> </tr> <tr> <td data-bbox="991 561 1087 672">2.</td> <td data-bbox="1087 561 1793 672"><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 561 1887 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 782">3.</td> <td data-bbox="1087 672 1793 782"><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 672 1887 782">100%</td> </tr> <tr> <td data-bbox="991 782 1087 893">4.</td> <td data-bbox="1087 782 1793 893"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 782 1887 893">100%</td> </tr> <tr> <td data-bbox="991 893 1087 906">5.</td> <td data-bbox="1087 893 1793 906"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 893 1887 906">100%</td> </tr> <tr> <td data-bbox="991 906 1087 974">6.</td> <td data-bbox="1087 906 1793 974"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 906 1887 974">100%</td> </tr> <tr> <td data-bbox="991 974 1087 1084">7.</td> <td data-bbox="1087 974 1793 1084"><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 974 1887 1084">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>	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><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</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 nine individuals who were admitted Hepatitis C positive during the review period (AD, DCT, DR, JH, JKC, LLH, RE, SAE and TAN) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><b><u>HIV Positive</u></b> Using the DMH IC HIV Positive Audit, ASH assessed its compliance based on a 100% sample (nine individuals) of individuals who were positive for HIV antibody in the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 930 1890 1421"> <tr> <td data-bbox="991 930 1087 1044">1.</td> <td data-bbox="1087 930 1793 1044"><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 930 1890 1044">100%</td> </tr> <tr> <td data-bbox="991 1044 1087 1157">2.</td> <td data-bbox="1087 1044 1793 1157"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 1044 1890 1157">100%</td> </tr> <tr> <td data-bbox="991 1157 1087 1271">3.</td> <td data-bbox="1087 1157 1793 1271"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 1157 1890 1271">100%</td> </tr> <tr> <td data-bbox="991 1271 1087 1385">4.</td> <td data-bbox="1087 1271 1793 1385"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 1271 1890 1385">N/A</td> </tr> <tr> <td data-bbox="991 1385 1087 1421">5.</td> <td data-bbox="1087 1385 1793 1421"><i>The individual is seen initially and followed up, as</i></td> <td data-bbox="1793 1385 1890 1421">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 test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as</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 test.</i>	100%															
3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%															
4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A															
5.	<i>The individual is seen initially and followed up, as</i>	100%															

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		<p><i>clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></p>	
6.	<p><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></p>	100%	
7.	<p><i>Appropriate objective is written to address the progression of the disease.</i></p>	100%	
8.	<p><i>Appropriate interventions are written.</i></p>	100%	
<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p>			
<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>			
<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>			
<p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</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 nine individuals who were admitted during the review period with HIV (ADW, BWS, CM, CSC, DE, DRF, JLM, RLF and WMC) found that all were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.</p>			
<p><b><u>Immunizations</u></b> Using the DMH IC Immunization Audit, ASH assessed its compliance based on an average sample of 10% of individuals admitted to the hospital</p>			

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		<p>during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 264 1887 604"> <tr> <td data-bbox="991 264 1087 341">1.</td> <td data-bbox="1087 264 1793 341"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 264 1887 341">100%</td> </tr> <tr> <td data-bbox="991 341 1087 417">2.</td> <td data-bbox="1087 341 1793 417"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 341 1887 417">100%</td> </tr> <tr> <td data-bbox="991 417 1087 493">3.</td> <td data-bbox="1087 417 1793 493"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 417 1887 493">100%</td> </tr> <tr> <td data-bbox="991 493 1087 604">4.</td> <td data-bbox="1087 493 1793 604"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 493 1887 604">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> None required.</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 15 individuals (ADH, ALS, AND, BNE, CAC, DDK, DLP, DLY, JR, ML, MT, SS, TJS, TT and WSA) 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>	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><b><u>Immunization Refusals</u></b>          Using the DMH IC Immunization Refusal Audit, ASH assessed its compliance based on a 60% sample of individuals in the hospital who refused to take their immunizations during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 414 1885 901"> <tr> <td data-bbox="991 414 1087 527">1.</td> <td data-bbox="1087 414 1795 527"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1795 414 1885 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 600">2.</td> <td data-bbox="1087 527 1795 600"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1795 527 1885 600">100%</td> </tr> <tr> <td data-bbox="991 600 1087 673">3.</td> <td data-bbox="1087 600 1795 673"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 600 1885 673">100%</td> </tr> <tr> <td data-bbox="991 673 1087 787">4.</td> <td data-bbox="1087 673 1795 787"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 673 1885 787">100%</td> </tr> <tr> <td data-bbox="991 787 1087 901">5.</td> <td data-bbox="1087 787 1795 901"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1795 787 1885 901">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 items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u>          No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>          None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u>          None required.</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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		<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 ten individuals who refused immunizations during the review period (AJ, AOO, DAB, JHA, JSA, LWH, RYC, SBH, TLJ and WAV) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><b><u>MRSA</u></b>            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 2010 - February 2011):</p> <table border="1" data-bbox="991 708 1887 1386"> <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 when an individual has a positive culture for MRSA.</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 a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 821 1887 935">100%</td> </tr> <tr> <td data-bbox="991 935 1087 1008">3.</td> <td data-bbox="1087 935 1793 1008"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 935 1887 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1087 1081">4.</td> <td data-bbox="1087 1008 1793 1081"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 1008 1887 1081">100%</td> </tr> <tr> <td data-bbox="991 1081 1087 1195">5.</td> <td data-bbox="1087 1081 1793 1195"><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 1081 1887 1195">100%</td> </tr> <tr> <td data-bbox="991 1195 1087 1235">6.</td> <td data-bbox="1087 1195 1793 1235"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 1195 1887 1235">100%</td> </tr> <tr> <td data-bbox="991 1235 1087 1308">7.</td> <td data-bbox="1087 1235 1793 1308"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 1235 1887 1308">100%</td> </tr> <tr> <td data-bbox="991 1308 1087 1386">8.</td> <td data-bbox="1087 1308 1793 1386"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 1308 1887 1386">100%</td> </tr> </table>	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%																								
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%																								

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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 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> None required.</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 10 individuals with MRSA (ACR, CED, DCT, FD, JCD, JJC, JL, KJR, RWW and WCH) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.</p> <p><b><u>Positive PPD</u></b> Using the DMH IC Positive PPD Audit, ASH assessed its compliance based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1188 1887 1414"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is</i></td> <td>N/A</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>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is</i>	N/A
1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%												
2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%												
3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%												
4.	<i>If active disease is identified, then individual is</i>	N/A												

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		<table border="1"> <tr> <td data-bbox="989 191 1094 269"></td> <td data-bbox="1094 191 1793 269"><i>transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1793 191 1890 269"></td> </tr> <tr> <td data-bbox="989 269 1094 310">5.</td> <td data-bbox="1094 269 1793 310"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1793 269 1890 310">100%</td> </tr> <tr> <td data-bbox="989 310 1094 418">6.</td> <td data-bbox="1094 310 1793 418"><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 310 1890 418">100%</td> </tr> <tr> <td data-bbox="989 418 1094 532">7.</td> <td data-bbox="1094 418 1793 532"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 418 1890 532">100%</td> </tr> </table>		<i>transferred to medical isolation and appropriate treatment is provided.</i>		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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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%													
		<p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</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 six individuals who had a positive PPD (ACT, BP, IC, MB, RB and VB) found that all individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p>													

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		<p><b><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u></b>          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 2010 - February 2011):</p> <table border="1"> <tr> <td data-bbox="989 451 1087 597">1.</td> <td data-bbox="1087 451 1793 597"><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 451 1887 597">100%</td> </tr> <tr> <td data-bbox="989 597 1087 673">2.</td> <td data-bbox="1087 597 1793 673"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 597 1887 673">100%</td> </tr> <tr> <td data-bbox="989 673 1087 750">3.</td> <td data-bbox="1087 673 1793 750"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 673 1887 750">100%</td> </tr> <tr> <td data-bbox="989 750 1087 826">4.</td> <td data-bbox="1087 750 1793 826"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 750 1887 826">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>          None required.</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 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%
1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%												
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4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%												

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		<p>A review of the records of eight individuals who refused admitting or annual labs/diagnostics (AAJ, AAV, ACCW, GL, JDM, JTP, MJA and RJB) found that all refusals were adequately addressed in the WRPs and four of the eight individuals actually decided to have the test/diagnostics.</p> <p><b><u>Sexually Transmitted Diseases</u></b></p> <p>Using the DMH IC Sexually Transmitted Disease (STD) Audit, ASH assessed its compliance based on a 100% sample of individuals in the hospital who tested positive for an STD during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1887 1203"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>An RPR is ordered during the admission process for each individual.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td>N/A</td> </tr> <tr> <td>6.</td> <td><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td>N/A</td> </tr> <tr> <td>7.</td> <td><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate objective(s) are written.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Appropriate interventions are written.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH has maintained a compliance rate of at least 90% from the previous review period for all items (items 5 and 6 were N/A in the previous period).</p>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%
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9.	<i>Appropriate interventions are written.</i>	100%																											

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		<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> None required.</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 with diagnosed STDs (DDP, DE, JCC and RLF) found that the appropriate lab work indicating a positive STD was obtained in all cases and the STD was adequately addressed in the WRP in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> ASH's key indicator data from the facility accurately reflected the infection control trends from the review period. See F.8.a.i for additional findings.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Review of the minutes of ASH's meetings verified that IC data are discussed at the Infection Control Committee and other discipline committee meetings and are included in the facility's Key Indicator data.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Methodology:</b></p> <p><u>Interviewed:</u> Jeff Shepherd, DDS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH Dental Services Audit summary data, September 2010 - February 2011</li> <li>2. ASH's Dental appointment logs</li> <li>3. Administrative Directive 553; Assisting Individuals to Adhere to the Plan of Care (Refusals) dated April 12, 2011</li> <li>4. Medical records for the following 70 individuals: AAP, AH, AK, ALL, AS, AVM, BA, CAV, CHB, CJE, CJG, DAP, DH, DJA, DJW, DLB, DNM, DO, EDD, EJT, EME, FBB, FFR, FLT, FOK, FRB, GTM, HAS, HEH, HLH, JAC, JEF, JEP, JKH, JKS, JLC, JMD, JOC, JUG, KQ, LKF, MB, MI, MLL, MOR, MPS, MPS, MSG, NC, OQ, PHA, RAH, RDT, RJM, ROP, RRP, SAM, SLL, TAH, TJP, TNC, TRW, TT, TWM, TYC, VIH, WAA, WFH, WJK and WSA</li> </ol>
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, ASH's Chief Dentist has retired and the department has used the services of a retired annuitant two to three days a week to provide dental services. Based on an interview with Dr. Jeff Shepherd and this reviewer's findings for this section, the facility had an adequate number of dentists to provide timely and adequate dental care and treatment.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p><b>Compliance:</b> Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 19% mean sample of individuals scheduled for comprehensive dental exams during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="989 933 1890 974"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals (ALL, AVM, DAP, DJA, EJT, HEH, JKH, JLC, KQ, LKF, RAH, RJM, TNC and WSA) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 15% mean sample of individuals who have been in the hospital for 90 days or less during the review period (September 2010 - February 2011):</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

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		<table border="1" data-bbox="991 228 1887 267"> <tr> <td data-bbox="991 228 1087 267">1.b</td> <td data-bbox="1087 228 1793 267"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 228 1887 267">100%</td> </tr> </table> <p data-bbox="991 310 1887 378">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 420 1887 526">A review of the records of 14 individuals (ALL, AVM, DAP, DJA, EJT, HEH, JKH, JLC, KQ, LKF, RAH, RJM, TNC and WSA) found that all individuals were timely seen for their admission exams.</p> <p data-bbox="991 568 1887 708">Using the DMH Dental Services Audit, ASH assessed its compliance based on a 15% mean sample of individuals due for annual routine dental examinations during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 750 1887 824"> <tr> <td data-bbox="991 750 1087 824">1.c</td> <td data-bbox="1087 750 1793 824"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 750 1887 824">100%</td> </tr> </table> <p data-bbox="991 867 1887 935">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 977 1887 1083">A review of the records of 11 individuals (AS, CJE, DH, EDD, GTM, HAS, MPS, PHA, RDT, ROP and VIH) found that all annual exams were timely completed.</p> <p data-bbox="991 1125 1887 1265">Using the DMH Dental Services Audit, ASH assessed its compliance based on a 16% mean sample of individuals with dental problems identified on admission or annual examination during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1307 1887 1416"> <tr> <td data-bbox="991 1307 1087 1416">1.d</td> <td data-bbox="1087 1307 1793 1416"><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 1307 1887 1416">100%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</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%
1.b	<i>If admission examination date was 90 days or less</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>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 25 individuals (ALL, AS, AVM, CJE, DAP, DH, DJA, EDD, EJT, GTM, HAS, HEH, JKH, JLC, KQ, LKF, MPS, PHA, RAH, RDT, RJM, ROP, TNC, VIH and WSA) found that all 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 2010 - February 2011):</p> <table border="1" data-bbox="991 708 1887 857"> <tr> <td data-bbox="991 708 1087 857">1.e</td> <td data-bbox="1087 708 1793 857"><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 708 1887 857">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 14 individuals (AAP, BA, DO, FOK, FRB, JAC, JEF, JUG, MI, MOR, MSG, WAA, WFH and WJK) found that all individuals received timely follow-up care.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 16% mean sample of individuals scheduled for follow-up dental care during the review months (September 2010 - February 2011), and reported a mean compliance rate of 100%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 25 individuals (ALL, AS, AVM, CJE, DAP, DH, DJA, EDD, EJT, GTM, HAS, HEH, JKH, JLC, KQ, LKF, MPS, PHA, RAH, RDT, RJM, ROP, TNC, VIH and WSA) found compliance with the documentation requirements in all cases.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 15% mean sample of individuals due for annual routine dental examinations during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 1227 1890 1341"> <tr> <td data-bbox="991 1227 1087 1341">3.a</td> <td data-bbox="1087 1227 1793 1341"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 1227 1890 1341">100%</td> </tr> </table> <p>Comparative data indicated that ASH maintained a compliance rate of at</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%			

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		<p>least 90% from the previous review period.</p> <p>A review of the records of 15 individuals (AK, CHB, CJG, DLB, DNM, FBB, FFR, FLT, JOC, OQ, RRP, SLL, TJP, TT and TYC) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="991 597 1890 673"> <tr> <td data-bbox="991 597 1087 673">3.c</td> <td data-bbox="1087 597 1793 673"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 597 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>A review of the records of five individuals (AH, DJW, JEP, JMD and MLL) found that all individuals received restorative care.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 10% sample of individuals who had tooth extractions during the review months (September 2010 - February 2011):</p>			

