REPORT 6

METROPOLITAN STATE HOSPITAL

March 9-13, 2009

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

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

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Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
C-PAS	Central Psychological Assessment Services

Acronyms used in this report

CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
EAP	Employee Assistance Program
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
ETRC	Enhanced Trigger Review Committee
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HIMD	Health Information Management Department

HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
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
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool

NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
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)
R&R	Rule(s) and Regulation(s)
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCD	Standards Compliance Department
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
VRAT	Vocational Rehabilitation Assessment Tool
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and three expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD and Elizabeth Chura, MSRN) visited Metropolitan State Hospital (MSH) from March 9 to 13, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). A fourth consultant (Monica Jackman, OTR/L) conducted a review of the facility's documents off-site and interviewed facility staff via phone conferences during the on-site tour. The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At

early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

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

B. Methodology

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

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

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

The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

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

In the ratings of compliance, the Monitor uses a scale of Noncompliance, Partial compliance and Substantial compliance. A rating of Noncompliance indicates lack of efforts and progress towards compliance. A rating of Partial compliance falls short of the Court Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of Substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

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

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

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

D. Findings

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

1. Key Indicator Data

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

   a. The data on allegations of abuse, neglect and exploitation display a pattern that may be non-random (the number of allegations often rises over two months and then reverses, falling over two months). If the data are correct, there should be an explanation for this pattern.

b. The data on changes in BMI, in particular the data on changes from a BMI below 25 to a BMI in the range of 25-29.9, display a spikiness that also appears to be non-random. If the data are correct, there should be an explanation for the pattern (e.g. BMI captured on a non-monthly basis, etc.).
c. The data on escape/AWOL suggest improved performance as there have been no incidents of unauthorized absence outside the facility and the number of incidents inside the facility has fallen from the February 2008 peak.
d. While low in absolute number, the number of falls has increased in the past year compared to the prior year. (The care of individuals with falls was a topic of review by the newly established Medical Risk Management Committee during this review period.)
e. While low in the absolute, the number of individuals testing positive for street drugs reached the highest reported level in January 2009.
f. Data counts on medication variances continue to raise questions. The facility's progress report included tallies that differed from those in the key indicator report.
g. The facility's data suggests that all eight individuals diagnosed with dysphagia as of September 2008 were discharged in October. While this is not impossible, this data should be reviewed for accuracy.
h. The downward spike in fractures followed by an upward spike in the last two months of the review period bears explaining.
i. The data on Hepatitis C are clearly incorrect. See F.8.a.ii for additional information.
j. There is room for skepticism regarding the number of individuals diagnosed with seizure disorder. MSH cares for significantly fewer individuals with the diagnosis relative to size of patient population than other facilities. The level typically reported prior to the sudden 70% drop in number of diagnoses looked more in line with the experience of the other facilities.
k. The data on phenytoin should be examined further. There is a spikiness to this data that is not typically seen at the other facilities or for the other medications graphed on the same chart.
l. The decline in the incidence of restraint since the monitoring process began is a positive development.

2. Monitoring, mentoring and self-evaluation

a. In general, MSH has made sufficient progress in formalizing the process of systemic and periodic review of the self-assessment data and this monitor's findings to ensure feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions.
b. Regarding the process of self-assessment, this monitor has requested the following:
   i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
      - Comparison of the mean compliance rates for the main indicator in the entire current review period to the previous period;

- 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 periods;
- 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 current review period to the previous periods.

iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.

c. In general, MSH has presented adequate data comparing the compliance rates from this review period to the previous period and from the month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable. However, in sections C.1 and C.2 in particular, the facility's data required further refinements in response to repeated requests for clarifications from the CM.

d. MSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP and made further progress in improving the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.

e. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. Continued data errors suggest that effective data reviews are not taking place. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

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

3. Implementation of the EP

a. Since the last review period, MSH has made further progress in several sections of the EP. This progress is summarized in each corresponding section in the body of the report.

b. The DMH has continued its efforts to develop medical and nursing care protocols. When fully implemented, these protocols have the potential to correct many of the process deficiencies in medical services. MSH has also recruited a new chief of medical services, who has initiated adequate administrative steps to improve the processes of oversight of medical services. However, this monitor's interviews with some staff members and reviews of the medical and nursing documentation in the

charts found that the facility has yet to take administrative measures to correct persistent process deficiencies in medical and nursing care. These corrections are required to ensure compliance within the specified timeframes.

c. MSH began the implementation of the new risk management procedure. This procedure outlines a system that meets generally accepted standards in this area. Interviews with various WRPTs found that, in general, the teams were adequately oriented to the new system. However, the facility has yet to improve the processes of oversight by its quality council and to fully implement and refine the three levels of intervention and follow up in response to established triggers and thresholds. These corrections are required to ensure compliance within the specified timeframes.
d. MSH has yet to make significant progress in the development and implementation of sufficient number of behavioral interventions consistent with the positive behavior support model. Corrective actions are required to ensure compliance within the specified timeframes.
e. Regarding the process of the WRPC, MSH appears to have reached a plateau due to some limitations in its current training and mentoring system. The current system has put in place an adequate process of review of different sections of the WRP during the meeting. However, the system has difficulties in utilizing data observations to inform actual improvements in the clinical care of individuals.
f. MSH has taken adequate administrative steps to improve its performance in the area of psychiatric medication management, primarily in the processes of drug utilization evaluation and intensive case analysis of adverse drug reactions.
g. MSH has initiated an adequate system of outcome assessment in the area of substance recovery.
h. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
i. Mall hours: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

DMH PSR MALL HOURS REQUIREMENTS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities
8am – 6pm: Active Treatment Official Mall Hours: Groups A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: morning group B: morning group LUNCH C: afternoon group D: afternoon group Individual Therapy Non-ABCD hours		
After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities		

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

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

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

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

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

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

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

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

4. Staffing

The MSH staffing table below shows the staffing pattern at the hospital as of January 31, 2009. These data were provided by the facility. The data indicates that there continues to be shortages of staff in several key areas: registered nurses, clinical social worker sand senior psychiatrists and psychologists.

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Nursing Classifications				
Hospital Worker	3.00	3.00	0.00	0.00%
Licensed Vocational Nurse	43.00	39.00	4.00	9.30%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT *	291.68	294.00	-2.32	-0.80%
Sr. Psychiatric Technician	43.00	34.00	9.00	20.93%
Registered Nurse *	189.84	141.00	48.84	25.73%
Supervising Registered Nurse	9.00	6.00	3.00	33.33%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Unit Supervisor	16.00	16.00	0.00	0.00%
Nurse Practitioner	1.00	1.00	0.00	0.00%
LOC Professional				
Physician & Surgeon	19.20	19.00	0.20	1.04%
Psychologist-HF, (Safety)	32.33	34.00	-1.67	-5.17%
Rehabilitation Therapist	40.40	38.60	1.80	4.46%
Clinical Social Worker	44.59	31.50	13.09	29.36%
Sr. Psychiatrist	12.50	8.00	4.50	36.00%
Sr. Psychologist (Spvr and Spec)	10.00	4.00	6.00	60.00%
Staff Psychiatrist	39.51	36.50	3.01	7.62%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	NA
Supervising Rehabilitation Therapist	4.00	4.00	0.00	0.00%
Other				
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	3.00	3.00	0.00	0.00%
Audiologist	0.00	0.00	0.00	NA
Chief Dentist	0.00	0.00	0.00	NA
Chief, Central Program Services	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief Psychologist	1.00	1.00	0.00	0.00%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	9.00	7.50	1.50	16.67%
Clinical Laboratory Technologist	4.00	4.00	0.00	0.00%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	0.00	0.00%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Dentist	2.00	2.00	0.00	0.00%
Dietetic Technician	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	0.00	0.00%
Food Service Technician I and II	78.00	67.00	11.00	14.10%
Hospital Police Lieutenant	2.00	2.00	0.00	0.00%
Hospital Police Sergeant	6.00	6.00	0.00	0.00%
Hospital Police Officer	52.00	46.00	6.00	11.54%
Health Record Technician I	26.00	22.00	4.00	15.38%
Health Record Techn II Sp	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	0.00	0.00%
Health Record Techn III	2.00	2.00	0.00	0.00%
Health Services Specialist	34.00	33.00	1.00	2.94%
Institution Artist Facilitator	1.00	1.00	0.00	0.00%
Medical Technical Assistant	0.00	0.00	0.00	NA
Medical Transcriber	5.00	4.00	1.00	20.00%
Medical Transcriber Sup	0.00	0.00	0.00	NA
Sr Medical Transcriber	0.00	0.00	0.00	NA
Nurse Instructor	4.00	4.00	0.00	0.00%
Nursing Coordinator	6.00	6.00	0.00	0.00%
Office Technician	41.00	36.00	5.00	12.20%
Pathologist	0.00	0.00	0.00	NA
Pharmacist I	17.60	16.60	1.00	5.68%
Pharmacist II	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	12.00	1.60	11.76%

Identified Clinical Positions at MSH	Caseload Allocations	Filled	Vacant	Vacancy Rate
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	NA
Program Assistant	7.00	5.00	2.00	28.57%
Program Consultant (RT, PSW)	2.00	1.00	1.00	50.00%
Program Director	6.00	5.00	1.00	16.67%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Public Health Nurse II/I	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Special Investigator	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.10	3.00	0.10	3.23%
Speech Pathologist I	0.00	0.00	0.00	NA
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	NA
Teacher-Adult Educ./Vocational Instructor	7.00	7.00	0.00	0.00%
Teaching Assistant	0.00	0.00	0.00	NA
Vocational Services Instructor	2.00	1.00	1.00	50.00%

Notes on staffing table:

The Hourly Intermittent FTE is not included in filled column.