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		<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></p>	<p>100%</p>
<p>F.9.c</p>	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p><b>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</b></p> <p>A review of the records of 14 individuals (AAP, BA, DO, FOK, FRB, JAC, JEF, JUG, MI, MOR, MSG, WAA, WFH and WJK) found that all records were in compliance with this requirement.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p> <hr/> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 16% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (September 2010 - February 2011), and reported a mean compliance rate of 100%. 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 25 individuals (ALL, AS, AVM, CJE, DAP, DH, DJA, EDD, EJT, GTM, HAS, HEH, JKH, JLC, KQ, LKF, MPS, PHA, RAH,</p>	

Section F: Specific Therapeutic and Rehabilitation Services

		<p>RDT, RJM, ROP, TNC, VIH and WSA) found that all records were in compliance with the documentation requirements.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																			
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 16% mean sample of individuals scheduled for dental appointments during the review months (September 2010 - February 2011):</p> <table border="1" data-bbox="993 932 1887 971"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>84%</td> </tr> </table> <p>Comparative data indicated an increase in compliance from 72% in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 1193 1866 1421"> <thead> <tr> <th>Month</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>Sept 2010</td> <td>37</td> <td>0</td> <td>0</td> </tr> <tr> <td>Oct 2010</td> <td>56</td> <td>0</td> <td>0</td> </tr> <tr> <td>Nov 2010</td> <td>46</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	6.a	<i>The individual attended the scheduled appointment</i>	84%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	Sept 2010	37	0	0	Oct 2010	56	0	0	Nov 2010	46	0	0
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Nov 2010	46	0	0																		

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="999 191 1871 305"> <tr> <td>Dec 2010</td> <td>58</td> <td>0</td> <td>0</td> </tr> <tr> <td>Jan 2011</td> <td>72</td> <td>0</td> <td>0</td> </tr> <tr> <td>Feb 2011</td> <td>54</td> <td>0</td> <td>0</td> </tr> </table> <p data-bbox="989 350 1898 456">A review of ASH's dental logs found that staff and transportation issues were not the major issues precluding individuals from attending dental appointments. See F.9.e for findings regarding dental refusals.</p> <p data-bbox="989 496 1140 561"><b>Compliance:</b> Substantial.</p> <p data-bbox="989 610 1457 675"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Dec 2010	58	0	0	Jan 2011	72	0	0	Feb 2011	54	0	0
Dec 2010	58	0	0											
Jan 2011	72	0	0											
Feb 2011	54	0	0											
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p data-bbox="989 724 1591 748"><b>Current findings on previous recommendations:</b></p> <p data-bbox="989 797 1829 902"><b>Recommendation 1, October 2010:</b> Formalize the process for addressing dental refusals into a written policy/procedure to ensure consistency.</p> <p data-bbox="989 943 1898 1049"><b>Findings:</b> At the time of the review, the procedure for dental refusals as reported by Jeff Shepherd, DDS included the following steps:</p> <ul data-bbox="989 1089 1898 1414" style="list-style-type: none"> <li>• When a dental refusal occurs, the dentist determines the risk level and documents this in the dental progress notes.</li> <li>• The dentist opens a Focus 6 problem.</li> <li>• The unit nurse for the individual develops a plan of care addressing the refusal within eight hours of notification of a high-risk refusal as reported by the Acting Nurse Administrator.</li> <li>• The Dental Department sends the list of high-risk refusals to CNS monthly.</li> <li>• 100% of high-risk dental refusals are being reviewed by the facility.</li> </ul>												

		<p>At the time of the review, the facility had developed Administrative Directive 553: Assisting Individuals to Adhere to the Plan of Care (Refusals). However, the above-outlined appropriate procedure for high-risk dental refusals and the eight-hour timeframe was not found in the document. The facility should formalize the process for addressing high-risk dental refusals into a written policy/procedure to ensure consistency.</p> <p><b>Recommendation 2, October 2010:</b> Ensure that WRPs addressing dental refusals are individualized.</p> <p><b>Findings:</b> ASH's Administrative Directive 553: Assisting Individuals to Adhere to the Plan of Care (Refusals), dated April 12, 2011 indicates that the RN Sponsor is to "ensure that the assessed risk level is clearly documented in the individual's next WRP (Present Status: Risk Factors section 8) along with the date and type of appointment refused, the individual's rationale for refusal, and the specific strategies the staff will implement to help the individual attend his appointment."</p> <p><b>Recommendation 3, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (September 2010 - February 2011), and reported a mean compliance rate of 81%. The facility had reported a compliance rate of 91% in the previous review period, but that compliance rate did not comport with this reviewer's chart review findings at the time.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 11 individuals designated as high risk for dental refusals (CAV, EME, HLH, JKS, MB, MPS, NC, SAM, TAH, TRW and TWM) found that all had the dental refusal documented in the Present Status section of the WRP; three individuals had actually attended their dental appointments after the initial refusals; and all had an open focus addressing refusals included in their WRPs. However, for individuals identified as being at high risk regarding their dental refusals, the content of the interventions included in the WRPs was basically no different than the content for individuals with lower refusal risk levels. In addition, the WRPs were found to be the exact same from month to month and not reflective of a higher level of intensity as should be found for a high risk level rating. The WRPs reviewed were not adequate for individuals deemed at high risk for dental refusals. The WRPs need to develop, regularly review, and revise adequate and appropriate WRPs in alignment with the risk levels of the dental refusals in order for this area to be in substantial compliance.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Formalize the process for addressing high-risk dental refusals into a written policy/procedure to ensure consistency.</li> <li>2. Develop, regularly review, and revise adequate and appropriate WRPs in alignment with the determined risk levels of the dental refusals.</li> <li>3. Continue to monitor this requirement.</li> </ol>
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Section G: Documentation

<b>G. Documentation</b>		
<b>G</b>	<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><b>Summary of Progress:</b> 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><b>Summary of Progress:</b>            ASH has achieved substantial compliance with the requirements of this section of the Enhancement Plan. The facility continues to be committed to decreasing the use the restraint and seclusion and although one incident of prone transportation occurred during the review period, ASH's systems for reviewing seclusion and restraint episodes for prone stabilization/transportation timely and appropriately identified the incident, critically reviewed the incident and associated documentation, and implemented corrective actions to avoid recurrence.</p>
H	<p>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>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Rosemary Morrison, RN, Acting Nurse Administrator</li> <li>2. Stan Wilt, RN, Central Nursing Services</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. ASH Seclusion/Restraint Audit summary data, September 2010 - February 2011</li> <li>2. ASH's Prone Stabilization report</li> <li>3. ASH's training rosters</li> <li>4. Incident Management Review Committee minutes dated 1/20/11</li> <li>5. Revised Seclusion/Restraint Debriefing Form (3/20/11)</li> <li>6. ASH's Count of Assaults by Program, Shift, and Unit from September 1 through March 31</li> <li>7. ASH's Assaultive Individuals by Program, Shift, and Unit data</li> <li>8. ASH's Seclusion and Restraint Interview Techniques curriculum</li> <li>9. ASH Violence Risk Management Committee Progress Report, October 2010 - March 2011</li> <li>10. Quality Council meeting minutes from 1/18/11 and 2/1/11</li> <li>11. Training documentation regarding use of prone transportation</li> </ol>

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

		<p>incident on 1/11/2011</p> <p>12. Medical records for the following 28 individuals: AAA, ACA, ADC, AH, AO, AT, AV, BLH, CAC, CJB, CL, CLC, CMD, CMV, DED, JL, JN, JV, LLD, MJG, MS, MSL, OJG, RAS, RM, SMB, WKK and ZSA</p>
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue to collect information on and review episodes of prone stabilization/transportation.</p> <p><b>Findings:</b> ASH continues to appropriately collect information on and review episodes of prone stabilization/transportation.</p> <p><b>Recommendations 2 and 3, October 2010:</b></p> <ul style="list-style-type: none"> <li>• Include specific methodology and address/document the resolution of problematic issues and corrective action in the IMRC minutes in the event that the prone restraints, prone containment and/or prone transportation are used.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> ASH reported that during the review period, there was one incident of prone transportation that occurred on January 11, 2011 to individual AV. The facility conducted a thorough review of the incident, which was reviewed in Quality Council on 1/18/11 and 2/1/11 as well as in the Incident Management Review Committee on 1/20/11. ASH's findings of these reviews indicated that although no injury occurred to the individual, the use of prone transportation was unwarranted and inappropriate. A review of the facility's corrective actions indicated that training was timely provided to the unit supervisors on Program VII on 1/19/11 and to all Program VII unit staff( completed by 3/11/11)</p>

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

		<p>addressing the prohibition of the use of prone restraints, prone containment and prone transportation. In addition, stencils stating "Face Up Only" were placed on all backboards hospital-wide as of 3/7/11 to remind staff not to use a prone position for transport. From review of this incident, ASH's system for review of seclusion and restraint episodes for prone stabilization/transportation timely and appropriately identified the incident, critically reviewed the incident and associated documentation, and implemented corrective actions to avoid recurrence. Thus, the systems that ASH currently had in place regarding seclusion and restraint were found to be adequate and effective.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to collect and review episodes of prone stabilization/transportation.</li> <li>2. Include specific methodology and ensure that the resolution of problematic issues and corrective action are addressed and documented in the IMRC in the event that the prone restraints, prone containment and/or prone transportation were used.</li> <li>3. Continue to monitor this requirement.</li> </ol>
H.2	Each State hospital shall ensure that restraints and seclusion:	<p><b>Compliance:</b> Substantial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance</p>

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

		<p>based on a 14% mean sample of initial seclusion orders each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 302 1890 529"> <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>98%</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 37 episodes of seclusion for 13 individuals (ACA, AH, BLH, CAC, CJB, CL, CMV, DED, JL, JV, LLD, WKK and ZSA) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 16% mean sample of initial restraint orders each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="993 1084 1890 1312"> <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>99%</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>	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>	98%	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>	99%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>A review of 37 episodes of restraint for 14 individuals (AAA, ADC, AO, AT, CLC, CMD, JN, MJG, MS, MSL, OJG, RAS, RM and SMB) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in 36 episodes and orders that included specific behaviors were found in all episodes.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 14% mean sample of initial seclusion orders each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 971 1890 1416"> <tr> <td data-bbox="991 971 1087 1044">4.</td> <td data-bbox="1087 971 1793 1044"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 971 1890 1044">97%</td> </tr> <tr> <td data-bbox="991 1044 1087 1268">5.</td> <td data-bbox="1087 1044 1793 1268"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 1044 1890 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1416">6.</td> <td data-bbox="1087 1268 1793 1416"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior</i></td> <td data-bbox="1793 1268 1890 1416">100%</td> </tr> </table>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	97%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" data-bbox="991 191 1892 267"> <tr> <td data-bbox="991 191 1094 267"></td> <td data-bbox="1094 191 1793 267"><i>as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 191 1892 267"></td> </tr> </table> <p data-bbox="991 310 1892 378">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 420 1892 597">A review of 37 episodes of seclusion for 13 individuals (ACA, AH, BLH, CAC, CJB, CL, CMV, DED, JL, JV, LLD, WKK and ZSA) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 36 episodes indicated that the individual was released when calm.</p> <p data-bbox="991 639 1892 748">Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 16% mean sample of initial restraint orders each month during the review period (September 2010 - February 2011):</p> <table border="1" data-bbox="991 784 1892 1308"> <tr> <td data-bbox="991 784 1094 860">4.</td> <td data-bbox="1094 784 1793 860"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 784 1892 860">91%</td> </tr> <tr> <td data-bbox="991 860 1094 1084">5.</td> <td data-bbox="1094 860 1793 1084"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 860 1892 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1094 1308">6.</td> <td data-bbox="1094 1084 1793 1308"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 1084 1892 1308">100%</td> </tr> </table> <p data-bbox="991 1351 1892 1419">Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period for all items.</p>		<i>as provided by the individual, or there is clinical 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>	91%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>A review of 37 episodes of restraint for 14 individuals (AAA, ADC, AO, AT, CLC, CMD, JN, MJG, MS, MSL, OJG, RAS, RM and SMB) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 36 episodes indicated that the individual was released when calm</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.2.c	are not used as part of a behavioral intervention; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.2.c.iv.</p> <p><b>Findings:</b> See F.2.c.iv.</p> <p><b>Current recommendation:</b> See F.2.c.iv.</p>
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 14% mean sample of episodes of seclusion each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 99%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p>

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

		<p>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 16% mean sample of episodes of restraint each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 99%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance with the one-hour requirement based on a 14% mean sample of initial seclusion orders each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 95%. Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 37 episodes of seclusion for 13 individuals (ACA, AH, BLH, CAC, CJB, CL, CMV, DED, JL, JV, LLD, WKK and ZSA) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in 35 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH also assessed its compliance with the one-hour requirement based on a 16% mean sample of initial restraint orders each month during the review period (September 2010 - February 2011) and reported a mean compliance rate of 94%.</p>

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

		<p>Comparative data indicated that ASH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 37 episodes of restraint for 14 individuals (AAA, ADC, AO, AT, CLC, CMD, JN, MJG, MS, MSL, OJG, RAS, RM and SMB) found that the RN conducted a timely assessment in 36 episodes and that the individual was timely seen by a psychiatrist in 36 episodes.</p> <p>ASH's training rosters indicated that all existing staff and newly hired staff that were required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, ASH continued to have the Standards Compliance Department 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. Additionally, the Ongoing Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly and</p>

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		<p>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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 82% mean sample of individuals who were in seclusion more than three times in 30 days during the review period (September 2010 - February 2011), and reported a mean compliance rate of 99% with the three-day review requirement. 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 eight individuals who were in seclusion more than three times in 30 days during the review period (ACA, BLH, CMV, DED, JL, JV, WKK and ZSA) found that all WRPs included documentation within three business days.</p> <p>Using the DMH Seclusion/Restraint Audit, ASH also assessed its compliance based on a 81% sample of individuals who were in restraint more than three times in 30 days during the review period (September</p>

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

		<p>2010 - February 2011), and reported a mean compliance rate of 94% with the three-day review requirement. 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 nine individuals who were in restraint more than three times in 30 days during the review period (AAA, AT, CLC, MJG, MS, OJG, RAS, RM and SMB) found that all WRPs included documentation within three business days.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> 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><b>Compliance:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>

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H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.3.a.iii.</p> <p><b>Findings:</b> See F.3.a.iii.</p> <p><b>Current recommendations:</b> See F.3.a.iii.</p>

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H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Same as in D.1.f, F.1.b and H.6.a.</p> <p><b>Findings:</b> Same as in D.1.f, F.1.b and H.6.a</p> <p><b>Current recommendations:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> See F.3.h.i and H.3.</p> <p><b>Findings:</b> See F.3.h.i and H.3.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.8	Each State hospital shall:	<p><b>Compliance:</b> 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	There were no previous recommendations, as side rails are no longer used at ASH.