** Plus, Registered Nurse - 10.17 FTE*

** Plus, Psychiatric Technician , PLPT, PTA, PTT - 22.5 FTE*

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

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

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

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;

6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. Three facilities have achieved substantial compliance with the requirements of Section D.7 of the EP (Court Assessments). Once a facility reaches substantial compliance in a section of the EP, the Court Monitor begins maintenance evaluation of that section for 18 consecutive months. If the facility maintains substantial compliance during the 18-month period, the Court Monitor's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to assume this responsibility as each section of the EP achieves maintenance status at each facility.

F. Next Steps

1. The Court Monitor's team is scheduled to return to Metropolitan State Hospital from August 31 to September 4, 2009 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to tour Atascadero State Hospital April 20-24, 2009.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. MSH has maintained compliance with the required staffing ratios on the long-term units. 2. MSH has maintained progress in the organization and content of the Present Status section of the case formulation. 3. MSH has maintained progress in the development of enrichment foci, objectives and interventions. 4. MSH has improved the development of interventions that specify who will do what and why. 5. MSH has improved the development of objectives that have behavioral outcomes. 6. MSH has systems in place that should deliver valid and reliable data regarding PSR Mall services.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Bala Gulasekaram, MD, Chief Psychiatrist 2. Donna Gilland, Program Director, Assistant to Clinical Administrator 3. Kenneth Layman, MS, Treatment Enhancement Coordinator (TEC) 4. Michael Barsom, MD, Medical Director <u>Reviewed</u>: 1. MSH WRPT member training database 2. MSH revised Foci and Objectives module 3. MSH outline of WRP revised eight-hour training sessions 4. MSH outline of revised WRP update training

		5. MSH outline of Computer Lab training 6. MSH WRP mentoring assignments 7. MSH Team Performance Summary 8. MSH WRPT Feedback Monthly Report, implemented January 2009 9. Draft Streamlined Focused Monthly WRPC Format 10. DMH WRP Observation Monitoring Form 11. DMH WRP Observation Monitoring Form Instructions 12. MSH WRP Observation Monitoring summary data (August 2008 to January 2009) 13. DMH Clinical Chart Auditing Form 14. DMH Clinical Chart Auditing Form Instructions 15. MSH Clinical Chart Auditing Form summary data (August 2008 to January 2009) 16. DMH WRP Team Facilitator Observation Monitoring Form 17. DMH WRP Team Facilitator Observation Monitoring Form Instructions 18. MSH WRP Team Facilitator Observation summary data (August 2008 to January 2009) 19. MSH data regarding staffing ratios on admissions and long-term units 20. MSH Mentoring Worksheet, implemented August 2008 <u>Observed</u>: 1. WRPC (Program I, unit 410) for monthly review of KS 2. WRPC (Program II, unit 414) for monthly review of RL 3. WRPC (Program II, unit 416) for monthly review of MLR 4. WRPC (Program III, unit 415) for monthly review of AFP 5. WRPC (Program V, unit 405) for monthly review of CL 6. WRPC (Program V, unit 405) for 14-Day review of VWS 7. WRPC (Program V, unit 405) for 14-Day review of EM 8. WRPC (Program V, unit 411) for monthly review of LS 9. WRPC (Program VI, unit 412) for monthly review of AB 10. WRPC (Program VI, unit 418) for monthly review of MD

C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. **Findings:** MSH has maintained the overall structure and function of its WRP training program. The following is a summary of modifications during this review period: 1. The facility revised the curriculum for the Foci and Objectives module to include specific examples of well-written foci and objectives. In addition, corresponding practical exercises were added. 2. MSH developed and implemented Computer Lab trainings during this review period. These trainings were tailored to each WRPT based on audits and observations of the team. The structure of the trainings allowed the WRPTs to apply the content of the training by modifying current WRPs during the lab. The WRPTs received feedback throughout the training. 3. The facility developed a new tool, the WRP Worksheet, during this review period. This worksheet delineates each discipline's areas of responsibility when finalizing WRPs. Teams were trained on implementation of the WRP Worksheet during the Computer Lab. 4. Discipline-Specific Training was developed and implemented for the disciplines of Social Work, Nursing and Rehabilitation Therapy. During this review period, MSH provided the following training activities: 1. Eight-hour WRP Training (five MSH modules): a. Training sessions were offered on a monthly basis (five total) this review period.

		b. 29 of 29 (100%) of new clinical employees and WRPT members who had not previously completed the modules attended. c. The WRP Master Trainer and three additional WRP trainers provided the training. d. Competency was measured though administration of the WRP Knowledge Assessment Test. All staff successfully completed the test during this review period. 2. 3.5-hour WRP Update: a. Three training sessions were offered during the last week of September 2008. b. Training focused on the updated Foci and Objective module. c. 108 of 219 (49%) WRPT members attended. d. The WRP Master Trainer and three additional WRP trainers provided the training. e. No specific competency data was provided, but MSH reported that each WRPT demonstrated competency during the training by writing an objective that met criteria outlined in the WRP Manual. f. MSH reported that the content of this class was also provided to WRPT nurses in the discipline-specific training described below. 3. Two-hour Computer Lab Help Sessions: a. Twenty-three training sessions were offered during November and December 2008. b. Training focused on a review of audits and observations specific to each WRPT (including WRPC process requirements), introduction to the newly implemented Risk Management system and training on the WRP Worksheet. c. 89 of 222 (40%) WRPT members attended. d. The Treatment Enhancement Coordinator (TEC), supported by the Discipline Chiefs and Senior Clinical Mentors, provided the training. 4. Discipline-Specific WRP Training: a. Social Work i) Four sessions were offered during October 2008 (1) and

		January 2009 (3). ii) Training focused on the role of Social Workers in discharge planning. iii) 13 of 28 (46%) social workers attended. iv) The Chief of Social Work provided the training. b. Nursing i) Training focused on the updated Foci and Objectives module (with specific nursing examples and exercises): (1) Five two-hour sessions were offered during this review period (October, November and December 2008). (2) 137 of 349 (39%) of RNs, LVNs and PTs attended. (3) The TEC and Nursing WRP mentors provided the training. ii) Training focused on creating and integrating WRP attachments: (1) One two-hour training session was offered in December 2008. (2) Nurses had the opportunity to revise the WRPs for individuals under their care. (3) 83 of 106 (78%) RNs attended. (4) The Clinical Nurse Supervisor and RN Mentors provided the training with a ratio of one facilitator to two nursing staff. c. Rehabilitation Therapy i) Training focused on the role of rehabilitation therapists in the WRP process, writing appropriate objectives and developing Focus 10. (1) Nine one-hour sessions were offered in the last three months of the review period. (2) 43 of 43 (100%) Rehabilitation Therapists attended and passed a written competency measure with a score of 90% or above. (3) The Chief of Rehabilitation and Senior Rehabilitation Therapists provided the training.

		ii) Training focused on the assessment components required by the enhancement plan and WRP integration: (1) Ten one-hour sessions were offered in the last three months of the review period. (2) 42 of 42 (100%) Rehabilitation Therapists attended and passed a written competency measure with a score of 90% or above. (3) The Chief of Rehabilitation and Senior Rehabilitation Therapists provided the training. **Recommendation 2, September 2008:** Provide documentation of WRP training competencies of WRPT members, including a. Information regarding numbers of staff who attended both types of training sessions vs. those who were required to attend; b. Clarification of whether and how the competency data are based on both types of training for current employees (e.g. employees who achieved the required competency are receiving the four-hour update; and c. The rates for the entire review period. **Findings:** MSH reported that as of January 2009, 100% of core WRPT members (psychiatrists, psychologists, social workers, rehabilitation therapists, nurses and psychiatric technicians) had completed the eight-hour WRP training on the five MSH modules and met the facility's competency threshold (a score of 95% or higher on the WRP Knowledge Assessment). **Recommendation 3, September 2008:** Formalize a process of systemic and periodic review of WRP training data to ensure that the WRPTs receive consistent feedback from the mentors, that trends and patterns are identified and that targeted corrective actions are provided. The reviews must occur at least monthly.