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H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	<b>Current findings on previous recommendation:</b>  <b>Recommendation, October 2010:</b> See H.8.a.  <b>Findings:</b> See H.8.a.  <b>Current recommendation:</b> None required.
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. In most instances, the investigations reviewed were comprehensively investigated and with a generously staffed OSI (with 14 retired annuitants), there were only a few lingering open cases. The facility continues to have each investigation report reviewed by the Hospital Administrative Resident before it is approved by the OSI Lead Investigator.</li> <li>2. Interviews were generally summarized adequately and all witnesses were interviewed. Investigators were particularly conscientious in asking individuals who were reluctant to cooperate with the investigation whether they had been threatened with retaliation.</li> <li>3. The IMRC continues to meet weekly to discuss substantiated cases. Unfounded and not substantiated cases are discussed if a committee member has a question or concern. The IMRC is provided information on the incident history of the named staff members and alleged victims in the cases on the agenda.</li> <li>4. ASH has developed technology that enables it to gather and analyze data with ease, on both facility-wide and individual-specific levels. Particularly impressive is the expanded Data Dashboard, a web-based application, available to anyone with a facility e-mail address. The demonstration at the Quality Council meeting included examples of the application's ability to graph aggression data for any time period selected, provide the names and units of individuals who have engaged in aggression during a specific time period, to rank individuals according to the number of aggressive acts in which they engaged, and to profile any individual providing real-time information on current medications, allergies, use of restraint and seclusion, and SIRs and triggers for any period of time selected. Every member of an individual's WRPT has access to the profiling data.</li> <li>5. The Violence Risk Management Committee Progress Report (10/10-3/11), a 47 page document, provides aggression data and analysis, identifying</li> </ol>

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		<p>locations of aggressive incidents, injuries, characteristics of individuals involved in aggressive incidents, and factors that correlate with aggression such as increased census and use of overtime. Following the analysis, the report provides a summary of administrative initiatives directed at reducing violence, actions to empower individuals, staff training initiatives, WRPT-based initiatives and next steps. It further identified 10+ violence reduction initiatives that have been implemented, some of which have already proven their effectiveness.</p> <ol style="list-style-type: none"> <li>6. The new Key Indicator Report identifies for scrutiny by the appropriate clinical leadership indicators in the current month that are substantially out of line (2-3 standard deviations) with the previous 12 months. This information is shared with the Quality Council.</li> <li>7. ASH identified 25+ initiatives recently accepted by the Quality Council that are designed to improve the safety of the individuals and staff members and are in various stages of planning and implementation.</li> <li>8. Review of the WRPs of individuals on behavioral and medical high-risk lists and those of individuals reviewed in risk management committees revealed positive findings that the WRPTs had been attentive to the problem under review in fashioning objectives and interventions and in addressing the recommendations of the risk management committees.</li> <li>9. ASH has maintained compliance with all of the requirements of Section I.2 for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</li> </ol> <p><b><i>Areas of Need include:</i></b></p> <ol style="list-style-type: none"> <li>1. <i>Ensure that analysis of key indicator aggression data includes comparisons of recurrent incidents within seven days and within 30 days;</i></li> <li>2. <i>Develop algorithms for improved and more aggressive pharmacological management of higher-risk individuals (on the proposed enhanced treatment unit);</i></li> <li>3. <i>Working within the DMH Strategic Action Plan, the facility needs to</i></li> </ol>
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		<p><i>utilize the violence risk assessment to identify the type of aggression in order to inform treatment planning for individuals.</i></p> <p>4. <i>Present monthly updates to the CM on the status of implementation of various initiatives and proposed corrective actions to reduce the risk of violence.</i></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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. A. Alvarez, Lead Investigator, OSI</li> <li>2. C. Williams, Standards Compliance</li> <li>3. D. Karas, Program Director</li> <li>4. D. Landrum, Hospital Administrative Resident II</li> <li>5. D. Landrum, Chief of Police</li> <li>6. L. Persons, Hospital Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ten A/N/E investigation reports</li> <li>2. Three DPS investigations of sexual contact incidents</li> <li>3. IMRC minutes for the review period</li> <li>4. IMRC Abuse and Neglect Trends Report</li> <li>5. Documents related to the unexpected deaths of two individuals</li> <li>6. Selected personnel information for 15 staff members</li> <li>7. Statement of rights forms for 12 individuals</li> <li>8. OSI listing of staff members named in A/N/E allegations</li> <li>9. Violence Risk Management Committee Progress Report (October 2010-March 2011)</li> </ol>
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><b>Compliance:</b> Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of	<p><b>Current findings on previous recommendation:</b></p>

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	<p>individuals;</p>	<p><b>Recommendation, October 2010:</b> Continue current practice and vigilant monitoring of failure to report A/N/E allegations in the manner required by policy.</p> <p><b>Findings:</b> The facility's data taken from the Investigation Compliance Monitoring Form (presented in I.1.b.iv.3(i) in the ASH progress report) indicated that in a single investigation closed in each of the months of September, November and January, one or more mandated reporters failed to report an allegation of A/N/E.</p> <table border="1" data-bbox="953 597 1877 789"> <thead> <tr> <th>Month</th> <th>Cases closed</th> <th>Cases sampled</th> <th>Cases in compliance</th> </tr> </thead> <tbody> <tr> <td>September</td> <td>17</td> <td>12 (71%)</td> <td>11 (94%)</td> </tr> <tr> <td>November</td> <td>29</td> <td>23 (79%)</td> <td>22 (97%)</td> </tr> <tr> <td>January</td> <td>21</td> <td>19 (90%)</td> <td>18 (95%)</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue to identify staff members' failure to report in investigation reports so that the IMRC is provided this information.</p>	Month	Cases closed	Cases sampled	Cases in compliance	September	17	12 (71%)	11 (94%)	November	29	23 (79%)	22 (97%)	January	21	19 (90%)	18 (95%)
Month	Cases closed	Cases sampled	Cases in compliance															
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<p>I.1.a.ii</p>	<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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> As agreed, apply the SO 263 definitions of psychological abuse in making determinations.</p> <p><b>Findings:</b> The facility reported that in making determinations regarding psychological abuse, the SIR definition is applied. In the investigation of the verbal abuse of JV (9/3/10), the named staff member acknowledged that he replied to JV's "f*** you" retort in kind. The allegation of verbal abuse was substantiated. The investigator interviewed the Chief of Psychiatry "to</p>																

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		<p>determine whether the verbal abuse could have long-term psychological effect." The Psychiatry Chief responded that as a one-time event, it would not cause long-term negative psychological effects. While not disagreeing with the verbal abuse substantiation and having no evidence or reason to question the conclusion of the Psychiatry Chief, this monitor would nonetheless caution that the SIR definition of psychological abuse has no element that requires the act to be the cause of long-term negative psychological effects.</p> <p><b>Current recommendation:</b> Apply the SO 263 definition of psychological abuse in making determinations.</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Comply with the procedures specified in SO 263 for removing staff members named in A/N/E incidents.</p> <p><b>Findings:</b> SO 263 states that the Program Director is responsible "for removing all alleged perpetrators of physical abuse from direct contact with individuals as soon as the perpetrators are identified as such." In the four investigations of allegations of physical abuse reviewed, six of the seven named staff members were not removed. The facility acknowledged it was not following the SO directive. Rather, the decision as to whether to remove a named staff member was made after consultation with the Clinical Administrator and the Police Chief. The rationales provided were not individualized and, for the most part, simply said that the named staff member was not a danger to the alleged victim. Some rationales written at the end of the review period provided additional information supporting the decision not to remove the staff member. In a discussion with the Executive Director, Hospital Administrator, Chief of Police, and the OSI</p>

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		<p>Lead Investigator, it was agreed that in instances in which it was physically impossible for the incident to have occurred as alleged (e.g., the named staff member was on vacation at the time of the incident), the facility would complete the DMH Allegation Checklist (attachment to SO 263) as a means of ensuring the documentation of all of the considerations that support the decision not to remove the staff member. The Executive Director further made clear that he will maintain the flexibility to move an individual or staff member based on the information available.</p> <p><b>Current recommendation:</b> Monitor the rationales for removal decisions to ensure they avoid rote generalized comments, but rather are specific to the incident.</p>																																												
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As shown in the table below, 10 of the 15 staff members sampled were current with annual A/N training.</p> <table border="1" data-bbox="953 1003 1822 1419"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_W</td> <td>11/16/81</td> <td>11/16/81</td> <td>10/27/86</td> <td>4/11/11</td> </tr> <tr> <td>_G</td> <td>1/4/99</td> <td>12/15/98</td> <td>1/4/98</td> <td>1/18/11</td> </tr> <tr> <td>_R</td> <td>10/19/09</td> <td>10/1/09</td> <td>9/28/09</td> <td>1/7/11</td> </tr> <tr> <td>_V</td> <td>4/7/08</td> <td>10/31/07</td> <td>1/8/08</td> <td>9/15/10</td> </tr> <tr> <td>_N</td> <td>10/4/99</td> <td>7/6/99</td> <td>10/4/99</td> <td>6/15/10</td> </tr> <tr> <td>_C</td> <td>1/3/05</td> <td>11/22/04</td> <td>1/3/05</td> <td>6/15/10</td> </tr> <tr> <td>_F</td> <td>4/26/04</td> <td>4/8/04</td> <td>4/26/04</td> <td>6/9/10</td> </tr> </tbody> </table>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_W	11/16/81	11/16/81	10/27/86	4/11/11	_G	1/4/99	12/15/98	1/4/98	1/18/11	_R	10/19/09	10/1/09	9/28/09	1/7/11	_V	4/7/08	10/31/07	1/8/08	9/15/10	_N	10/4/99	7/6/99	10/4/99	6/15/10	_C	1/3/05	11/22/04	1/3/05	6/15/10	_F	4/26/04	4/8/04	4/26/04	6/9/10
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I.1.a.v	<p data-bbox="354 834 924 1273">notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p data-bbox="955 834 1541 862"><b>Current findings on previous recommendation:</b></p> <p data-bbox="955 906 1377 933"><b>Recommendation, October 2010:</b></p> <p data-bbox="955 945 1470 972">Continue current practice and monitoring.</p> <p data-bbox="955 1016 1068 1044"><b>Findings:</b></p> <p data-bbox="955 1055 1902 1382">Please see the table above which indicates that 13 of the 15 staff members sampled signed the mandatory reporter form prior to or on the date of hire. One staff member who did not was hired in 1981 when the form may not have been required. This staff member signed the form in 1986. There is no HR record of the second staff member (a contract employee) having signed the form. There is also no HR record of this same contract staff member having attended A/N/E training. Three other sampled staff members should attend A/N/E training soon, as they were due for annual training in January 2011.</p>																																								

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		<p><b>Other findings:</b> See also I.1.c for disciplinary actions taken in response to a failure to report abuse or neglect.</p> <p><b>Current recommendation:</b> Continue monitoring and ensure compliance of those staff members cited above who are out of compliance for training.</p>																												
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As shown below, 14 of the 16 statements of rights reviewed were signed within the last 12 months by the individual or the individual's refusal was documented.</p> <table border="1" data-bbox="961 857 1717 1391"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>ER</td> <td>4/4/11</td> </tr> <tr> <td>ES</td> <td>4/4/11</td> </tr> <tr> <td>DW</td> <td>3/18/11</td> </tr> <tr> <td>JP</td> <td>3/14/11</td> </tr> <tr> <td>JT</td> <td>3/14/11</td> </tr> <tr> <td>JZ</td> <td>DOA 3/14/11--form not completed</td> </tr> <tr> <td>OC</td> <td>1/28/11</td> </tr> <tr> <td>RP</td> <td>No signature by RP--staff signed 1/19/11</td> </tr> <tr> <td>MK</td> <td>1/6/11</td> </tr> <tr> <td>RR</td> <td>11/29/10</td> </tr> <tr> <td>ET</td> <td>10/28/10</td> </tr> <tr> <td>MC</td> <td>10/6/10</td> </tr> <tr> <td>JW</td> <td>8/10/10</td> </tr> </tbody> </table>	Individual	Date of most recent signing	ER	4/4/11	ES	4/4/11	DW	3/18/11	JP	3/14/11	JT	3/14/11	JZ	DOA 3/14/11--form not completed	OC	1/28/11	RP	No signature by RP--staff signed 1/19/11	MK	1/6/11	RR	11/29/10	ET	10/28/10	MC	10/6/10	JW	8/10/10
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		<table border="1"> <tr> <td>CK</td> <td>7/15/10</td> </tr> <tr> <td>AF</td> <td>5/11/10</td> </tr> <tr> <td>GZ</td> <td>4/8/10 refused to sign</td> </tr> </table> <p><b>Current recommendation:</b> Continue current practice.</p>	CK	7/15/10	AF	5/11/10	GZ	4/8/10 refused to sign
CK	7/15/10							
AF	5/11/10							
GZ	4/8/10 refused to sign							
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The statement of individuals' rights was posted in a common area on each unit toured.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						
I.1.a. viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Several examples of the facility's referrals to the DA were found in the investigations sampled.</p> <ul style="list-style-type: none"> <li>• The facility forwarded to the DA a case against individual JR for assaulting staff on 12/30/10. The case was rejected in the interest of justice.</li> <li>• Individuals ED and _F were fighting on 11/5/10 with _F punching ED in the face and ED retaliating by putting _F in a headlock. ED alleged that</li> </ul>						