		Findings: A summary of improvements in MSH's mentoring system follows: 1. Each WRPT was assigned its own Senior Clinical Mentor. 2. A WRP Mentor Worksheet was developed and implemented in August 2008. Mentors completed this worksheet when observing WRPCs. MSH reported that at the conclusion of the WRPC, mentors were to provide the WRPT feedback based on the WRP Mentor Worksheet. 3. The WRP Master Trainer and TEC facilitate a monthly meeting with the mentors to discuss the WRP Mentor Worksheet aggregate data and discuss methods to improve WRPT performance. 4. Based on auditing data, the WRP Master Trainer and TEC selected five teams for enhanced mentoring. These teams received mentoring from the WRP Master Trainer, TEC and their assigned Senior Clinical Mentor. MSH reported that the enhanced mentoring resulted in an increase in WRP process and chart auditing scores of 6.5% and 20.7% respectively. 5. Prior to January 2009, the TEC provided mentors with data summaries of WRPT performance. Beginning in January, this process was formalized. WRPTs now receive the WRPT Feedback Monthly Report which includes the team's comparative performance on WRP process and chart auditing as well as suggestions for improving performance. 6. The MSH Corrective Action Form (CAF) was developed and implemented (November 2008) as a mechanism for mentoring specific to psychiatric care. This form provides feedback that is specific to each physician's compliance with EP requirements. **Recommendation 4, September 2008:** Monitor this requirement using the DMH Clinical Chart Auditing Form based on a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the

reporting period and compared to the last period).

Findings:
MSH used the DMH WRP Clinical Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The overall mean for inter-rater reliability was 70%, which calls into question the reliability of data from this form. The average sample was 16% of the quarterly and annual WRPCs held each month.

MSH implemented a draft tool during December 2008 and January 2009 which did not include item 1. The facility reported that this has been modified and data on this item will be available during the next review. The following summarizes the data:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care*	74%
2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services*	86%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	76%	74%
2.	86%	86%

	Previous period	Current period
Compliance rate in last month of period		
1.	78%	79% (Nov)
2	100%	80%

Other findings:
The monitor and his experts attended 10 WRPCs. In some areas, the facility maintained the progress that was demonstrated during the previous review, but overall there was no evidence of further progress in the process of the WRPC. The following is a summary of observations of adequate WRPC processes:

1. In general, the meetings started on time.
2. Further improvement was noted in attendance and participation by core team members, including PTs.
3. In general, the team leaders were able to facilitate the presentation of disciplinary assessments, the updates of the present status section of the case formulation, the review of risk factors and the identification of key questions prior to the individual's arrival.
4. In general, the WRPTs approached the individuals with respect and made efforts to engage the individuals during the meetings.
5. In general, the WRPTs reviewed the diagnosis, objectives and interventions with the individual.
6. In general, the WRPTs made an effort to review the individual's attendance (and participation) at the assigned groups, including review of the revised Mall Facilitator Progress notes.
7. In general, the WRPTs reviewed the By Choice participation and point allocation with the individual.

However, significant process deficiencies were noted as follows:

		1. Some of the teams did not revise objectives and interventions that were not aligned with the individual's needs, including objectives that had been attained but listed as not met/partially met, objectives that were not attainable and objectives and interventions that did not account for the individual's cognitive level and/or inability to communicate in English. 2. A few team leaders appeared to lack the skills required to communicate with individuals who had difficulty accepting the label of mental illness. This deficiency resulted in a team process marked by argumentativeness with the individual and failure to develop objectives and interventions geared towards the individual's demonstrated adaptive behaviors. 3. One team leader appeared to lack the necessary skills to communicate with the individual in the English language. 4. In general, the WRPTs did not ensure adequate linkage between Mall groups and the WRP objectives. 5. The WRPTs did not revise/update the case formulation, foci, objectives and interventions as a result of the discussion with the individual. 6. The WRPTs did not utilize the updated life goals and the individual's strengths in the WRP. 7. The reviews of diagnosis, foci, objectives and interventions were not consistently informed by the assessments/consultations and the case formulation. 8. The reviews of the discharge criteria were either generic or did not occur, and the teams did not consistently discuss with the individual progress needed to meet each criterion. The above deficiencies must be corrected to achieve substantial compliance with EP requirements regarding the process of WRP. **Compliance:** Partial.

		Current recommendations: 1. Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor above. 2. Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should include: a. Name of the training, b. Number of sessions offered, c. Schedule of training sessions, d. Specific focus of the training, e. Number of staff who attended vs. those who were required to attend, f. Facilitator(s) of training, and g. Outcome of any competency measures. 3. Ensure that all staff required to complete the trainings described above have completed applicable trainings. 4. Consider streamlining the current WRPC monthly review format to facilitate completion of important tasks within allocated time limits. 5. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 6. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 7. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using WRP Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively.

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

Findings:
MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the quarterly and annual WRPCs held each month. The following summarizes the data:

1.	*Each team is led by a clinical professional who is involved in the care of the individual:*	99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form (August 2008 to January 2009) to assess compliance. Several items on this auditing form were modified or consolidated during this review to decrease repetition and clarify that any WRPT member can function as a team facilitator.

The current review was based on an average sample of 26% of the expected observations (two per WRPT psychiatrist per month). Although this is an increase in sample size from the previous review (1%), it does not meet the recommended sample size of 100%. The following summarizes the data:

1.	*The team psychiatrist was present during the WRP conference.*	100%
2.	*The team facilitator encouraged meaningful participation of all disciplines.*	93%
3.	*The discussion of the clinical data was substantially*	96%

	incorporated into the Present Status section.	
4.	*The interventions reviewed were linked to the objectives.*	67%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for item 1; improvement in compliance from 89% and 38% for items 2 and 3 respectively, and decline in compliance for item 4:

	Previous period	Current period
Mean compliance rate		
4.	89%	67%
Compliance rate in last month of period		
4.	83%	100%

The facility reported that it plans to improve compliance in this area with the mentoring/training outlined in C.1.a above.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively
2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. Two sub-items were re-worded for clarity and one sub-item was deleted due to redundancy during the review period. The average sample was 21% of the quarterly and annual WRPCs held each month. The following summarizes the data:

2.	*Each team functions in an interdisciplinary fashion.*	35%
2.a	*Perspectives from multiple disciplines on assessments (formal/informal) were presented.*	51%
2.b	*The team reviews and updates the DMH WRPC Task Tracking Form.*	87%
2.c	*Perspectives from multiple disciplines on outcomes are presented.*	53%

Comparative data showed improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	30%	35%

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<tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>22%</td><td>40%</td></tr>
<tr><td>2.a</td><td>40%</td><td>48%</td></tr>
<tr><td>2.b</td><td>84%</td><td>84%</td></tr>
<tr><td>2.c</td><td>43%</td><td>56%</td></tr>
</table>

The facility reported that it plans to improve compliance in this area with the mentoring/training outlined in C.1.a above.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
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<td>C.1.d</td>
<td>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</td>
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Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:
• Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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Findings:
MSH used the DMH WRP Clinical Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 16% of the quarterly and annual WRPCs held each month. The following summarizes the data:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.*	76%
1.a	*The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)*	91%
1.b	*A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)*	82%

Comparative data showed no change in mean compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	76%	76%
Compliance rate in last month of period		
1.	78%	85%
1.a	96%	89%
1.b	78%	92%

MSH reported that further data analysis indicated that two specific

		programs had low compliance in this area. As a result, the facility intends to provide additional mentoring to these two programs related to aligning assessments with the case formulation. Additionally, the TEC reported that he intends to increase the frequency of auditing data aggregation and review and subsequent feedback to the WRPTs. The intended outcome is an increase in timely identification and remediation of deficiencies. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Audit Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.1.e	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. One sub-item was deleted to reduce redundancy during the review period. The average

sample was 21% of the quarterly and annual WRPCs held each month. The following summarizes the data:

3.	*Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.*	27%
3.a	*Team members present relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.*	45%
3.b	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	82%

Comparative data showed improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	26%	27%
Compliance rate in last month of period		
3.	22%	37%
3.a	39%	41%
3.b	77%	84%

MSH reported that the facility's data analysis of the WRP Observation Monitoring Form, in regards to the participation of WRPT members from all disciplines, indicated that the scores may have resulted from an auditing error. MSH reported that auditors were retrained in February 2009.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH reported a mean compliance rate of 23% compared to 25% during the last review period. The rate for the last month of the period increased to 52% from 22% during the last review period. The facility reported that it plans to improve compliance in this area with the mentoring/training outlined in C.1.a above as well as retraining of auditors as described in C.1.e. **Compliance:** Partial.

		Current recommendations: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.1.g	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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using the WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis addressing sub-items of this requirement. The analysis must evaluate areas of low compliance and delineate areas of relative improvement. **Findings:** MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. During this review period, the two sub-items were incorporated into the overall item in an effort to increase efficiency of this tool. The following summarizes the data: 5. *The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.* — 61% MSH reported a mean compliance rate of 61% compared to 64% during

		the last review period. The rate for the last month of this period increased to 88% from 63% during the last review period. MSH reported that the facility's data analysis of the WRP Observation Monitoring Form, in regards to scheduling of conferences, indicated that WRPTs were inconsistent in the implementation of the Flexible Sequence WRP Process. Subsequently, team members were retrained on this process during the Computer Lab training. Additionally, MSH reported that this item has been added to the Monthly Feedback Reports distributed to the WRPTs. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.1.h	Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Monitor this requirement using process observation based on at least a 20% sample. **Findings:** MSH presented data based on a mean sample of 21% of the scheduled WRPCs per month. Data showed that all core members' attendance rates have increased since the last review period with the exception of

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<td>Rehabilitation Therapists. The following is a summary of the data for the last three review periods:

<table>
<tr><td></td><td>Aug 2007-Jan 2008</td><td>Feb-Jul 2008</td><td>Aug 2008-Jan 2009</td></tr>
<tr><td>Individual</td><td></td><td>96%</td><td>99%</td></tr>
<tr><td>Psychiatrist</td><td>92%</td><td>91%</td><td>95%</td></tr>
<tr><td>Psychologist</td><td>66%</td><td>77%</td><td>84%</td></tr>
<tr><td>Social Worker</td><td>89%</td><td>81%</td><td>84%</td></tr>
<tr><td>Rehabilitation Therapist</td><td>73%</td><td>78%</td><td>70%</td></tr>
<tr><td>Registered Nurse</td><td>98%</td><td>99%</td><td>99%</td></tr>
<tr><td>Psychiatric Technician</td><td>76%</td><td>77%</td><td>83%</td></tr>
</table>

Recommendation 2, September 2008:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH reported that vacancies in the Rehabilitation Therapy department contributed to decreased attendance at WRPCs. Three vacancies were filled in January 2009.