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		<p>staff abused him when they responded to the scene. He said a staff member put him in a choke hold, they both fell to the ground, and a second staff member kicked his right cheek. This case was sent to the DA on 11/10/10 and was rejected due to lack of evidence.</p> <ul style="list-style-type: none"> <li>• The containment of MM (9/30/10) went terribly wrong and MM suffered a skull fracture and required surgery. The case against the named staff member for Battery with Serious Bodily Injury was sent to the DA. It was dismissed for insufficient evidence to warrant criminal prosecution and in the interest of justice.</li> <li>• One incident of alleged coerced sexual contact between CS and DH (10/9/10) that was investigated by HPD was referred to the local DA. It was rejected due to lack of evidence.</li> </ul> <p><b>Current recommendation:</b> Continue to forward to the DA those cases found to be appropriate.</p>
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> 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> <p><b>Findings:</b> Several of the investigations reviewed specifically noted that the investigator questioned the alleged victim about fear of retaliation. Specifically, when the victim (ED) alleged that staff physically assaulted him during a containment but refused to speak with the investigator, the investigator asked him if he was being threatened or coerced or if he feared retaliation. ED responded that he was/did not.</p> <p>Similarly, when MM, the alleged victim of physical abuse, refused to talk to</p>

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		<p>the investigator, the investigator asked if the reason was because he feared retaliation. MM replied no, he was feeling good.</p> <p>When the alleged victim (JV) of a sexual battery by another individual said he did not wish to press charges, the investigator asked him if he was threatened or if he feared he would be harmed. He answered in the negative.</p> <p><b>Current recommendation:</b> Continue current practice of questioning alleged victims about fear of retaliation or threats.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p><b>Compliance:</b> Substantial.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue to implement SO 205.05: Mortality Review.</p> <p><b>Findings:</b> During the review period there were two unexpected deaths at ASH: KM died on 10/8/10 and DL died on 12/5/10. No autopsies were performed.</p> <p>KM was 63 years old when he died at Sierra Vista Regional Medical Center of a deep brain bleed as the result of a stroke. In the weeks before his death, KM was in and out of the facility. 9/12/10—transferred to Twin Cities Community Hospital for high blood pressure. 9/13—returned to ASH. 9/15—transferred back to TCCH for fever, treated in ICU for pneumonia. 9/28—returned to ASH. 10/5—lethargic, irregular pulse, BP 230/90,</p>

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		<p>transported to TCCH by ambulance. ASH implemented SO 205.05 as follows:</p> <ul style="list-style-type: none"><li>• Preliminary Medical Death Summary (10/22/10) found medical care was appropriate and every measure was taken to reduce the discomfort of KM's final days and hours.</li><li>• Medical Death Summary (10/10/10) lists probable cause of death as a CVA with intraparenchymal bleed with four other contributing conditions.</li><li>• Internal Discipline Death Review (11/11/10) notes the atypical NMS presentation and states that the care provided by medical physicians was appropriate, timely, well thought-out and consistent with standards of care in the community and conformed to facility procedures. Same can be said for care by psychiatrist and nursing staff.</li><li>• Nursing Death Summary (10/19/10) identifies four areas for improvement.</li><li>• MIRC (10/22/10) states there are no remarkable issues and all guidelines and protocols were followed.</li><li>• Independent External Review (12/6/10) commended the quality of the Medical Death Summary, raised issues for the MIRC to query, and made no recommendations.</li><li>• Final MIRC (1/13/11) identifies measures taken, which include a revision to the AD governing lab orders to clarify that when necessary, they should indicate when repeat attempts should occur and development of an annual refresher course on atypical NMS presentations for medical and psychiatric staff.</li></ul> <p>DL was 59 years old when he died at ASH. He had severe COPD with complications from polio. On 12/15/10, he was short of breath, was given his albuterol inhaler and shortly thereafter was found unresponsive. Life saving-measures commenced by the NOD, unit staff and the Fire Dept. DL was transported to Unit 1 via emergency cart and was pronounced dead at 2:40 AM. The initial MIRC (12/16/10) viewed this as an expected death.</p>
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		<p>Later this designation was changed to unexpected.</p> <ul style="list-style-type: none"> <li>• OSI investigation report (12/15/10) states "all records indicate DL received proper care and treatment. There is no evidence DL was the victim of abuse or neglect."</li> <li>• Preliminary Death Summary (12/15/10)</li> <li>• Medical Death Summary (4/11/11) concluded that medical care was appropriate and every measure was taken to address DL's presenting symptoms in a timely manner.</li> <li>• Nursing Death Summary (12/10/10) found no gaps in staff performance or facility procedures that affected DL's care.</li> <li>• MIRC (4/13/11) notes the delay in notifying the External Independent Reviewer because of the reclassification of the death from expected to unexpected. All materials have been sent to the External Reviewer.</li> </ul> <p><b>Current recommendation:</b> OSI investigators should avoid making judgments beyond their scope of expertise, e.g., all records indicate [the individual] received proper care and treatment.</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Allegations of theft, sexual assault and other potentially criminal activity are investigated by HPD who have had investigation training.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The OSI investigations note the safeguarding of audiotapes of the named staff members. In the investigation of the allegation of physical abuse of MM, the investigator took seven photos of the scene and transferred them to a disk.</p> <p><b>Current recommendation:</b> 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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Protect the integrity of investigations by ensuring that all witnesses are interviewed.</p> <p><b>Findings:</b> In each of the investigation reports reviewed, all witnesses are listed on the face sheets and in the RMS reporting forms attached.</p> <p><b>Recommendation 2, October 2010:</b> As agreed, discontinue the use of the form wherein the psychiatrist makes a determination as to the veracity of an allegation.</p> <p><b>Findings:</b> The facility reported that this form is no longer used. The investigations reviewed held no evidence of its use.</p>

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		<p><b>Current recommendation:</b> Continue current practice.</p>																																								
I.1.b. iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The investigations reviewed indicated that the HPD responded quickly and well within the 24-hour limit when advised of an incident.</p> <p><b>Current recommendation:</b> Continue current practice.</p>																																								
I.1.b. iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b></p> <table border="1"> <thead> <tr> <th>Incident/ allegation type</th> <th>Date incident reported</th> <th>To OSI</th> <th>Date investigation closed</th> </tr> </thead> <tbody> <tr> <td>Verbal abuse</td> <td>9/3/10</td> <td>9/3/10</td> <td>10/13/10</td> </tr> <tr> <td>Verbal abuse</td> <td>9/21/10</td> <td>9/23/10</td> <td>12/16/10</td> </tr> <tr> <td>Physical abuse</td> <td>9/30/10</td> <td>10/6/10</td> <td>11/10/10</td> </tr> <tr> <td>Violation of rights</td> <td>10/6/10</td> <td>10/13/10</td> <td>11/17/10</td> </tr> <tr> <td>Neglect</td> <td>10/10/10</td> <td>10/13/10</td> <td>1/7/11</td> </tr> <tr> <td>Neglect</td> <td>10/18/10</td> <td>10/21/10</td> <td>11/12/10</td> </tr> <tr> <td>Physical abuse</td> <td>11/5/10</td> <td>11/10/10</td> <td>1/25/11</td> </tr> <tr> <td>Physical abuse</td> <td>12/30/10</td> <td>1/4/11</td> <td>2/3/11</td> </tr> <tr> <td>Physical abuse</td> <td>1/3/11</td> <td>1/6/11</td> <td>2/9/11</td> </tr> </tbody> </table>	Incident/ allegation type	Date incident reported	To OSI	Date investigation closed	Verbal abuse	9/3/10	9/3/10	10/13/10	Verbal abuse	9/21/10	9/23/10	12/16/10	Physical abuse	9/30/10	10/6/10	11/10/10	Violation of rights	10/6/10	10/13/10	11/17/10	Neglect	10/10/10	10/13/10	1/7/11	Neglect	10/18/10	10/21/10	11/12/10	Physical abuse	11/5/10	11/10/10	1/25/11	Physical abuse	12/30/10	1/4/11	2/3/11	Physical abuse	1/3/11	1/6/11	2/9/11
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		Neglect	1/11/11	1/12/11	2/23/11
I.1.b. iv.3	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Seven of the 10 investigations reviewed were closed within 30 business days.</p> <p><b>Other findings:</b> The facility reports that during the review period, 86% of the cases due to close met the 30 business day or five-day extension EP timeline. A review of open cases at the time of the CM visit found no heavy backlog; seven A/N/E cases were open with the oldest incident having occurred 12/27/10.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Ensure that rationales provide sufficient justification for determinations.</p> <p><b>Findings:</b> Review of the conclusion sections of the investigations reviewed yielded variable findings related to the quality of the rationales for the determinations. In some cases, the rationale simply said that based on the documents reviewed and the findings of the investigation, the case was determined to be sustained, not sustained, or unfounded. This type of rationale provides no insight into the investigator's weighing of the evidence. In contrast, the investigation report of alleged neglect against Plant Operations staff for failing to quickly install an electrical outlet in a dorm room of an individual who needed a CPAP machine clearly supports the unfounding of the allegation by noting that the delay was due in part to each party (residential unit and Plant Ops) having different identifiers for the room in question.</p>			

		<p><b>Other findings:</b></p> <p>The conclusion in the investigation of the alleged physical assault of MM raises several questions. MM was seriously hurt (skull fracture and brain hemorrhage treated surgically and from which he recovered) during a take-down incident. The named staff member saw MM hitting another staff member on the head and to save the staff member from injury single-handedly took MM to the floor using a wrestling move--bear hug around the waist and then swept MM's feet out from under him. MM fell face forward onto the floor and the named staff member landed partially on top of him. The allegation of physical abuse was unfounded with the rationale that the named staff member "responded by automatic reflex to protect the life of another human being. It was an unfortunate accident that [MM] was injured. The protection of life is the primary concern and supersedes all else. The Subject Matter Expert concluded that [named staff member] was justified in his actions."</p> <p>The use of a wrestling move on an individual to take him to the floor increases the chances someone will be hurt. Wrestling moves are "harmless" when performed on a prepared surface by skilled persons who know how to fall and protect themselves. It is less "accident" and more a foreseeable consequence when such moves are used on untrained individuals. One purpose of teaching specific approved techniques for containing an individual is to equip staff so that they will avoid the use of reflexive street fighting and wrestling moves to protect themselves and others.</p> <p>The ASH Police Department forwarded the case against the named staff member to the DA's office for Battery with Serious Bodily Harm. If they believed that the incident met the elements of the criminal charge, it is difficult to understand how the OSI concluded there was no physical abuse, i.e., no "unnecessary roughness in the provision of care."</p> <p><b>Current recommendation:</b></p> <p>Ensure that rationales provide sufficient justification for determinations</p>
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		and that determinations consider all elements of the SIR definition and rest upon findings of fact.
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> When more than one allegation is embedded in a case, ensure that the investigation covers each allegation and provides a determination on each.</p> <p><b>Findings:</b> No investigations reviewed included an allegation that was left uninvestigated.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> In the investigations reviewed, the names of persons involved in or witness to an investigation are identified on the face sheet of the OSI investigation report and on the accompanying RMS reporting form.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p>

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		<p><b>Findings:</b> All investigations reviewed identified the alleged victims and perpetrators.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The names and titles of all persons interviewed were clearly documented in the investigation reports reviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> All investigation reports reviewed included a summary of each interview conducted, including the location of the interview and the circumstance (with or without union representation). The allegation of neglect of SS, who was left behind when everyone went to dinner, came to the attention of OSI on 10/13/10. The first interviews were not conducted until 11/2/10 and SS was not interviewed until 11/4/10. The named staff member was interviewed on 11/9/10.</p>

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		<p><b>Current recommendation:</b> Interview relevant persons in as timely a manner as possible to avoid opening the integrity of the investigation to question.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Each investigation report reviewed included a listing of the documents reviewed. In the report of the investigation of the alleged neglect of SS, who was left behind locked in his dorm when everyone left for dinner, the investigator secured a copy of the staffing sheet for the day in question in order to determine the identity of the Shift Lead. In the investigation of the alleged neglect of JR, whose vital signs were not taken as ordered before he received medication, the investigator secured a copy of the assignment roster, the physician's medication orders, and the Medication Administration Record.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3 (vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Information regarding prior cases involving the named staff member is not included in the investigation report but is provided to the IMRC and recorded in the minutes of that committee. The IMRC follows the same pattern each month as provided in the example of the 10/7/10 IMRC</p>

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		<p>minutes, which indicate that four unfounded or not sustained cases were on the consent agenda (these cases are not discussed unless a committee member has brought up a question or comment when he/she reviewed the investigations prior to the meeting). For each case, the agenda documents whether the named staff member had any prior cases and, if yes, the nature of the allegation and the determination. This same information was provided for the named staff members in the two sustained cases to be discussed during the meeting and for all alleged victims.</p> <p><b>Current recommendation:</b> Continue current practice.</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice of identifying failures to follow facility policies and procedures in investigations.</p> <p><b>Findings:</b> Several of the investigations reviewed yielded findings related to violations of facility policies. The investigation of the allegation of neglect of JR found that the named staff member had violated Nursing Procedure 307.0 related to the administration of medication. Similarly, the investigation of the allegation of neglect of SS found that the named staff member had violated AD 804 related to Census Count.</p> <p><b>Other findings:</b> The information in the table below was drawn from the Case Activity Subject List and is not a count of cases, but rather a count of allegations. A single investigation case may contain multiple allegations against multiple staff members.</p>

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		Feb-Aug 2010		Sep 2010 - Feb 2011	
		# invest- tigated	# sub- stantiated	# invest- tigated	# sub- stantiated
		Allegation type			
		Physical Abuse	32	1	38
		Verbal Abuse	29	6	48
		Psychological	11	4	11
		Sexual Abuse	1	0	9
		Neglect	27	17	55
		Failure to follow policy	38	32	52
		<p><b>Current recommendation:</b> Continue current practice of identifying failures to follow facility policies and procedures in investigations.</p>			
I.1.b. iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Ensure that conclusions accurately represent the facts established during the investigation.</p> <p><b>Findings:</b> In the investigation of the physical abuse of MM, the named staff member, witnesses and the staff victim gave differing descriptions of MM's attack on the staff victim. Staff witness #1 saw the staff victim duck down and did not see any blows land; staff witness #2 saw MM throw a right-handed punch with force that landed on the staff victim. Staff witness #3 saw MM swinging both fists and hitting the staff victim 4-5 times in the back of the head. Staff witness #4 saw MM swinging his right fist at the back of the staff victim's head. The named staff member saw MM pummeling the staff victim's head with both fists. The staff victim said he felt someone punch him on the left side of his face. Then, after he saw the named staff member grab MM around the waist, he felt a second punch graze the back right side of his head. The investigation report states that the staff victim</p>			