Compliance:
Partial.

Current recommendation:
Continue efforts to increase attendance of all WRPT members at WRPCs.</td>
</tr>
<tr>
<td>C.1.i</td>
<td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:
• Ensure compliance with the required ratios for Social Workers on the</td>
</tr>
</table>

time.

admission units.

- Provide data regarding case loads on both the admission and long-term units.

Findings:
Except for Psychology, each core team discipline's mean staffing ratio was greater than the expected (1:15) for admission teams. The following is a summary of the facility's data for this review period:

	Mean Ratios Previous Period	Mean Ratios Current Period
MDs	1:15	1:16
PhDs	1:15	1:15
SWs	1:16	1:16
RTs	1:15	1:16
RNs	1:15	1:16
PTs	1:15	1:16

All disciplines met the expectation of 1:25 on non-admission units. The following is a summary of the facility's data for this review period:

	Mean Ratios Previous Period	Mean Ratios Current Period
MDs	1:21	1:22
PhDs	1:24	1:24
SWs	1:22	1:22
RTs	1:20	1:21
RNs	1:20	1:19
PTs	1:21	1:19

The facility reported that it intends to make staffing adjustments on the admission units to improve compliance with the required ratios.

		Compliance: Partial. **Current recommendation**: Ensure that staffing ratios are met.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. **Compliance:** Partial. **Current recommendation**: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Two individuals: JC and PS 2. Alex Guerrero, PsyD, PBS Team Leader 3. Andrea Cirota, Supervising Rehabilitation Therapist 4. Angela Appaiah, RN, Acting Nurse Coordinator 5. Ashvind Singh, PhD, Consulting Psychologist, PSR Mall Services 6. Bala Gulasekaram, MD, Chief Psychiatrist 7. Bruce Abrams, MD, Senior Psychiatrist 8. Carol Provo, PsyD, Substance Abuse Counselor 9. Chris Marshall, Director of Nutrition Services 10. Christopher Cooper, PhD, PSSC Coordinator 11. Cindy Lusch, Clinical Administrator 12. Constance Nunley, WRP Auditor 13. Darren Sush, PsyD, PBS Team Leader 14. Donna Gilland, Program Director, Assistant to Clinical Administrator 15. Geovanne Dimas, Assistant Director of Nutrition Services 16. Jack McClary, Supervisor of Vocational Services 17. Jamie Critie, Supervising Rehabilitation Therapist 18. John Lusch, Program Director 19. Jon Fogel, PhD, DCAT Leader 20. Kenneth Layman, MS, Treatment Enhancement Coordinator 21. Kevin Buckheim, Mall Coordinator for Programs 1 and 2 22. Lisa Adams, Supervising Rehabilitation Therapist 23. Mari Cobb, Chief of Rehabilitation Services 24. Marion Paclibar, Physical Therapist 25. Michael Barsom, MD, Medical Director 26. Michael Nunley, Standards Compliance Director 27. Portia Salvacion, Assistant Director of Nutrition Services 28. Rebecca McClary, Rehabilitation Therapy Program Assistant 29. Ruth Flores, WRP Auditor

		30. Sharin Karimi, Chief, Department of Social Work 31. Sharon Smith Nevins, Executive Director 32. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 33. Siobhan Donovan, PsyD, Psychologist 34. Socorro Manzanilla, MD, Psychiatrist 35. Steven Jones, Mall Assistant 36. Swati Roy, PhD, Chief Department of Psychology 37. Terez Henson, Supervising Rehabilitation Therapist 38. Virginia Tovar, Assistant Director of Nutrition Services <u>Reviewed</u>: 1. The charts of the following 142 individuals: AB, AC, ADF, AEE, ALH, AM, AMP, AW, BA, BB, BE, BJW, BMY, BNJ, CAC, CC, CDJ, CF-1, CF-2, CG, CH, CI, CM, CN, CP, CPP, DAC, DC, DE, DEM, DG, DKL, DM, DMW, DR, DS, DY, EA, EAB, EGW, ERM, EW, FJ, FR-1, FR-2, FTR, GD, GM, GR, GS, GSZ, HDF, HL, IR, JA, JC-1, JC-2, JCY, JDB, JE, JF, JHT, JJS, JJV, JLH, JM-1, JM-2, JP, JS, JVM, JWR, KDL, KF, KFB, KGE, KIM, KJ, KJE, KRD, KRS, KS-1, KS-2, KS-3, KZ, LAD, LB, LEY, LJ-1, LJ-2, LJS, LL-1, LL-2, LO, LS, MAB, MCL, MMS, NB, NV, OH, PA, PAS, PDF, PF, PM, PMH, RCB, RD, RJA, RLF, RLH, RM, RMB, RNM, RR-1, RR-2, RR-3, RS, RU, RWL, SB, SC, SD, SET, SHP, SL, SM, SMR, SO-1, SO-2, SS, SW-1, SW-2TDR, TG-1, TG-2, TG-3, TME, TP-1, TP-2, VLA, WH and WOS 2. MSH revised Foci and Objectives module 3. DMH finalized template for the Mall Facilitator Monthly Progress Note 4. MSH Standardized Curriculum for Medication Education 5. DMH WRP Observation Monitoring Form 6. DMH WRP Observation Monitoring Form Instructions 7. MSH WRP Observation Monitoring summary data (August 2008 to January 2009) 8. DMH Chart Auditing Form 9. DMH Chart Auditing Form Instructions

		10. MSH Chart Auditing summary data (August 2008 to January 2009) 11. DMH Clinical Chart Auditing Form 12. DMH Clinical Chart Auditing Form Instructions 13. MSH Clinical Chart Auditing Form summary data (August 2008 to January 2009) 14. DMH Mall Alignment Monitoring Form 15. DMH Mall Alignment Monitoring Form Instructions 16. MSH Mall Alignment Monitoring summary data (August 2008 to January 2009) 17. DMH WRP Substance Abuse Monitoring Form 18. DMH WRP Substance Abuse Monitoring Form Instructions 19. MSH Substance Abuse Monitoring summary data (August 2008 to January 2009) 20. AD 3415: Screening Individuals for Substance Abuse 21. Enrichment Activity Schedules 22. Enrichment Facilitator Consultation Instructions 23. List of individuals assessed to need family therapy 24. List of individuals with missed medical appointments 25. Mall Progress Notes 26. MAPP Data for Mall Hours Scheduled 27. Mortality Interdisciplinary Review Committee Meeting Minutes 28. MSH List of Enrichment Groups 29. PSR Mall Data Variables from Disciplines' Integrated Assessments 30. PSR Services Add/Drop Request Form 31. PSR Services Add/Drop Request Procedures 32. PSR Services Course Catalog 33. PSST Responses to Triggering Individuals 34. Special Order 262 (Risk Management) 35. Substance Abuse Provider Training Curriculum 36. Substance Abuse Treatment Program Plan of Improvement <u>Observed</u>: 1. WRPC (Program I, unit 410) for monthly review of KS

		2. WRPC (Program II, unit 414) for monthly review of RL 3. WRPC (Program II, unit 416) for monthly review of MLR 4. WRPC (Program III, unit 415) for monthly review of AFP 5. WRPC (Program V, unit 405) for monthly review of CL 6. WRPC (Program V, unit 405) for 14-Day review of VWS 7. WRPC (Program V, unit 405) for 14-Day review of EM 8. WRPC (Program V, unit 411) for monthly review of LS 9. WRPC (Program VI, unit 412) for monthly review of AB 10. WRPC (Program VI, unit 418) for monthly review of MD 11. PSR Mall group: Acceptance and Commitment 12. PSR Mall group: Coping Skills 13. PSR Mall group: Medical Health and Wellness 14. PSR Mall group: Substance Recovery 15. Demonstration of MSH MAPP Reporting Portal
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue current training and mentoring regarding engagement of individuals. **Findings:** The facility's training and monitoring activities are summarized in C.1.a. **Recommendation 2, September 2008:** Monitor this requirement using process observation based on at least a 20% sample. **Findings:** MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the quarterly and annual WRPCs held each month. The following summarizes the data:

6.	*Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.*	48%
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	65%
6.b	*When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.*	70%
6.c	*The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.*	70%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.*	66%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	49%	48%
Compliance rate in last month of period		
6.	45%	55%
6.a	74%	74%

6.b	74%	67%
6.c	71%	69%
6.d	81%	58%

Recommendation 3, September 2008:
Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
MSH reported that data analysis indicated three areas for improvement:

1. Implementation of the Flexible Sequence WRP Process to ensure an efficient discussion of foci, objectives and interventions with the individual;
2. WRPT preparation prior to discussing new groups with individuals after objectives have been met;
3. WRPT members' understanding of integrating cultural factors into the WRP.

As corrective actions, the facility reported that it plans to:

1. Implement the training and mentoring processes described in C.1.a.
2. Retrain all WRPT members on cultural factors.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

		compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice, including self-monitoring. **Findings:** MSH used the DMH Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 16% of the A-WPRs due each month. The facility reported a compliance rate of 100% for this requirement. This is consistent with the previous review period's compliance rate of 100%. **Other findings:** This monitor reviewed the charts of 10 individuals (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS) and found compliance in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement and ensure a sample size of at least 20%.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP))	**Current findings on previous recommendation:**

	are completed within 7 days of admission; and	**Recommendation, September 2008:** Continue current practice, including self-monitoring. **Findings:** MSH used the DMH Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 18% of the 7-day WPRs due each month. The facility reported a compliance rate of 82%. This is an increase from 67% during the previous review period. However, examination of the compliance rate by month revealed a significant trend of decreasing compliance throughout the review period as well as from the last month of the previous review period (100%) to the last month of the current review period (60%). MSH reported that scheduling errors contributed to compliance rates for this indicator. The facility reported that it intends to implement a system in which only the Program Manager is authorized to change the WRPC schedule and the TEC monitors scheduling on a weekly basis. **Other findings:** This monitor reviewed the charts of 10 individuals (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS) and found compliance in all charts reviewed. **Compliance:** Partial. **Current recommendation:** Ensure that WRPs are completed in accordance with this requirement.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Monitor this requirement using chart audits based on at least a 20% sample.

review is the annual review.

Findings:
MSH used the DMH Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The following is a summary of the facility's data:

WRP Review	Mean sample size	Mean compliance rate
14-Day	30%	75%
Monthly	15%	77%
Quarterly	26%	81%
Annual	27%	88%

Comparative data showed improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
14-Day Review	51%	75%
Monthly Review	38%	77%
Quarterly Review	39%	81%
Annual Review	49%	88%
Compliance rate in last month of period		
14-Day Review	66%	76%
Monthly Review	62%	74%
Quarterly Review	59%	71%
Annual Review	60%	85%

Recommendation 2, September 2008:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

		compared to the last period). **Findings:** See C.2.b.ii above for the facility's analysis of the issue and corrective actions. **Other findings:** This monitor reviewed the charts of 10 individuals (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS). The review found compliance in eight charts (CN, CP, EA, PAS, RR, RU, SD and SM) and partial compliance in two (OH and SS). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.2.c	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;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using the Clinical Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used the DMH WRP Clinical Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 16% of the quarterly and annual WRPCs held each month. This sample was not based on the number of individuals (N) who were diagnosed with the specified disorders.

The sub-item that previously referred to mental retardation has been included within sub-item 2.a, cognitive disorders, to eliminate redundancy within this item. The following summarizes the data:

2.	*Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.*	86%
2.a	*When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.*	69%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	89%
2.c	*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.*	100%

MSH implemented a draft tool during December 2008 and January 2009 which did not include sub-items 2.a or 2.c. The facility reported that this has been modified and data on those sub-items will be available during the next review. Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	86%	86%
Compliance rate in last month of period		
2.	100%	80%
2.a	100%	100% (Nov)
2.b	100%	83%
2.c	100%	100% (Nov)

The facility's WRP training and monitoring activities are summarized in C.1.a.

Recommendation 3, September 2008:
Implement adequate corrective actions to address the deficiencies outlined by this monitor above.

Findings:
The facility did not report any corrective actions in addition to those summarized in C.1.a.

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

1. Documentation of some foci, objectives and interventions to address the needs of individuals diagnosed with dementing illnesses and seizure disorders;
2. Decreased use of ongoing treatment with anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments (JM and KZ);

		3. Documentation of the status of some individuals suffering from seizure disorders (in the present status section of the case formulation); and 4. The use of objectives and interventions based on learning outcomes for some individuals suffering from seizure disorders. However, the review also found a pattern of persistent deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (AM, EW, GS, JM, KZ, LEY, SO and RJA): a. The WRPs did not include focus, objectives or interventions to address the needs of individuals diagnosed with cognitive impairments including Dementia Due To General Medical Condition, With Behavioral Disturbance (GS and SO), Mild Mental Retardation (JM) and Cognitive Disorder NOS (LEY and RJA). b. The WRP included a generic focus statement for an individual diagnosed with Vascular Dementia, Uncomplicated (EW). c. The WRPs did not include interventions to assess the risks of ongoing treatment with high-risk medications, including phenytoin (JM) and clonazepam and chlorpromazine (SO). d. The present status sections of the case formulations did not adequately address the status of individuals diagnosed with Dementia Due To General Medical Condition, With Behavioral Disturbance (SO), Vascular Dementia (EW) or Cognitive Disorder NOS (LEY). e. The WRPs did not include adequate measures/consultations to assess, determine the etiology of and/or finalize diagnoses of Cognitive Disorder, NOS (e.g., LEY and RJA). 2. Individuals diagnosed with seizure disorders (AM, CI, JJV, JM, KS SM and TG):

		a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in all charts reviewed. b. The WRP included an objective statement that was not learning-based (CI). c. The present status section of the WRP did not address the status of seizure activity during the interval (CI). d. Some WRPs included interventions that did not address the specified objective of learning to recognize and verbalize the signs and symptoms of impending seizure (JM). e. The WRPs did not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medications and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (CI, JM, TG and AM) and individuals receiving both phenytoin and phenobarbital (KS and SM). Some of these individuals had diagnoses of cognitive impairments, which increase the risk of this treatment. Examples included Mild Mental Retardation (JM) and Cognitive Disorder NOS (SM). **Compliance:** Partial. **Current recommendations**: 1. Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations. 2. Implement adequate corrective actions to address the deficiencies outlined by this monitor above. 3. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 5. Provide a summary outline of improvements in practice made as a

		result of the facility's review of internal monitoring data.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above. **Findings:** The facility's training and monitoring activities are summarized in C.1.a. **Recommendations 2 and 3, September 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH WRP Clinical Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 16% of the quarterly and annual WRPCs held each month. The sub-items for this indicator were reworded during this review period

to increase clarity. The following summarizes the data:

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	82%
3.a	*Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and*	88%
3.b	*The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.*	91%

Comparative data showed an overall decrease in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
3.	88%	82%
Compliance rate in last month of period		
3.	96%	89%
3.a	100%	89%
3.b	96%	97%

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. An overall decrease in compliance was noted for the indicators and sub-indicators during this review period.

MSH reported that further data analysis indicated two specific programs accounted for misalignment between assessments and case formulation. The facility reported its training/mentoring activities summarized in C.1.a

		as corrective actions. **Other findings:** Chart reviews and WRPCs attended by this monitor and his consultants demonstrated that MSH has maintained progress noted during the last review in the organization and content of the present status section of the case formulation. However, the content of many formulations showed deficiencies that must be corrected to achieve substantial compliance. The following are the main examples: 1. The present status section did not consistently review the cognitive status of individuals suffering from a variety of cognitive impairments. 2. The present status section did not consistently review the circumstances leading to the use of restrictive interventions or provide modifications in treatment to reduce the risk of future occurrences of behaviors leading to this use. 3. The present status section did not include sufficient review and analysis of clinical progress towards individualized discharge criteria. 4. In general, there was inadequate linkage within the 6-p components of the case formulation and between the material in the case formulation and the individual's life goals and strengths as utilized in the objectives and interventions. **Current recommendations**: 1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above. 2. Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low

<table>
<tr><td></td><td></td><td>compliance and relative improvement (during the reporting period and compared to the last period).
4. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td></tr>
<tr><td>C.2.d.ii</td><td>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</td><td>
<table>
<tr><td>4.</td><td>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</td><td>11%</td></tr>
<tr><td>4.a</td><td>Clinical outcomes and responses to treatment in described in clinical notes (done in the last 3 months for a quarterly WRP and in the last 12 months for an annual WRP) are incorporated into the case formulation.</td><td>77%</td></tr>
<tr><td>4.b</td><td>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WPR) has been summarized in the Previous Treatment Section of the Case Formulation.</td><td>17%</td></tr>
</table>

Comparative data indicated maintenance of low compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>13%</td><td>11%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>21%</td><td>25%</td></tr>
</table>