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		<p>sustained a contusion to his left ear.</p> <p>The investigation report wisely acknowledges "these types of scenarios are difficult to recount and explain by the witnesses who try and recall the incident circumstances when viewed only by quick glimpses of the incident."</p> <p><b>Current recommendation:</b> Continue attempts to reconcile conflicting accounts of incidents during the investigation process.</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 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Ensure that any issues/questions that the IMRC raises are documented in the minutes along with the response, in subsequent minutes if necessary.</p> <p><b>Findings:</b> A review of the IMRC minutes for the review period found very few questions raised about the contents of investigations and these few were answered by the OSI Lead Investigator or Chief of Police. See also I.1.d.ii and I.1.d.iii for data reviewed by the IMRC.</p> <p>All investigations reviewed were approved by the OSI Lead Investigator after review by the Hospital Administrative Resident.</p> <p><b>Other findings:</b> Following the failure to take pictures of injuries sustained during an incident, the January 20, 2011 IMRC minutes document that the Chief of Police will ensure that all officers are aware of the requirement to "photograph injuries that require sutures and/or critical medical care."</p> <p><b>Current recommendation:</b> Continue the review of investigations by the Hospital Administrative</p>

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		Resident for as long as necessary.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring of the timely and effective person-specific and systemic corrective actions resulting from incidents and performance improvement studies.</p> <p><b>Findings:</b> The facility recognized the seriousness of the incident and undertook an exceptional review of the events resulting in the serious injury of MM during containment. The findings and recommendations were shared with the IMRC and the Quality Council on 1/6/11:</p> <ul style="list-style-type: none"> <li>• The current process failed to ensure timely notification to the named staff member that he had been removed from the secure area.</li> <li>• Staff morale was affected by staff's lack of knowledge concerning the staff removal process. This information will be added to A/N/E Reporting training and TSI training.</li> <li>• The named staff member was not informed of the staff debriefing held on the unit. In the future each case will be reviewed independently to determine if the named staff member should attend. If the decision is made that he/she should not attend, HR will provide a referral to EAP.</li> <li>• Clarification will be provided on the role of the Nurse Practitioner during medical emergencies.</li> <li>• First Aid training will include the use of the Stryker chair.</li> <li>• All individuals being transferred from a unit to an outside hospital via ambulance will be cared for in the Urgent Care Room unless the ambulance and EMTs have arrived and transfer of care is completed immediately upon arrival. UCR will remain open until the transfer of the individual occurs. A policy revision will reflect this change.</li> <li>• Ensure UCR assessment/treatment and/or UCR physician clearance is in</li> </ul>

		<p>place before DPS interviews begin.</p> <ul style="list-style-type: none"> <li>• A message will inform all staff that they may be contacted after hours during an investigation.</li> <li>• TSI training and emergency drills will include training for staff on how to shift focus from a behavioral incident to a medical emergency.</li> <li>• Notification of outcome of the investigation to the Program Director should occur prior to the outcome letter being sent to the named staff member.</li> </ul> <p>This review identified numerous areas for improvement that were not evident simply from reading the investigation report. It did not identify a significant root cause of this incident, namely, the use of single-man wrestling moves to contain MM rather than interventions and procedures taught in TSI classes. Furthermore, this review did not direct attention to another root cause of the incident--the fact that many of the staff were in the office, chart room or nurses' station when the take-down occurred and were not available to assist. This may be because the containment occurred at approximately 2:45 PM and this may have been change of shift. However, this was not explored and no recommendations addressed this issue.</p> <p><b>Other findings:</b> Disciplinary actions, as reported by HR, were applied to several staff members involved in the incident investigations reviewed.</p> <ul style="list-style-type: none"> <li>• Failure to report psychological abuse—employee given verbal instruction;</li> <li>• Sustained verbal abuse—employee provided written counseling;</li> <li>• Violations of facility policy— two employees provided letters of instruction;</li> <li>• Failure to report verbal abuse—employee given letter of instruction.</li> </ul> <p><b>Compliance:</b> Substantial.</p>
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		<p><b>Current recommendation:</b> Continue to undertake exceptional reviews for very serious incidents. Use of the Joint Commission RCA format would be helpful.</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><b>Compliance:</b> Substantial.</p>																								
I.1.d.i	type of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility reported the following:</p> <table border="1"> <thead> <tr> <th>Incident type</th> <th>March-August 2010</th> <th>September 2010 - February 2011</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer altercation</td> <td>418</td> <td>429</td> </tr> <tr> <td>Individuals involved as victim or aggressor in peer altercations</td> <td>863</td> <td>875</td> </tr> <tr> <td>Physical abuse</td> <td>23</td> <td>29</td> </tr> <tr> <td>Verbal abuse</td> <td>21</td> <td>33</td> </tr> <tr> <td>Psychological abuse</td> <td>9</td> <td>11</td> </tr> <tr> <td>Neglect</td> <td>16</td> <td>27</td> </tr> <tr> <td>Exploitation</td> <td>1</td> <td>0</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue current practice of collecting incident data.</p>	Incident type	March-August 2010	September 2010 - February 2011	Peer-to-peer altercation	418	429	Individuals involved as victim or aggressor in peer altercations	863	875	Physical abuse	23	29	Verbal abuse	21	33	Psychological abuse	9	11	Neglect	16	27	Exploitation	1	0
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I.1.d.ii	staff involved and staff present;	<p><b>Current findings on previous recommendation:</b></p>																								

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		<p><b>Recommendation, October 2010:</b> Continue current practice and document the IMRC review in the minutes.</p> <p><b>Findings:</b> As noted previously, the number, type and determination of prior cases in which the staff member was named is noted in the IMRC minutes when the investigation is on the agenda.</p> <p><b>Other findings:</b> The Case Activity Subject (named staff) Listing for 9/1/10-2/28/11 indicates that nine staff members were named in two incidents, one staff member was named in three incidents, and one staff member was named in four. All other staff members listed were named in a single incident. The same listing for the period 2/1/10—8/31/10 indicates five staff were named in two incidents and one staff was named in three. None of the staff members named in multiple cases during the earlier period repeated as named in multiple cases in the September—February period.</p> <p>The IMRC reviewed an Abuse/Outcome Tracking and Trending Report for the period September 1, 2010—February 28, 2011, which found that no employees had more than one sustained A/N/E finding.</p> <p><b>Current recommendation:</b> Continue to maintain the Case Activity Subject listing and the IMRC documentation of prior case involvement. Share the Case Activity Subject listing with the IMRC.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and document the IMRC review in the minutes.</p>

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		<p><b>Findings:</b> The IMRC minutes note the previous investigations in which the individual was the alleged victim. The Abuse/Outcome Tracking and Trending Report for the period September 1, 2010—February 28, 2011 indicated that 11 individuals were involved in multiple incidents. These individuals were identified by name along with the incident type and the investigation outcome.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Periodically run the Case Activity Complainant listing and share it with the IMRC.</li> <li>2. Continue the review of the Abuse/ Outcome Tracking and Trending Report on a periodic basis by the IMRC.</li> </ol>
I.1.d.iv	location of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice of monitoring the location of incidents.</p> <p><b>Findings:</b> Facility data in the Violence Risk Management Committee Progress Report (October 2010-March 2011) indicates that for the months of November and December 2010 and February and March 2011, aggressive incidents were distributed during the AM and PM shifts across the programs as follows:</p> <ul style="list-style-type: none"> <li>• Program I—93 incidents</li> <li>• Program III—108 incidents</li> <li>• Program V—45 incidents</li> <li>• Program VI—96 incidents</li> <li>• Program VII—92 incidents</li> </ul> <p>The same progress report identifies units that raise concern because the current frequency of aggressive SIRs (March 2011) significantly exceeded</p>

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		<p>the six-month mean for that unit. These were Unit 13 in Program I where the March total of aggressive SIRs was 11 and the six-month mean was eight; Unit 14 in Program III with a total of 7 aggressive SIRs in March and a six-month mean of 3.1; and Unit 10 in Program V with a total of 9 aggressive SIRs in March and a six-month mean of 5.6.</p> <p><b>Current recommendation:</b> Continue current practice.</p>																																										
I.1.d.v	date and time of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice of presenting data with analysis and where appropriate the implication of the findings.</p> <p><b>Findings:</b> Using facility data from the same source as used in the cell above, one finds that 58% of the aggressive incidents in the four sampled months occurred during the PM shift.</p> <p>Using the six-month figures provided in the VRMC Progress Report, one finds a similar pattern in the percentage of PM aggressive SIRs:</p> <table border="1" data-bbox="953 1044 1793 1312"> <thead> <tr> <th>Program</th> <th>AM</th> <th>PM</th> <th>NOC</th> <th>Total</th> <th>% PM</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>74</td> <td>103</td> <td>7</td> <td>184</td> <td>56%</td> </tr> <tr> <td>3</td> <td>71</td> <td>94</td> <td>7</td> <td>172</td> <td>55%</td> </tr> <tr> <td>5</td> <td>37</td> <td>41</td> <td>1</td> <td>79</td> <td>52%</td> </tr> <tr> <td>6</td> <td>55</td> <td>89</td> <td>9</td> <td>153</td> <td>58%</td> </tr> <tr> <td>7</td> <td>55</td> <td>91</td> <td>9</td> <td>155</td> <td>59%</td> </tr> <tr> <td>Total</td> <td>292</td> <td>418</td> <td>31</td> <td>741</td> <td>56%</td> </tr> </tbody> </table> <p><b>Other findings:</b> The VRMC Progress report concludes that violence happens most frequently</p>	Program	AM	PM	NOC	Total	% PM	1	74	103	7	184	56%	3	71	94	7	172	55%	5	37	41	1	79	52%	6	55	89	9	153	58%	7	55	91	9	155	59%	Total	292	418	31	741	56%
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		<p>between 5 PM and 9 PM. Violence tends to peak around breakfast and dinner times.</p> <p><b>Current recommendation:</b> Continue current practice of supplying and analyzing incident and violence data.</p>
I.1.d.vi	cause(s) of incident; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> The IMRC minutes identify programmatic cause for some incidents. For example:</p> <ul style="list-style-type: none"> <li>• The September 16, 2010 minutes discuss the use of tree branches as weapons. A recommendation was made to trim the trees with a blunt cut rather than angling them and leaving a sharp edge.</li> <li>• The facility completed an audit in September 2010 of 13 staff members providing 1:1 observation and found that when approached, three were reading a book, one was charting and the others were attending to the individual in their care. All 13 staff members knew why the individual was on 1:1 observation.</li> <li>• The October 14, 2010 minutes discuss an incident in which pepper spray was used and suggested that it could have been avoided if unit staffing were increased and the use of inexperienced or floating staff were minimized.</li> <li>• The IMRC reviewed three incidents of prone events that occurred in the past year. Performance improvement measures identified included the need for the SIR reviews to determine and document the root cause of the event and document a plan of correction to prevent recurrence. All cases of prone restraint will be reviewed in IMRC.</li> </ul>

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		<p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.1.d. vii	outcome of investigation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice, include analysis of substantiation rate.</p> <p><b>Findings:</b> Please see the table in I.1.b.v.3(viii) for the determinations (outcomes) of investigations completed during the current and previous review period.</p> <p>The IMRC reviewed outcome data for A/N investigations for the period July 2010—January 2011 that found three sustained allegations in September, seven sustained allegations in October, none in November and December, and two in January. Twenty-eight sustained neglect allegations in August stemmed from one case. There was considerable discussion in the IMRC about whether to maintain the sustained determination, since there has been a change in the policy governing the actions of the staff members.</p> <p><b>Current recommendation:</b> Continue to provide the IMRC with periodic data on substantiation rates.</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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Conform facility practice regarding removing alleged staff perpetrators in A/N/E investigations to the procedure in SO 263.</p> <p><b>Findings:</b> Please see I.1.a.iii for ASH procedures for removing a named staff member in incidents alleging A/N/E.</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><b>Other findings:</b> As shown in the table in I.1.a.iv, the background checks of 14 of the 15 staff members sampled were completed prior their date of hire. The facility reports that all staff hired during the review period had cleared the background check.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrew Seymour, Psychiatric Technician</li> <li>2. Angela Zavala-Zeron, Clinical Social Worker</li> <li>3. Angeline De Guzman, MD, Staff Psychiatrist</li> <li>4. Aravinda Kolan, MD, Staff Psychiatrist</li> <li>5. Arlene Cruz, PsyD, Unit Psychologist</li> <li>6. Ashley Duffus, Senior Psychiatric Technician</li> <li>7. Asop Coussararian, Registered Nurse</li> <li>8. Belinda Roetker, Registered Nurse</li> <li>9. Bella Prestoza, MD, Staff Psychiatrist</li> <li>10. Cara Innis, Occupational Therapist</li> <li>11. Catherine Manning, Licensed Clinical Social Worker</li> <li>12. Charlie Joslin, Clinical Administrator (QC)</li> <li>13. Christopher Duncan, Registered Nurse</li> <li>14. Cindy Elliott, MD, Unit Psychiatrist</li> <li>15. D. Karas, Program I Director</li> <li>16. Dane Morley, Rehabilitation Therapist</li> <li>17. Debbie Dunham, Social Worker</li> <li>18. Debbie Pennington, Program Director</li> <li>19. Debra Hewitt, PhD, PBS for Behavioral Medical cases (QC)</li> <li>20. Diane Imrem, PhD, Chief of Psychology (QC)</li> <li>21. Donna Nelson, Director, Standards Compliance Department (QC)</li> <li>22. Douglas Shelton, MD, Chief Physician and Surgeon (QC)</li> <li>23. Douglas Simmons, Rehabilitation Therapist</li> <li>24. Garth Purcell, Unit Supervisor</li> <li>25. Gayle Gains, MD, Staff Psychiatrist</li> <li>26. Gene Courter, Licensed Clinical Social Worker</li> <li>27. Greg Macedo, Program Director (QC)</li> <li>28. Guy Marziello, Joint Commission Coordinator, Standards Compliance (QC)</li> <li>29. Harold Light, Social Worker</li> </ol>

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		<p>30. Heidi Rogers, Unit Supervisor  31. Henry Allstrom, PhD, Unit Psychologist  32. Holly Schneider, Unit Psychologist  33. Jason Black, Program Director  34. Jennifer Marx, PsyD, Unit Psychologist  35. Jim Utter, Rehabilitation Therapist  36. Jon DeMorales, Executive Director (Chair, Quality Council)  37. Joseph Morrow Jr, PsyD, Acting PBS I Team Leader  38. Joshua Deanne, MD, Acting Chief of Psychiatry (QC)  39. Kate Bailey, Psychiatric Technician, Standards Compliance Department (QC)  40. Killorin Riddell, PhD, Coordinator of Psychology Specialist Services (QC)  41. Laurel Peterson, Registered Nurse  42. Leon Holmes, Registered Nurse  43. Lev Iofis, MD, Senior Psychiatrist  44. Louise Scott, Clinical Social Worker  45. Mary E Allen, Rehabilitation Therapist  46. Melissa Roper, Unit Supervisor  47. Michelle Schaefer, Risk Management Coordinator, Standards Compliance Department (QC)  48. Mike Hughes, RN, Assistant to Clinical Administrator (QC) and Co-Chair of Violence Reduction Management Committee  49. Patricia Littlewood, Registered Nurse  50. Rebecca Sanchez, Unit Supervisor  51. Robin Banks, Licensed Clinical Social Worker  52. Shannon Fair, Rehabilitation Therapist  53. Stephanie Chavez, Data Manager, Standards Compliance Department (QC)  54. Steve Kendrick, Psychiatric Technician  55. Tamara Rauset, Unit Psychologist  56. Tesfamichael Mehari, MD, Staff Psychiatrist  57. Thomas Cahill, MD, Acting Medical Director (QC)  58. Victor Perez, MD, Senior Psychiatrist</p>
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		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"><li>1. 18 WRPs of individuals at high risk for medical conditions or who met medical key indicators—reviewed by M. Jackman</li><li>2. Violence Risk Management Committee Progress Report (10/10-3/11)</li><li>3. New ASH Key Indicator Report</li><li>4. WRPs of seven individuals for reference to 17 Risk Management Committee recommendations</li><li>5. Individuals who reached behavioral triggers in two or more months in the review period</li><li>6. WRPs of 13 individuals on behavioral high risk lists</li><li>7. Key Indicator and aggression data</li><li>10. The Risk Management System's level I, II and III response/ recommendations for the following eight individuals: CC, CJ, DC, DH, GT, JS LP and LR</li><li>11. Special Order 205.05, Mortality Review, 3/17/08</li><li>12. Mortality Review documents on individual DBL:<ol style="list-style-type: none"><li>a. Notification of patient death, 12/6/10</li><li>b. Certificate of Death, 12/7/10</li><li>c. Mortality Review Task Tracking Log</li><li>d. Special Investigations Report of Resident Death, 12/14/10</li><li>e. Preliminary Medical Death Summary, 12/15/10</li><li>f. Medical Death Summary, 4/8/11</li><li>g. Nursing Death Summary, 12/10/10</li><li>h. Change in Death Status Mortality Interdisciplinary Review Committee Summary Report (MIRC)</li></ol></li><li>13. Mortality Review documents on individual KTM:<ol style="list-style-type: none"><li>a. Certificate of Death, 10/14/10</li><li>b. Mortality Review Task Tracking Log</li><li>c. Special Investigations Report of Resident Death, 10/12/10</li><li>d. Preliminary Medical Death Summary, 10/22/10</li><li>e. Internal Disciplinary Death Review, 11/1/10</li><li>f. Nursing Death Summary, 10/19/10</li></ol></li></ol>
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		<ul style="list-style-type: none"> <li>g. Initial Mortality Interdisciplinary Review Committee Summary, 10/22/10</li> <li>h. Independent External Medical Review, 12/6/10</li> <li>i. Final Mortality Interdisciplinary Review Committee Summary Report, 1/13/11</li> </ul> <p>14. Violence Risk Management Program binder:</p> <ul style="list-style-type: none"> <li>a. Performance Improvement Power Point</li> <li>b. The Violence Risk Management Plan</li> <li>c. Executive Director Bulletin Articles</li> <li>d. April 2011 - Six month review of Violence Risk Management Activities; Oct 2010 - March 2011</li> <li>e. October 2010 - Six month review of Violence Risk Management Activities; April - Sept 2010</li> <li>f. April 2010 - Six month review of Violence Risk Management Activities; Oct 2009 - March 2010</li> <li>g. October 2009 - Six month review of Violence Risk Management Activities; April - Sept 2009</li> <li>h. Governing Body Report - June 2009</li> <li>i. April 2009 - Six month review of Violence Risk Management Activities; Oct 2008 - March 2009</li> <li>j. February 2009 - Review of the implementation of violence risk management initiatives to date</li> <li>k. October 2008 - Six month review of Violence Risk Management Activities; April - Sept 2008</li> <li>l. Quality Council July 2008</li> <li>m. May 2008 - Initial findings of Ad Hoc Committee of Violence Prevention</li> <li>n. Dr. Riddell's Violence Study</li> <li>o. Ad Hoc Reports</li> <li>p. Therapeutic Milieu Enhancement Team (TMET)</li> <li>q. PBS Medical Behavioral</li> <li>r. Informational PowerPoint presentation for staff on violence risk management findings and activities</li> </ul>
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		<p>s. Performance Improvement and Risk Management Administrative Directives; 102.5.2 Performance Improvement Program and 421 Risk Management, and Special Order 262 Risk Management</p> <p>15. Psychogenic Polydipsia Protocol Tracking binder, August 2009 to the present: timelines and actions plans of various committees (Medical Executive Committee, Department of Medicine and Department of Psychiatry)</p> <p><u>Attended:</u> Quality Council meeting</p>																							
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p><b>Compliance:</b> 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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and self-monitoring of the safety of individuals in care.</p> <p><b>Findings:</b> The facility provided the following data on aggressive acts:</p> <table border="1" data-bbox="955 1117 1858 1271"> <thead> <tr> <th></th> <th>Mar-Aug 2010</th> <th>Sep 2010-Feb 2011</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer altercations</td> <td>418</td> <td>429</td> </tr> <tr> <td>Individuals involved in peer-to-peer altercations</td> <td>863</td> <td>875</td> </tr> </tbody> </table> <table border="1" data-bbox="955 1307 1759 1385"> <thead> <tr> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>284</td> <td>231</td> <td>329</td> <td>316</td> <td>390</td> <td>290</td> <td>1840</td> </tr> </tbody> </table>		Mar-Aug 2010	Sep 2010-Feb 2011	Peer-to-peer altercations	418	429	Individuals involved in peer-to-peer altercations	863	875	Sep	Oct	Nov	Dec	Jan	Feb	Total	284	231	329	316	390	290	1840
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		<p><b>Other findings:</b> ASH Key Indicator data provided the information below.</p> <table border="1" data-bbox="953 302 1892 867"> <thead> <tr> <th></th> <th>Mar-Aug 2010</th> <th>Sep 2010-Feb 2011</th> <th>% change</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>83</td> <td>65</td> <td>-22%</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>11</td> <td>15</td> <td>+36%</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>65</td> <td>40</td> <td>-38%</td> </tr> <tr> <td>Individuals with two or more aggressive acts to others in 7 days</td> <td>195</td> <td>163</td> <td>-16%</td> </tr> <tr> <td>Individuals with four or more aggressive acts to others in 30 days</td> <td>58</td> <td>49</td> <td>-16%</td> </tr> <tr> <td>Suicide attempts</td> <td>3</td> <td>2</td> <td>-33%</td> </tr> </tbody> </table> <p>The facility now produces a Key Indicator Report which presents the findings of a five-step procedure that includes a comparison of current month data with the previous 12-month period to identify those indicators that are two or three standard deviations above the mean and which culminates with review of the findings by the Quality Council. The current report includes a comparative analysis of Key Indicator data from Report 9 and Report 10 and an action plan.</p> <p>An example is the analysis of medication variances, which totaled 499 at the time of Report 9 and 1022 at the time of Report 10. Identified factors contributing to the dramatic increase include illegible addressograph printing and physician orders without the duration specified. The action plan notes that Plant Operations fast-tracked the evaluation and repair of the addressograph machines, and malfunctions began to decrease in February.</p>		Mar-Aug 2010	Sep 2010-Feb 2011	% change	Peer-to-peer aggression resulting in major injury	83	65	-22%	Aggression to self resulting in major injury	11	15	+36%	Aggression to staff resulting in major injury	65	40	-38%	Individuals with two or more aggressive acts to others in 7 days	195	163	-16%	Individuals with four or more aggressive acts to others in 30 days	58	49	-16%	Suicide attempts	3	2	-33%
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		<p>Orders with incomplete durations were returned to the prescriber for correction.</p> <p><b>Current recommendation:</b> Continue current practice and self-monitoring</p>
I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> See the tables in the cells below. With only a few exceptions, the WRPs of individuals sampled who were on high risk lists for behavioral or medical conditions or who had reached behavioral or medical triggers identified the risks and included treatment objectives and interventions addressing the condition.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.2.a.iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The Violence Risk Management Committee Progress Report for Oct 2010-March 2011 provides data to support the following conclusions in the report:</p> <ul style="list-style-type: none"> <li>• The majority of aggressive incidents were distributed evenly among the MDO programs (Programs I, VI and VII).</li> <li>• A disproportionate amount of violence occurs on the PM shift.</li> </ul>

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		<ul style="list-style-type: none"> <li>• Aggressive episodes correlate with the rate of admissions.</li> <li>• The trend line for the frequency of aggressive incidents over the last three years is flat.</li> <li>• There is an injury of some kind associated with almost every aggressive incident.</li> <li>• Individuals committed as Incompetent to Stand Trial (PC 1370) who agreed to take meds and who had no order for involuntary medications had longer lengths of stay and committed more aggressive acts—30% higher than men admitted with an order.</li> <li>• A small percentage (less than 4%) of the population is responsible for a disproportionately large number of violent incidents. On average, approximately 67% of the individuals never assault.</li> <li>• Individuals between the ages of 26 and 33 are at highest risk for being both victims and perpetrators of violence.</li> <li>• A significant correlation was found between the rate of change in psychiatrist assignment and aggression on units.</li> </ul> <p><b>Current recommendation:</b> Continue current practice.</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><b>Compliance:</b> Substantial.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Each of the individuals selected for review below reached an aggression</p>

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		<p>trigger (self or others) in two or more months during the review period, except DP who triggered in one month for a suicide attempt. This review yielded positive results, as the recommendations made by the RM Committees were addressed in the individuals' WRPs. This finding is consistent with the findings of the Standards Compliance audit of 444 actions proposed by WRPTs during the review period, which found that 98% of the proposed actions were documented as implemented in the WRP.</p>
Individual	RM Committee/ Recommendation	Implementation status
AA	ETRC 9/22/10—Request blood levels	WRP 10/11/10—Depakote level drawn on 9/27
AA	PRC 1/27/11—Adjust medication regimen	WRP 3/7/11—on 2/3, three medications lowered
BM	PRC 9/19/10—Requesting PBS review	WRP 10/14/10—Referred to DCAT, PBS assessment completed
BM	ETRC 10/6/10—Continue medication adjustment	WRP 11/12/10—Meds adjusted on 11/4/10
BM	PRC 10/19/10—Obtain socks with built-in shin guards	WRP 11/12/10—Present status: Using shin guards
BM	ETRC 10/27/10—Start Zyprexa	WRP 12/7/10—Currently being treated with Zyprexa
BM	PSSC 11/1/10—Revise BGs to address aggressive acts to self	WRP 12/7/10—In addition to BGs, a 1:1 intervention was initiated on 11/9 to assist him in phasing out his 1:1 status for SIB
BM	PRC 11/30/10—Clarify diagnosis	WRP 12/7/10—shows change in Axis I diagnosis
BM	PRC 11/2/10—Refer to FRC	Seen in FRC on 11/10/10
MP	ETRC 11/3/10—Review tx plan to determine if it permits	WRP 11/22—Polydipsia protocol is under review

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			excessive weight gain from water intake	
		MP	PSSC 11/8/10—Revise BGs to include new interventions for polydipsia	WRP 11/22—BGs will continue w/o modifications until 12/16/10. WRP 12/16—Responding to tx, gaining less weight; BGs will continue through 1/13/11
		BR	PRC 12/23/10—Adjust medication	WRRP 1/14/11—A medication was added to regimen. WRP 2/11/11—dosage of another medication was increased.
		MG	ETRC 11/17/10—Review dx. Consider IED and DD. Consider titration of Prolixin.	WRP 12/28/10—Mild MR added to Axis II. WRP 1/19/11—Prolixin titrated.
		MG	PRC 12/16/10—Refer for psychopharmacology consult	WRP 12/28/10—Consult requested 11/23, completed 12/23 and approved 12/30/10
		DP	PSSC 10/4/10—PBS to monitor	WRP 11/23/10—PBS plan for SIB implemented 10/26/10
		OG	PRC 12/16/10-- Refer to PSSC for PBS or DCAT assessment	WRP 12/21/10—PBS team informed us they will be working to assist with OG in January
		OG	PSSC 1/10/11—Complete assessment and implement BGs	Emergency BGs implemented on 1/13 and revised on 1/21/11
		<p><b>Other findings:</b> The monitor and his experts interviewed members of WRPTs who provided care to eight individuals (CC, CJ, DC, DH, GT, JS LP and LR) who met a variety of high-risk triggers/thresholds including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions</p>		