Comparison of the compliance rate from last month to last month for the
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<tr><td></td><td></td><td>sub-indicators is not available as they were modified during this review period.</td></tr>
<tr><td>C.2.d.iii</td><td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td><td>During this review period, the sub-items for this indicator were removed and the item was reworded to increase alignment with the EP requirements.
<table>
<tr><td>5.</td><td>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</td><td>48%</td></tr>
</table>
Comparative data indicated maintenance of low compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>46%</td><td>48%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>5.</td><td>56%</td><td>57%</td></tr>
</table></td></tr>
<tr><td>C.2.d.iv</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</td><td>
<table>
<tr><td>6.</td><td>The case formulation considers such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions.</td><td>70%</td></tr>
<tr><td>6.a</td><td>Age, gender, culture, treatment adherence, and medication issues, as clinically appropriate,</td><td>74%</td></tr>
<tr><td>6.b</td><td>(The formulation) addresses how they affect treatment and rehabilitation outcomes</td><td>75%</td></tr>
</table>
Comparative data indicated decreases in compliance from the previous review period:</td></tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>78%</td><td>70%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>89%</td><td>54%</td></tr>
<tr><td>6.a</td><td>93%</td><td>60%</td></tr>
<tr><td>6.b</td><td>89%</td><td>57%</td></tr>
</table>
</td>
</tr>
<tr>
<td>C.2.d.v</td>
<td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</td>
<td>
<table>
<tr><td>7.</td><td>The case formulation supports the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists. There is a completed DSM IV-TR Checklist that supports the diagnosis:</td><td>63%</td></tr>
<tr><td>7.a</td><td>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</td><td>66%</td></tr>
<tr><td>7.b</td><td>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</td><td>64%</td></tr>
</table>

Comparative data indicated declines in compliance from the previous review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>79%</td><td>63%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>93%</td><td>33%</td></tr>
<tr><td>7.a</td><td>93%</td><td>43%</td></tr>
<tr><td>7.b</td><td>89%</td><td>18%</td></tr>
</table>
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<table>
<tr>
<td>C.2.d.vi</td>
<td>enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</td>
<td>
During the review period, three sub-items for this indicator were removed as the content was redundant with other audits. Two sub-items were reworded for clarity.
<table>
<tr><td>8.</td><td>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</td><td>51%</td></tr>
<tr><td>8.a</td><td>The present status section addresses the following: Treatment, Rehabilitation and Enrichment</td><td>68%</td></tr>
<tr><td>8.b</td><td>The case formulation documents the individual's progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives</td><td>83%</td></tr>
<tr><td>8.c</td><td>The case formulation documents a pathway to the discharge setting</td><td>86%</td></tr>
<tr><td>8.d</td><td>There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section</td><td>87%</td></tr>
</table>
Comparative data indicated no change in mean compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>8.</td><td>51%</td><td>51%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>8.</td><td>50%</td><td>54%</td></tr>
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8.a	79%	57%
8.b	89%	89%
8.c	89%	74%
8.d	82%	74%

C.2.e

The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);

Current findings on previous recommendation:

Recommendation, September 2008:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Other findings:
MSH presented compliance data based on the DMH WRP Chart Auditing Form (August 2008 to January 2009). The average sample was 27% of the quarterly and annual WRPs due each month. The following summarizes the data:

4.	*The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).*	11%
4.a	*There is a focus of hospitalization for each axis I, II, and III diagnosis*	71%
4.b	*There is a focus for each discharge criteria*	51%
4.c	*Each focus has an objective and an intervention*	78%
4.d	*Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.*	37%
4.e	*Each objective includes a staff intervention in the therapeutic milieu.*	50%

Comparative data showed a modest increase in mean compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
4.	3%	11%
Compliance rate in last month of period		
4.	0%	10%
4.a	74%	71%
4.b	24%	59%
4.c	76%	81%
4.d	14%	43%
4.e	7%	72%

A review of records of 14 individuals (BJW, DM, FR, JJS, JLH, KF, MAB, PA, PMH, RD, RLH, RM, SC and VLA) receiving Rehabilitation Therapy and Nutrition Services (including PSR Mall groups and direct treatment) to assess compliance with C.2.e found seven records in partial compliance (BJW, DM, JJS, KF, PMH, RM and SC) and seven records not in compliance (FR, JLH, MAB, PA, RD, RLH and VLA). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Focus, objective, and intervention associated with the service provided are not included in the WRP.
2. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP.
3. Foci, objectives and interventions are not consistently aligned in the WRP.

A review of records of 18 individuals (AC, ALH, CM, CPP, DR, ERM, GSZ,

		HL, JC, JWR, LJ, PM, PMH, SET, SHP, SW, TG and TP) who had IA-RTS assessments and Rehabilitation Therapy focused assessments during the review period to assess compliance with C.2.e found five records in substantial compliance (AC, DR, JWR, SHP and TP), eight records in partial compliance (ALH, CM, GSZ, HL, JC, LJ, PM and SW), and five records not in compliance (CPP, ERM, PMH, SET and TG). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Focus, objective, and intervention associated with the assessment provided are not included in the WRP. 2. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 3. Foci, objectives and interventions are not consistently aligned in the WRP. A review of records of 13 individuals (ADF, AMP, BA, CC, CDJ, FTR, JCY, LB, LL, RLF, RR, SC and SMR) with completed Nutrition Care assessments across sub-types to assess compliance with having an adequate focus, objective and intervention integrated into the WRP found five records in substantial compliance (CC, FTR, JCY, RR and SMR) and eight records in partial compliance (ADF, AMP, BA, CDJ, LB, LL, RLF and SC). An identified pattern of deficiency that the facility should focus on in order to improve compliance is that WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Same as in C.2.c, C.2.f, C.2.g and C.2.o.

C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Monitor this requirement based on at least a 20% sample. **Findings:** MSH used the DMH WRP Chart Auditing Form (August 2008 to January 2009) to assess compliance with the requirements in C.2.f.i through C.2.f.v. The average sample was 27% of the quarterly and annual WRPCs held each month. The following summarizes the data:

5.	*The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.*	21%
5.a	*All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change*	53%
5.b	*The individual's strengths are used in the interventions.*	49%
5.c	*There is documented rationale in the focus area if*	12%

	any focus of hospitalization does not have an objective or an intervention.	

Comparative data showed mixed changes in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
5.	15%	21%
Compliance rate in last month of period		
5.	12%	38%
5.a	55%	64%
5.b	24%	51%
5.c	10%	8%

MSH also used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the WRPCs each month. The following summarizes the data:

7.	*The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.*	56%
7.a	*Strengths are identified and incorporated into the interventions offered.*	69%
7.b	*The strengths are related to each treatment, rehabilitation or enrichment objective.*	59%

Comparative data showed decreased compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
7.	57%	56%
Compliance rate in last month of period		
7.	83%	65%
7.a	87%	87%
7.b	83%	65%

Recommendation 2, September 2008:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
The facility's WRP training and monitoring activities are summarized in C.1.a.

Other findings:
This monitor reviewed the charts of five individuals (AEE, CF, EAB, JE and RCB). The review found compliance in two charts (EAB and JE) and partial compliance in three (AEE, CF and RCB).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

<table>
<tr><td></td><td></td><td>compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.</td></tr>
<tr><td>C.2.f.ii</td><td>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</td><td>

Current findings on previous recommendation:

Recommendation, September 2008:
Same as in C.2.f.i.

Findings:
MSH used the DMH WRP Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 27% of the quarterly and annual WRPCs held each month. The following summarizes the data.

<table>
<tr><td>6.</td><td>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</td><td>66%</td></tr>
<tr><td>6.a</td><td>There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR mall.</td><td>73%</td></tr>
<tr><td>6.b</td><td>There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.</td><td>81%</td></tr>
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Comparative data showed improvements in compliance since the previous review as follows:

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>22%</td><td>66%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>26%</td><td>84%</td></tr>
<tr><td>6.a</td><td>40%</td><td>87%</td></tr>
<tr><td>6.b</td><td>50%</td><td>87%</td></tr>
</table>

Other findings:
This monitor found compliance in all five charts reviewed (AEE, CF, EAB, JE and RCB).

Compliance:
Partial.

Current recommendation:
Same as in C.2.f.i.
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<tr>
<td>C.2.f.iii</td>
<td>write the objectives in behavioral, observable, and/or measurable terms;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Same as in C.2.f.i.

Findings:
The facility reported two inconsistent values for mean compliance rate during this review period, precluding a comparison to the previous review period. The facility reported that the compliance rate for the last month of the current review period was 88% compared to 33% in the last month of the previous review period.
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		Other findings: This monitor found compliance in two charts (JE and RCB), partial compliance in one (AEE) and noncompliance in two (CF and EAB). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.i.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 60% compared to 45% during the last review period. The compliance rate for the last month of the current review period was 61%, compared to 67% in the last month of the previous review period. **Other findings:** This monitor found compliance in three charts (AEE, JE and RCB), partial compliance in one (CF) and noncompliance in one (EAB). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.i.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what,	**Current findings on previous recommendation:**

	within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Recommendation, September 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 67% compared to 15% during the last review period. The compliance rate for the last month of the current review period was 57%, compared to 14% in the last month of the previous review period. **Other findings:** This monitor found compliance in three charts (AEE, JE and RCB) and partial compliance in two (CF and EAB). **Compliance:** Partial. **Current recommendation**: Same as in C.2.f.i.
C.2.f.vi	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;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Monitor hours of active treatment (scheduled and attended). **Findings:** Since the last review, MSH has developed a number of tools and strategic plans to assist teams in achieving compliance with EP requirements, including a Lesson Plan Development Manual; training protocols for providers on incorporating strengths, preferences, and interests identified during assessment into service delivery; hospital-wide CASAS testing to identify individuals' needs; curricula in Spanish; standardized PSR Mall schedules across the facility; clinical needs assessment across the hospital to establish a course offerings baseline; reliability and

integrity analysis of the MAPP scheduling; a Course Catalog indicating groups organized by Foci; and a newly designed PSR Services intranet and MAPP Reports Portal.