		<p>(seclusion/restraint). These interviews included reviews of the charts of these individuals. The main purpose of this review was to assess implementation of the current DMH Risk Management policy/procedure relative to this requirement. There was general evidence of adequate implementation of the current Risk Management SO including, the following areas:</p> <ol style="list-style-type: none"><li>1. Documentation of the incident;</li><li>2. Review of the incident by the treating or on-call psychiatrist within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individual and/or others;</li><li>3. Attention by the WRPT to the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;</li><li>4. Tracking by risk management staff of the incidents that constitute triggers or thresholds requiring progressive levels of reviews;</li><li>5. Timely and adequate implementation of behavioral guidelines, including proactive measures to reduce maladaptive behaviors;</li><li>6. Review by the Program Review, Enhanced Trigger Review and Psychology Specialty Services Committees and documentation of treatment recommendations based on these reviews;</li><li>7. Timeliness and quality of behavioral interventions, as indicated; and</li><li>8. Follow-up by the WRPTs on recommendations from higher levels of review.</li></ol> <p>Some of the behavioral interventions could be improved with a better alignment between the predictive behaviors and staging of the preventive and reactive strategies, and data collection on the replacement behaviors.</p> <p>None of these individuals required the final level review by the FRC. In general, this is a measure of the effectiveness of the interventions at the first and second levels of reviews.</p>
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		<p><b>Current recommendation:</b> Continue current practice and monitoring.</p>																																	
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> A review of the numbers of individuals who reached behavioral triggers in two or more months during the six-month review period yielded positive results. In view of a census of over 1150 individuals, comparatively few individuals reached this threshold as shown below. This suggests that treatment was effective.</p> <table border="1" data-bbox="953 786 1887 1416"> <thead> <tr> <th>Trigger</th> <th>Individual</th> <th>Trigger Months</th> </tr> </thead> <tbody> <tr> <td rowspan="3">2.1 Aggression to peer resulting in major injury</td> <td>OG</td> <td>Dec., Feb.</td> </tr> <tr> <td>DW</td> <td>Sep., Dec.</td> </tr> <tr> <td>60 individuals</td> <td>Triggered in 1 month</td> </tr> <tr> <td rowspan="3">2.2 Aggression to staff resulting in major injury</td> <td>OC</td> <td>Jan., Feb.</td> </tr> <tr> <td>JL</td> <td>Nov., Jan.</td> </tr> <tr> <td>ET</td> <td>Sep., Oct. Jan.</td> </tr> <tr> <td></td> <td>36 individuals</td> <td>Triggered in 1 month</td> </tr> <tr> <td rowspan="6">2.3 2 aggressive acts in 7 days</td> <td>RE</td> <td>Five months: Sep.-Jan.</td> </tr> <tr> <td>OG</td> <td>Nov., Dec., Jan.</td> </tr> <tr> <td>AA</td> <td>Sep., Dec., Feb.</td> </tr> <tr> <td>RS</td> <td>Oct., Nov., Dec.</td> </tr> <tr> <td>BM</td> <td>Sep., Oct., Nov.</td> </tr> <tr> <td>AA</td> <td>Dec., Jan., Feb.</td> </tr> </tbody> </table>	Trigger	Individual	Trigger Months	2.1 Aggression to peer resulting in major injury	OG	Dec., Feb.	DW	Sep., Dec.	60 individuals	Triggered in 1 month	2.2 Aggression to staff resulting in major injury	OC	Jan., Feb.	JL	Nov., Jan.	ET	Sep., Oct. Jan.		36 individuals	Triggered in 1 month	2.3 2 aggressive acts in 7 days	RE	Five months: Sep.-Jan.	OG	Nov., Dec., Jan.	AA	Sep., Dec., Feb.	RS	Oct., Nov., Dec.	BM	Sep., Oct., Nov.	AA	Dec., Jan., Feb.
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			18 individuals 105 individuals	Triggered in 2 months Triggered in 1 month
		2.4 4 aggressive acts in 30 days	RE  5 individuals 36 individuals	Oct., Nov., Dec., Jan.  Triggered in 2 months Triggered in 1 month
		1.1 Aggression to self resulting in major injury	RL  13 individuals	Oct., Dec.  Triggered in 1 month
		1.2 2 aggressive acts to self in 7 days	AA BM  6 individuals 16 individuals	Sep., Nov., Jan. Sep., Oct., Nov.  Triggered in 2 months Triggered in 1 month
		1.3 4 aggressive acts to self in 30 days	BM MG  9 individuals	Sep., Oct., Nov. Nov., Dec.  Triggered in 1 month
		<p>RE, who triggered for two aggressive acts to peers in seven days, continued on to trigger for four aggressive acts to peers in 30 days. Similarly, BM, who triggered for two aggressive acts to self in seven days, continued to trigger for 4 aggressive acts to self in 30 days. OG, who triggered in November, December and January for two aggressive acts in seven days, also triggered in December for aggression resulting in serious injury. These are patterns one hopes treatment will minimize.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>		
I.2.b. iii	formalized systems for the notification of teams and needed disciplines to support	<b>Current findings on previous recommendation:</b>		

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	<p>appropriate interventions and other corrective actions;</p>	<p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As indicated below, the medical triggers reached by the individuals in the sample or their high risk status were noted in the WRP in nearly all instances. Similarly, in nearly all instances the individual was referred for an assessment or was receiving services for the condition. In several instances, no open focus addressed the condition.</p> <table border="1" data-bbox="953 561 1913 1414"> <thead> <tr> <th data-bbox="953 561 1062 602"></th> <th data-bbox="1062 561 1381 602">Issue</th> <th data-bbox="1381 561 1913 602">WRP documentation</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 602 1062 1117">AT</td> <td data-bbox="1062 602 1381 1117">1/18/11, 1/25/11, 3/5/11 met trigger 7.2 for three or more falls in 30 days (as documented in WRPs)</td> <td data-bbox="1381 602 1913 1117">WRPs dated 3/3/11 and 3/22/11 discussed fall triggers and listed individual as at high fall risk. Individual assigned to 1:1 and medication change reported, but no open focus for fall risk until attachment on 3/30/11, with objective and intervention related to verbalizing three ways to avoid falling. Gait difficulties identified in fall risk assessment dated 3/24/11 done in response to fall on same date indicated unsteady gait prior to fall. Subsequent referral made to physical therapy on 4/1/11.</td> </tr> <tr> <td data-bbox="953 1117 1062 1414">DTR</td> <td data-bbox="1062 1117 1381 1414">Met trigger 7.1 for fall with major injury on 1/07/11</td> <td data-bbox="1381 1117 1913 1414">Fall trigger and fall risk documented in WRP dated 2/18/11. Referral for physical therapy made for assessment of gait and balance, and assessment completed 2/2/11 with recommended objectives for reduced back pain and improved trunk stability and gait. However, only pain objective is included</td> </tr> </tbody> </table>		Issue	WRP documentation	AT	1/18/11, 1/25/11, 3/5/11 met trigger 7.2 for three or more falls in 30 days (as documented in WRPs)	WRPs dated 3/3/11 and 3/22/11 discussed fall triggers and listed individual as at high fall risk. Individual assigned to 1:1 and medication change reported, but no open focus for fall risk until attachment on 3/30/11, with objective and intervention related to verbalizing three ways to avoid falling. Gait difficulties identified in fall risk assessment dated 3/24/11 done in response to fall on same date indicated unsteady gait prior to fall. Subsequent referral made to physical therapy on 4/1/11.	DTR	Met trigger 7.1 for fall with major injury on 1/07/11	Fall trigger and fall risk documented in WRP dated 2/18/11. Referral for physical therapy made for assessment of gait and balance, and assessment completed 2/2/11 with recommended objectives for reduced back pain and improved trunk stability and gait. However, only pain objective is included
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			in the WRP dated 2/18/11, under existing focus 6.4 for degenerative disk disease. No open focus specifically related to fall risk.
		AGA	New diagnosis of diabetes The WRP dated 3/03/11 has DM listed but not as an Axis III diagnosis; diagnosis made and problem opened on 2/01/11. Focus 6.26 objectives and intervention in place for identifying diabetes complications with RN intervention. No referral made to Nutrition upon diagnosis.
		AT	New diagnosis of diabetes The WRP dated 2/24/11 has DM listed but not as an Axis III diagnosis; diagnosis made and problem opened on 2/07/11. Focus 6.19 objectives and intervention in place for identifying diabetes complications with RN intervention. Referral to dietitian made on 2/8/11 secondary to new diagnosis and assessment completed, with documentation that thorough education regarding carbohydrate intake and diabetes management was provided to the individual.
		JD	New diagnosis of diabetes The WRP dated 1/13/11 has DM listed as an Axis III diagnosis; problem opened on 9/27/11. Focus 6.11 objectives and intervention in place for identifying symptoms of hyper- and hypoglycemia with RN intervention. Referral to dietitian made on 10/6/11 secondary to new diagnosis and

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			assessment completed, with documentation that thorough education regarding carbohydrate intake and diabetes management was performed with individual.
		GAB	<p>Recurrent decubitus ulcer on sacrum/ coccyx area, pressure ulcer on heel 12/27/10</p> <p>WRP dated 2/2/11 listed problem, listed individual as at high risk for compromised skin integrity, and had an open focus 6.31 to address recurrent wound on coccyx and 6.32 to address pressure ulcer on heel. Both objectives and interventions aimed at education related to condition. Individual in wheelchair and with limited mobility, yet no referral has been made to physical or occupational therapy to evaluate the need for enhanced physical supports related to positioning and pressure. Nutrition assessment dated 1/24/11 revealed albumin levels within normal limits, but wound healing related to nutrition not specifically addressed.</p>
		DRS	<p>Diagnosis of aspiration pneumonia (opened 1/3/11)</p> <p>WRP dated 2/8/11 listed aspiration pneumonia incident and open focus 6.14 for choking and aspiration risk with objective and interventions related to decreasing choking risk by being fed slowly by nursing staff. Individual has been followed monthly by the speech therapist due to dysphagia diagnosis since prior to his diagnosis, and 24-hour plan to prevent aspiration and support safety and function during intake was</p>

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			developed and revised on 2/1/11 based on reassessment findings.
	DAY	Reported choking incident on 1/14/11	SIR review showed that individual did not choke but broke his tooth during dinner.
	JKK	Choking incident on 2/25/11	Following incident, individual assessed by MD, who observed him swallowing water and a cracker, and subsequently found "no evidence of swallowing disorder or dysphagia". No speech therapy evaluation or assessment of individual eating the item he choked on (peanut butter sandwich), or similar items within his current diet texture was performed. Choking incident, medical intervention (Heimlich) not documented in WRP following incident dated 3/15/11.
	SO	At high risk for metabolic syndrome	WRP dated 11/16/11 that followed date that entrance criteria for high risk were met (listed as 11/01/10) lists high risk for metabolic syndrome under risk factors. Focus 6.6 open for elevated BMI, with objective and intervention open for education. Nutrition Assessment dated 10/14/10 addressed elevated BMI and weight change.
	RT	At high risk for metabolic syndrome	High risk due to elevated BMI, waist circumference above 40, and hypertension identified in the present status of the most recent WRP dated 1/04/11; open foci 6.4 for abnormal BMI and 6.21 for hypertension.

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				Dietitian assessment dated 1/14/11 mentioned contributing risk factors of obesity and provided nutrition education, and dietary recommendations to manage risk.
		WAC	At high risk for falls	High risk identified in the present status of WRP dated 1/10/11. Open focus 6.15 for chronic unsteady gait with physical therapy objective and intervention for improving balance and ambulation. Physical therapy referral written on 10/14/10 and assessment completed on 10/21/10; individual enrolled in direct physical therapy to address balance and ambulation deficits.
		SCK	At high risk for falls	High risk identified in the present status of WRP dated 2/3/11. No open focus related to fall risk. Fall Risk assessment dated 12/03/10 indicated impaired mobility as a risk factor but no referral to physical therapy assessment written.
		MBB	At high risk for falls	High risk identified in the present status of WRP dated 2/10/11. Referred 12/28/10 for physical therapy assessment for falls risk, unsteady gait, mobility and dizziness. Assessment completed 1/10/11, with recommendations for direct physical therapy treatment. However, no open focus in WRP dated 2/10/11 to include physical therapy objectives and interventions

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				related to fall risk, strength, endurance, and balance deficits. In addition, mobility section of 24-hour support plan not completed.
		FDS	At high risk for falls	High risk per fall risk assessment following fall on 1/15/11. Temporary condition opened for gait instability on 1/15/1 and closed on 2/11/11 though no rationale for closing condition was documented in WRP dated 2/15/11. Open focus for knee instability in WRP dated 2/15/11. Individual received direct physical therapy treatment for knee pain in previous review period.
		RR	At high risk for impaired skin integrity- opened 10/17/10	High risk identified in the present status of the most recent WRP dated 11/19/10; no open focus to address risk in WRP documents dated 11/19/10, 12/17/10, or 1/18/11.
		GP	At high risk for choking	High risk identified in the present status of the WRP dated 2/18/11, but no focus open to address risk. Speech Therapy evaluation referral for dysphagia was written on 11/5/10 and assessment was completed on 11/10/10. Speech therapy assessment found no difficulties with eating prescribed diet, and recommended close monitoring during meals.
		MBB	At high risk for choking	High risk identified in the present status of the WRP dated 1/7/11, with focus 6.7 open to address risk with objectives and interventions relate to

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 60%;">                     identifying choking prevention strategies and demonstration of safe eating strategies. Speech Therapy evaluation referral for history was written and assessment completed on 12/14/10, with 24 hour support plan developed and implemented to address choking risk. MBSS performed on 2/1/11 and 24-hour plan updated 2/11/11.                 </td> </tr> <tr> <td colspan="3"> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p> </td> </tr> </table>			identifying choking prevention strategies and demonstration of safe eating strategies. Speech Therapy evaluation referral for history was written and assessment completed on 12/14/10, with 24 hour support plan developed and implemented to address choking risk. MBSS performed on 2/1/11 and 24-hour plan updated 2/11/11.	<p><b>Current recommendation:</b> Continue current practice and monitoring.</p>		
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<p>I.2.b. iv</p>	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> WRPTs respond electronically to notification that an individual has reached a trigger by identifying the intended intervention. Standards Compliance reviews a sample to determine if implementation is addressed in the WRP. The findings reported in the cells above provide evidence that in the vast majority of cases, the system is working as intended.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						
<p>I.2.b.v</p>	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Continue current practice as related to WRP address of high risk conditions.</p>						

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		<p><b>Findings:</b> See the table below, which indicates that the WRPs of most of the individuals sampled from a behavioral high risk list cited the risk and nearly all had an open focus addressing the issue.</p> <p><b>Recommendation 2, October 2010:</b> Clarify expectations around WRP response to recommendations made at Risk Management meetings.</p> <p><b>Findings:</b> The facility reported that in December, the SC Director and Chief Psychiatrist met with the Senior Psychiatrists and informed them that interventions in response to triggers and RM Committee recommendations were to be included in the individuals' WRPs. The Senior Psychiatrists then trained the psychiatrists within their Programs.</p> <p><b>Other findings:</b></p> <table border="1" data-bbox="961 893 1858 1421"> <thead> <tr> <th>Individual</th> <th>High Risk Category</th> <th>Cited in Risk Factors</th> <th>Addressed in WRP</th> </tr> </thead> <tbody> <tr> <td>KH</td> <td>Aggression</td> <td>Yes</td> <td>4/20/11 WRP; Focus 3.1</td> </tr> <tr> <td>PS</td> <td>Aggression</td> <td>Yes</td> <td>WRP 5/6/11; Focus 3.1</td> </tr> <tr> <td>MS</td> <td>Aggression</td> <td>Yes</td> <td>WRP 4/11/11; Focus 1.1</td> </tr> <tr> <td>DW</td> <td>Aggression</td> <td>No</td> <td>WRP 5/1/11; Focus 3.1**</td> </tr> <tr> <td>LR</td> <td>Aggression</td> <td>No</td> <td>WRP 4/21/11; Focus 3.1</td> </tr> <tr> <td>AD</td> <td>Aggression</td> <td>No</td> <td>WRP 12/16/10;</td> </tr> </tbody> </table>	Individual	High Risk Category	Cited in Risk Factors	Addressed in WRP	KH	Aggression	Yes	4/20/11 WRP; Focus 3.1	PS	Aggression	Yes	WRP 5/6/11; Focus 3.1	MS	Aggression	Yes	WRP 4/11/11; Focus 1.1	DW	Aggression	No	WRP 5/1/11; Focus 3.1**	LR	Aggression	No	WRP 4/21/11; Focus 3.1	AD	Aggression	No	WRP 12/16/10;
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BS	Aggression to Self	Yes	WRP 4/1/11; Focus 3.4																																
AA	Aggression to Self	Yes	WRP 10/11/10; no open focus																																
HH	Aggression to Self	Yes	WRP 4/13/11; Focus 3.2																																
MR	Aggression to Self	Yes	WRP 12/9/10; no open focus																																
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice including the study of violence and efforts directed at reducing violence.</p> <p><b>Findings:</b> The Progress Report of the Violence Reduction Risk Management Committee describes initiatives that have been accepted by the Quality Council. These</p>																																	

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		Develop a pilot program for pre-scheduling voluntary overtime	TBA
		Develop draft language for legislative changes re: involuntary medication processes for 1370 patients	TBA
		Suggest changes in the language concerning treatment outlined in PC 2962 (MDO) patients	TBA
		Require that malingering assessments be completed at county jails and CDCR for 1370/2684 commitments prior to admission to state hospitals	May 1
		Improve the process for identifying individuals at high risk for aggression	TBA
		Develop a Specialty Treatment Unit proposal including entrance and exit criteria, treatment modalities and cost estimates	April 1
		Identify ways to increase staff presence on the units during times when aggression is most likely to occur according to data	May 1
		Develop strategies to decrease aggression during identified peak hours	May 1
		Engage staff in reviewing aggression data	May 1
		Make the Hospital Access System (HAS) level 3 more valuable to individuals as an incentive for non-violent behavior	July 1
		Standardize how level increases/decreases are made to ensure unsafe individuals are not in the hallways unsupervised	July 1
		Train staff to ensure consistency in the application of the HAS level system	July 1
		Identify Specialty Treatment Units by type	TBA
		Develop staff in de-escalation techniques and in working with forensically mentally ill individuals	July 1

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		<p><b>Other findings:</b> The facility has completed the implementation of a number of violence reduction initiatives. These include, but are not limited to:</p> <ol style="list-style-type: none"><li>1. Replacement of dayroom chairs with heavy and hard-to-throw alternatives when it was discovered the chairs were used as a weapon;</li><li>2. Replacement of dayroom banquet tables with safer alternatives when it was discovered that their legs could be removed and used as clubs;</li><li>3. Replacement of all doors to side rooms with doors that permitted individuals to lock themselves in their rooms without locking staff out and that had reconfigured observation windows for maximum visibility;</li><li>4. Installment of motion sensor devices in hallways of one unit (to evaluate this method of monitoring hallways during the NOC shift);</li><li>5. Use of color-filtered flashlights to improve visibility through windows of patient rooms at night without disturbing sleep;</li><li>6. Establishing a peer mentoring program for individuals with cognitive disorders;</li><li>7. Alerting Programs when high-risk individuals have been assigned to Mall groups that are not safe for them because of the equipment used;</li><li>8. Revising the debriefing process for individuals after being released from restraint or seclusion;</li><li>9. Training 1255 staff members in therapeutic milieu enrichment;</li><li>10. Enhancing TSI training;</li><li>11. Revising the Non-Violence Incentive Program with one that rewards units when violence is low for a month with a Special Monthly Activity—Peace Night Bingo;</li><li>12. Increasing Evening Supplemental Activities;</li><li>13. Including in the DMH five-year plan the plans for a Secure Unit; and</li><li>14. Creating databases and applications such as the Forensic Services database to ensure that orders for involuntary medications are not overlooked or allowed to lapse and the Data Dashboard that provides real-time retrieval of SIR data for clinical and administrative violence prevention purposes.</li></ol>
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		<p>In general, the monitor's reviews found evidence that ASH has the most established and functional system of performance improvement among the four California facilities. This system includes effective oversight by the Executive Director and the Quality Council, access to real-time databases from multiple sources (including SIR and key indicator data) and structures and reporting channels that facilitate the following:</p> <ol style="list-style-type: none"><li>i. Timely identification, by the individual practitioners, the WRPTs, various risk management committees and the Quality Council, of risk profiles of specific individuals and of aggregate data on trends and patterns addressing actual and potential high-risk situations;</li><li>ii. Analysis of trends and patterns of high-risk events (based on both SIR and KI data);</li><li>iii. Development and implementation of data-based corrective actions to reduce the risk of harm; and</li><li>iv. Determination of the outcome of corrective actions.</li></ol> <p>In reviewing trends in the facility's key indicator data for the past 18 months, the monitor found preliminary evidence of positive outcomes of this system. For example, long-term rate of aggression to others resulting in injury has remained stable despite significant increase in the admission rate and the admission to the facility of higher-risk mentally disordered offenders. The facility has yet to conduct analysis of key indicators to compare the rates for individuals with two or more aggressive incidents within seven days to individuals with four or more aggressive incidents within 30 days. However, this monitor's review of the facility's data found a persistent gap between the two rates. Ideally, a widening gap would indicate effectiveness of the current risk management system. Although many variables must be accounted for before drawing definite conclusions, the persistence of this gap, in general, suggests a positive outcome of current treatment and rehabilitation efforts at the facility.</p>
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		<p>This monitor reviewed the facility's Mortality Review documents pertaining to both unexpected mortalities (DBL and KTM) that occurred during this review period. There was general evidence of adequate implementation of the Mortality Review SO, including recommendations for systemic corrective actions as appropriate.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue current practice of analyzing data, identifying and implementing initiatives to make the environment safer, and measuring effectiveness. Ensure that analysis includes comparisons of recurrent incidents within seven day and within 30 days.</li><li>2. Develop algorithms for improved and more aggressive pharmacological management of higher-risk individuals (on the proposed enhanced treatment unit).</li><li>3. Working within the DMH Strategic Action Plan, the facility needs to utilize the violence risk assessment to identify the type of aggression in order to inform treatment planning for individuals.</li><li>4. Present periodic updates to the CM on the status of implementation of various initiatives and proposed corrective actions to reduce the risk of violence.</li></ol>
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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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. L. Beuler, Chief of Plant Operations</li> <li>2. S. Everett, Health and Safety Officer</li> </ol> <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"> <li>1. WRPs of eight individuals with the problem of incontinence</li> <li>2. Clinical records of seven individuals involved in sexual incidents</li> </ol> <p><u>Toured:</u></p> <p>Units 4, 6, 22, 30 and 31</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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, October 2010:</b> Investigate the possibility of paying individuals who have a job more frequently to reduce individuals' need to spend quickly and hoard large quantities of snacks.</p> <p><b>Findings:</b> During the current tour, we observed no instances of individuals storing bags full of snacks.</p> <p><b>Recommendation 2, October 2010:</b> Add cleaning of the nightstands to the standard bedroom clean-up routine.</p> <p><b>Findings:</b> Similarly, nightstands were cleaner during this tour than during the last.</p>

		<p>The problem of dirty plastic cups remains. These cups are purchased by individuals and used for bringing beverages to their rooms. They reportedly are not dishwasher-safe and individuals do not routinely wash them.</p> <p><b>Other findings:</b>          During the tour, we saw some of the environmental changes that the facility continues implement to make the environment safer. These include:</p> <ul style="list-style-type: none"> <li>• On each unit, staff were able to locate the cut-down instrument. It was kept in the same place on each unit—in a locked box in the medication room. All units toured had working flashlights for making nighttime rounds.</li> <li>• In the old section of the hospital, the two-stall bathrooms had no gaps between the stall uprights and the walls, the stall doors were angled and affixed with piano hinges, and the uprights were short and did not extend to the ceiling.</li> <li>• The facility continues to equip the bedrooms with very heavy no-throw nightstands. Approximately 300 more nightstands are needed.</li> <li>• In the old section of the hospital, the bedroom door locks have been replaced with ones that lock from the inside (with an outside over-ride) and the fixture will not hold a ligature. The small observation windows in the doors have been replaced with vertical windows.</li> <li>• The facility continues to remount the lights in the bedrooms in the old section of the hospital so that a ligature cannot be passed between the light fixture and the wall.</li> <li>• In Units 30 and 31 in the new section of the hospital, beds in the dorms had been rearranged so that each is visible from the hall windows while maintaining some measure of privacy.</li> <li>• The bars on the clothing pass-through in the shower room that presented a suicide hazard have been replaced with a Lexan window with a cut-out for exchanging clothes. The shower heads and levers and towel hooks do not present suicide hazards.</li> </ul>
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		<p>The facility studied the effect of the exchange of chairs for no-throw chairs on their use in violent encounters with positive results. Prior to the change, chairs were used as weapons in 26% of the events; after the change, this figure was reduced to 6%. Similarly, a study of the impact of changing the bedroom door locks and windows found that after replacement, 68.75% of units had no aggressive incidents in side rooms as compared with 50% prior to the change. The change was found not to have increased the risk of engaging in self-harm.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to address environmental hazards, making the environment safer as resources are available.</p>
I.3.b	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation , October 2010:</b> Continue current practice and monitoring of unit temperatures.</p> <p><b>Findings:</b> The temperature on the units toured was comfortable.</p> <p><b>Other findings:</b> The facility reports that in September and October, 77 open areas were monitored each month for daily temperatures and the temperature was acceptable in all instances.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue current practice</p>																											
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As shown below, each of the eight individuals reviewed had an open focus addressing the problem of incontinence or the focus was recently closed as the individual no longer had the condition.</p> <table border="1" data-bbox="955 673 1726 1019"> <thead> <tr> <th>Individual</th> <th>Axis III</th> <th>WRP /Focus 6</th> </tr> </thead> <tbody> <tr> <td>DB</td> <td>No</td> <td>3/4/11-6.24</td> </tr> <tr> <td>DS</td> <td>No</td> <td>3/9/11-6.18</td> </tr> <tr> <td>JL</td> <td>No</td> <td>4/15/11-6.4</td> </tr> <tr> <td>LM</td> <td>No</td> <td>3/30/11-focus closed on 1/20</td> </tr> <tr> <td>MR</td> <td>Yes</td> <td>4/5/11-6.12</td> </tr> <tr> <td>NC</td> <td>No</td> <td>4/4/11-6.5</td> </tr> <tr> <td>RC</td> <td>No</td> <td>3/1/11-6.16</td> </tr> <tr> <td>RH</td> <td>No</td> <td>3/22/11-6.5</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	Individual	Axis III	WRP /Focus 6	DB	No	3/4/11-6.24	DS	No	3/9/11-6.18	JL	No	4/15/11-6.4	LM	No	3/30/11-focus closed on 1/20	MR	Yes	4/5/11-6.12	NC	No	4/4/11-6.5	RC	No	3/1/11-6.16	RH	No	3/22/11-6.5
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I.3.d	<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</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, October 2010:</b> Reinforce the standard procedure that all services provided as a result of a</p>																											

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<p>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;</p>	<p>sexual or other incident be documented in the individual's record.</p> <p><b>Findings:</b>  A review of the clinical records of seven individuals involved in sexual incidents yielded mostly positive results with documentation of personal attention by staff members, including psychologists, to both the victim and the aggressor. Exceptions are the intervention in the WRP of SH and the absence of any mention of the incident in the WRP of GD.</p> <ul style="list-style-type: none"> <li>• SH (aggressor) and BV (victim) were involved in a sexual assault incident on 2/5/11. SH's record includes an IDN describing the allegation. This was followed on 2/10/11 with a psychology note stating that PBS and DCAT are being consulted regarding SH's aggression and that the WRP has been updated to include this allegation. The 2/23/11 WRP focus 3.1 includes a poorly written objective: Mr. H will be able to <u>demonstrate</u> that sex offending is a problem for which there is no cure and involves the risk of relapse. The clinical record of BV describes the incident and states that BV was examined by a physician, given a START exam and transferred to another unit for his safety. A 2/10/11 psychology note states that over the two days following the incident, BV was offered individualized support from a nurse practitioner, a psychology senior staff member, and the staff psychologist who met with him to discuss his emotional reaction and coping process. It further noted that the WRPT may consider offering BV a trauma support group through recovery Mall services.</li> <li>• GD was the alleged victim of a sexual assault on 2/2/11 by a peer whom he could not identify or describe. IDNs describe the allegation and GD talking with DPS and asking for transfer to another unit. The 2/25/11 WRP does not reference the incident.</li> <li>• On 12/27/10, JV was the victim of a sexual incident identified as unwanted sexual contact between adults. IDNs describe the allegation and JV's fear of his peer. His acuity level was increased. His 12/30/10 WRP notes victimization in Risk Factors. A psychology note (12/28/10)</li> </ul>
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		<p>states that staff counseled JV and will closely monitor him for future victimization. The clinical record for FK, the aggressor in the 12/27/10 incident, states he does not want to discuss the incident. A psychology note states staff will monitor him for retaliation. [Because he had been discharged for more than 90 days, it was not possible to review FK's subsequent WRP.]</p> <ul style="list-style-type: none"> <li>• CS (aggressor) and DH (victim) were involved in a sexual assault incident on 10/15/10. IDNs in CS's record state that he is sick of people coming to staff and saying that he is sexually assaulting them and he did not do it. The interviewer told CS that his job was to keep everybody safe. CS was discharged on 11/5, so there was no revision to the WRP.</li> <li>• The IDNs for DH noted that he was examined and suffered no injury. DPS was notified and responded. A psychology note on 10/18 again describes the incident and states that the writer was unable to interview DH due to his recent discharge. DH was discharge to CDCR on 10/15/10.</li> </ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, October 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility stated that all non-clinical Mall providers were in compliance with training requirements and provided the names of these staff members and the dates that each had completed TSI-1, Abuse and Neglect, By Choice, Mall Overview, Group Facilitator and Learning Strategies training.</p>

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		<p>TSI-1 training is required every two years and Abuse and Neglect training is required annually; the others are one-time trainings.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor.</p>
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Section J: First Amendment and Due Process

<b>J. First Amendment and Due Process</b>		
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.	As of the tour conducted in October 2010, ASH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.