MSH conducted a demonstration of the MAPP portal for this monitor. The newly developed system is an excellent instrument that will assist the facility in obtaining real-time information about activities, group caps, current membership, attendance, and group availability. This application should make it much easier for WRPTs to align and assign individuals to appropriate PSR services. The PSR Mall Services staff also set up useful resources to assist disciplines and PSR service providers in developing curricula, in developing lesson plans, and in preparing Mall group activities.

The table below showing the average number of individuals in the facility (N) during this review period, the category of hours in five-hour increments, the mean hours scheduled per category, and the mean hours attended is a summary of the facility's data:

	Number of individuals by category	
	Mean scheduled hours	Mean attended hours
N	666	666
Hours:		
0-5	40	43
6-10	40	66
11-15	92	199
16-20	494	358

The non-adherence list showed 113 individuals for January 2009.

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

by individuals.

Findings:
This monitor compared the documentation of active treatment hours listed in the WRP and corresponding MAPP data regarding hours scheduled and attended for seven individuals. The table below is a summary of the findings:

Individual	WRP scheduled	MAPP scheduled	MAPP attended
BE	11	14	3
CH	16	20	14
DY	14	20	3
JF	20	18	8
LL	12	20	3
SL	12	14	3
SW	15	18	1

The mean Mall hours scheduled in the WRPs of these individuals is 14.3 hours per week, the mean hours shown in the MAPP data is 17.7 hours per week, and the mean hours attended for these individuals is poor at five hours per week. There continue to be differences between Mall groups scheduled in the individuals' WRPs and the scheduled hours shown in the MAPP report. The Enhancement Plan Coordinator indicated that the facility is addressing this deficiency.

As the table above also shows, WRPTs do not always assign individuals to their maximum 20 hours per week of Mall participation, though in some cases the WRPTs have assigned individuals to more than 20 Mall hours per week (for example JG and CAC).

Barriers to compliance include: WRPTs fail to consistently write appropriate interventions in all active foci into the WRP; WRPCs and

		other activities are being conducted during Mall hours; there is inadequate discipline coverage for staff absences; and there appears to be a lack of reliability and integrity with the current MAPP data and reporting system. According to the PSR Mall services staff, MAPP data reports are not centralized through the Mall Director's office. A structural analysis of Programs III and V identified gaps between assessed needs, treatment provision, and available physical space to conduct the necessary number of Mall groups. To improve compliance, MSH plans to restructure MAPP data reporting and enhance end user utility including presentation of real-time information about activities, classroom caps, current membership, attendance, and group availability during WRPCs; correct the MAPP errors; establish a database and reporting system for discipline-specific assessment data to PSR Services; increase discipline involvement and self-monitoring in active treatment service provision, increase the number of groups provided in Spanish and align the course catalog with identified resources to provide system stability. PSR Services will also consult with the Coordinator of Psychology Specialist Services regarding issues related to the integration of BY CHOICE into treatment and community activities, utilize CASAS data to identify areas of educational weakness and develop training protocols for group providers on compensatory teaching strategies, establish a database and reporting system regarding individuals' progress through discipline- and content-specific curricula, reanalyze participation data relative to provided data to obtain reliable data on non-attendance. **Compliance:** Partial. **Current recommendations**: 1. Monitor hours of active treatment (scheduled and attended). 2. Correct factors related to inadequate scheduling by the WRPTs,

		inaccurate reporting of hours scheduled on the WRP and MAPP, disconnection between WRP and MAPP data and inadequate participation by individuals.
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Monitor this requirement using at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Improve data presentation regarding actual delivery of programs in the community. **Findings:** Using the DMH Chart Auditing Form, MSH assessed its compliance using 61% of the quarterly and annual WRPs due each month of this review period (August 2008 to January 2009) of individuals whose legal and clinical status allows for off-facility PSR Mall activities: 10. *Off-facility activities are scheduled in the interventions for those individuals whose legal and clinical status allows them to be off-facility for PSR Mall activities* — 25% Comparative data indicated improvement in mean compliance from the previous review period: Mean compliance rate 10. — Previous period: 13%; Current period: 25%

	Previous period	Current period
Compliance rate in last month of period		
10.	10%	9%

It appears that the data is not valid because of confusion over the definition used to determine this criterion. MSH has at times included data for individuals who were out of the compound but inside the facility. The definition has now been revised (MH-C 9006). In addition, many of the off-facility trips did not have proper objectives and/or interventions stated in the intervention sections of the individuals' WRPs.

This monitor interviewed Kevin Buckheim, the Mall Coordinator for Programs 1 and 2, who has oversight of this process. According to the Mall Coordinator, MSH is considering a number of changes to ensure that the process meets EP requirements and achieves compliance. The plan is to ensure that all qualifying individuals have identified Social and Independent Living Skills according to their cognitive levels, and are engaged in the community during their off-facility PSR Mall activities. MSH also plans to move the program to the afternoon so that they can have sufficient time to practice their skills in the community.

This monitor reviewed the charts of ten individuals who were admitted under civil commitments (AW, BMY, DY, FR, JP, KRS, LO, NV, SO and TP). Based on the functional status, maladaptive behaviors, and triggers documented in the individuals' WRPs, this monitor determined that five of the individuals (AW, BMY, DY, KRS and LO) were eligible for off-facility trips for PSR Mall activities. The remaining five (FR, JP, NV, SO and TP) had various behaviors (for example, elopement, dangerousness to self and/or other challenging behaviors) that precluded their participation in the off-facility activities. However, of the five that qualified, only one (BMY) had been off the facility as part of the Mall trip

		during this review period. To improve compliance, MSH will develop a database to provide PSR Services with discipline-specific data, and use the data to consult with facilitators on the development of PSR groups specific to the community including Course Outlines and Lesson Plans. WRPTs will review the WRPs of all individuals eligible for community treatment and write community integration interventions into individuals' WRPs as required, and address low compliance at the department level. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using at least a 20% sample 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Improve data presentation regarding actual delivery of programs in the community.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using the Mall Alignment Monitoring Form. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance using 16% of all quarterly and annual WRPs due each month of this review period (August 2008 to January 2009). The following is a

summary of the data:

1.	*Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs*	28%
1.a	*According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP, or*	28%
1.b	*The reviewed course outlines' content is aligned with the corresponding objectives in the individual's WRP.*	16%

As the table above shows, the facility found minimal alignment between the course outlines and the individual's WRP, and that course outlines did not align well with the current group offerings.

Comparative data showed mixed changes since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	20%	28%
Compliance rate in last month of period		
1.	11%	15%
1.a	11%	15%
1.b	11%	0%

		Four of the WRPs (CDJ, GM, PDF and RS) in the ten charts (CDJ, DAC, GM, HDF, JA, JDB, JM, KRD, PDF and RS) reviewed by this monitor were in compliance. The remaining six were missing and/or were deficient in one or more of the elements to meet compliance. **Recommendation 3, September 2008:** Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs. **Findings:** This monitor reviewed six charts (BB, DAC, EGW, NB, RMB and SB). Five (BB, DAC, EGW, NB and RMB) contained a number of Mall progress notes. Most of the notes did not provide the information needed to adequately develop and revise the WRP, or the information provided was in error or internally inconsistent. The information in the progress notes were integrated into three of the WRPs (BB, DAC and EGW). According to MSH, the data collected from August to December were unreliable due to inconsistent procedures. The facility now has changed the data collection method (MH-C 9020) with improved reliability of alignment data in January 2009. WRPTs were not writing interventions into the WRP correctly, were scheduling individuals for groups that were not clinically indicated, or were scheduling one type of group multiple times during the course of the week. In addition, the facility found that there was a lack of involvement by disciplines in the Course Outline and Lesson Plan development. To improve compliance, MSH will increase discipline-specific monitoring and mentoring of WRPTs regarding the correct scheduling of groups and writing of objectives in the WRP, and will address areas of low compliance at the departmental level.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the Mall Alignment Monitoring Form. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** 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. **Other findings:** This monitor found partial compliance in two charts (JE and RCB) and noncompliance in three (AEE, CF and EAB). Additionally, a review of records of nine individuals (BJW, DEM, FR, GSZ, JS, KS, MAB, PA and PMH) receiving direct Occupational and Physical Therapy services found eight records in compliance (BJW, FR, GSZ, JS, KS, MAB, PA and PMH) and one record not in compliance (DEM). **Compliance:** Partial. **Current recommendation**: Same as C.2.t.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendation 1 and 2, September 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. **Findings:** MSH used the DMH WRP Chart Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. MSH implemented a draft tool during December 2008 and January 2009 which did not include item 11. The facility reported that this has been modified and data will be available during the next review.

The average sample was 27% of the WRPCs held each month. The following summarizes the data:

11.	*The team revised 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).*	14%

Comparative data showed mixed changes in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
11.	41%	14%
Compliance rate in last month of period		
11.	0%	50% (Nov)

MSH reported that it is expected that the implementation of the new DMH Risk Management Special Order in December 2008 will improve compliance with this indicator. This new procedure contains mechanisms to identify thresholds and triggers, to communicate thresholds and triggers to the WRPTs and track timeliness of WRP revisions.

Other findings:
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (AB, BMY, DMW, RR, RWL and TME). The review focused on the documentation in the present status section of the circumstances leading to the use of restrictive interventions, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of

		future occurrences. The review found partial compliance in five charts (AB, BMY, DMW, RR and RWL) and noncompliance in one (TME). The main deficiencies involved the following areas: 1. Consistency between the present status section of the case formulation (risk factors) and nursing documentation regarding the events that led to the use of seclusion and/or restraints (TME); 2. Discussion of the circumstances that triggered the use of seclusion and/or restraint; 3. Treatment provided to avert the use of restrictive intervention; and 4. Modification of the treatment to decrease future risk. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the revised monitoring tool based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the quarterly and annual WRPCs held each month. The item number (but not content) changed during this review period due to deletion of other items within the tool. The following summarizes the data:

7.	*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.*	61%
7.a	*The team reviews all foci that are barriers to discharge.*	90%
7.b	*The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.*	63%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
7.	59%	61%
Compliance rate in last month of period		
7.	52%	65%
7.a	87%	87%
7.b	52%	65%

The facility reported that it intends to improve compliance in this area with the mentoring/training outlined in C.1.a above.

		Other findings: This monitor reviewed the charts of five individuals (AEE, CF, EAB, JE and RCB). The review focused on the documentation of individualized discharge criteria and the discussion of the individual's progress towards discharge (in the present status section of the case formulation). The review found partial compliance in three charts (AEE, EAB and JE) and noncompliance in two (CF and RCB). There was a persistent pattern of deficiencies involving the development of individualized criteria other than the legal criteria, and the documentation of the individuals' progress towards discharge. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i.

Recommendation 2, September 2008:
Same as in C.2.f.viii.

Findings:
Same as in C.2.f.viii.

Other findings:
MSH used the DMH WRP Observation Monitoring Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the quarterly and annual WRPCs held each month. The item number (but not content) changed during this review period due to deletion of other items within the tool. The following summarizes the data:

8.	*Base progress reviews and revision recommendations are on data collected as specified in the therapeutic and rehabilitation service plan.*	46%
8.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.*	45%
8.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	61%

Comparative data showed mixed changes in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
8.	48%	46%

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>8.</td><td>43%</td><td>55%</td></tr>
<tr><td>8.a</td><td>52%</td><td>55%</td></tr>
<tr><td>8.b</td><td>38%</td><td>68%</td></tr>
</table>

This monitor found compliance in one chart (EAB) and partial compliance in four (AEE, CF, JE and RCB). The review found that the facility had implemented the DMH revised format of the Mall Facilitator Note, that the notes were completed in a timely manner and that the content of the notes were adequate to inform the WRP review in most cases. However, the main deficiency involved the WRPTs' integration of information in these notes in the reviews and revisions of the WRPs.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using DMH WRP Observation Monitoring Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.
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<tr>
<td>C.2.h</td>
<td>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that all PBS plans are trained to certification across environments before implementation.</td>
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Findings:
Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance using 100% of the PBS plans in effect during this review period (August 2008 to January 2009):

<table>
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<td>14.</td>
<td>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.</td>
<td>92%</td>
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</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period. According to MSH sub-indicator "b" in the table above has been removed and no longer is audited.

This monitor's findings from review of eight plans (AB, BMY, CG, CH, DY, LS, MCL and WH) are in agreement with the facility's data. Documentation and data were presented on staff training and fidelity checks for the PBS plans. The PBS teams track and monitor behavior intervention needs of individuals through the task tracking form, trigger data, and WRPT referrals. MSH also uses the PSSC to ensure that individuals needing assessment/intervention are tracked and monitored.

Compliance:
Substantial.

Current recommendation:
Ensure that all PBS plans are trained to certification across environments before implementation.

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<tr>
<td>C.2.i</td>
<td>Adequate active psychosocial rehabilitation is provided, consistent with generally accepted</td>
<td>

Compliance:
Partial.

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	professional standards of care, that:	
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions. **Findings:** Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance using 16% of all WRPs due each month during the review period (August 2008 to January 2009):

2.	*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions*	21%
2.a	*All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP*	21%
2.b	*The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning*	5%

Comparative data indicated improvement in mean compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	0%	21%
Compliance rate in last month of period		
2.	0%	26%

2.a	0%	26%
2.b	0%	0%

This monitor reviewed eleven charts (CDJ, DAC, DG, GM, HDF, KIM, KRD, PF, RMB, RS and WOS). The individual's needs were appropriately addressed through the foci, objectives, and interventions in four of the WRPs in the charts (CDJ, DAC, GM and RS) and a number of deficiencies were noted in the remaining seven WRPs in the charts (DG, HDF, KIM, KRD, PF, RMB and WOS), including the absence of an appropriate Mall group, incorrect stages of change, and poor alignment of the objectives and recommended PSR Mall services.

Recommendation 2, September 2008:
Ensure that group leaders are consistent and enduring for specific groups.

Findings:
According to the Mall Director, MSH has a system in place to capture enduring group providers, and all current facilitators are enduring providers to their specific groups (exceptions are when providers are absent due to illness or vacation).

This monitor observed a few Mall groups. Interview of the providers and select individuals in these groups indicated that these providers were enduring to their specific groups.

Recommendation 3, September 2008:
Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.

Findings:
MSH psychologists offer Motivational Interviewing, which is designed to

		address an individual's adherence to his/her assigned PSR services. The facility did not provide any Narrative Restructuring Therapy (NRT) due to staffing shortage. A new staff member hired to provide NRT is undergoing training. **Other findings:** A review of records of 18 individuals (BJW, DEM, FR, GSZ, IR, JJS, JLH, JS, KS, MAB, PA, PMH, RD, RLH, RM, SC, TDR and VLA) receiving Rehabilitation Therapy Services (including PSR Mall groups and direct treatment) to assess compliance with C.2.i.i found all records in compliance. **Current recommendations**: 1. The WRPT should select all available group and individual therapies that will meet the needs of the individual and then allow the individual to choose from these interventions. 2. Ensure that group leaders are consistent and enduring for specific groups. 3. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that each objective is directly linked to a relevant focus of hospitalization. **Findings:** Using the DMH WRP Chart Auditing Form, MSH assessed its compliance based on 27% of all WRPs due each month during the review period (August 2008 to January 2009):

7.	*The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.*	69%

Comparative data showed progress in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
7.	23%	69%
Compliance rate in last month of period		
7.	33%	88%

Six (GD, KDL, KJE, KRD, LJ and LJS) of the nine WRPs in the charts reviewed by this monitor had their objectives written in an observable/measurable manner, and the remaining three did not (CF, JCY and JVM).

WRPT members do not always write objectives in an observable/ measurable manner. To improve compliance, MSH plans to continue to train and mentor to ensure that WRPT members consistently write all objectives in an observable/measurable manner. The Director of Nursing will ensure that all nurses receive competency-based training in writing objectives and interventions. The facility will also increase oversight of Focus 6 objectives by nursing and nursing mentors.

Current recommendation:
Ensure that each objective is directly linked to a relevant focus of hospitalization.

C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and	**Current findings on previous recommendations:**

	Recovery Plan	**Recommendation 1, September 2008:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** Same as C.2.i.ii. **Recommendation 2, September 2008:** Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. **Findings:** Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance using 16% of all WRPs due each month during the review period (August 2008 to January 2009): 1. *Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP* — 28% 1.a *According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP, or* — 28% 1.b *The reviewed course outlines' content is aligned with the corresponding objectives in the individual's WRP.* — 16% Comparative data showed modest improvement in mean compliance since

the previous review period as follows:

	Previous period	Current period
Mean compliance rate		
1.	20%	28%
Compliance rate in last month of period		
1	11%	15%
1.a	11%	15%
1.b	11%	0%

This monitor reviewed 15 charts (DG, DKL, GD, JCY, JF, JVM, KGE, KIM, KJ, KRD, LAD, LJS, PF, RMB and WOS). The therapies and rehabilitation services provided in the Malls and the individual's assessed needs were aligned in nine of the WRPs in the charts (GD, JCY, JF, JVM, KGE, KJ, KRD, LAD, and LJS). The services provided in the remaining five WRPs (DG, DKL, KIM, PF, RMB and WOS) were not aligned with the individual's needs. In a number of cases, the individual's life goals did not have a focus and interventions and/or the services were not provided at the individual's cognitive level.

Changes in the Course Outline and Lesson Plan format (introduced in October 2008) resulted in unreliable data collection, which affected compliance. MSH now has corrected the data collection methods by revising MH-C 9020. An additional barrier is that WRPTs write interventions incorrectly, schedule individuals to groups not clinically indicated, or schedule the same type of group multiple times during the course of the week. Curricula and lesson plans have not been completed by the various disciplines. To improve compliance, MSH will increase discipline-specific monitoring and mentoring of WRPTs regarding the scheduling of groups and writing of objectives. Low compliance with this recommendation will be dealt with at the departmental level.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms.
2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.</td></tr>
<tr><td>C.2.i.iv</td><td>utilizes the individual's strengths, preferences, and interests;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.

Findings:
Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance using a 4% sample of the Mall group facilitators for the review month (August to November, 2008):

<table>
<tr><td>5.</td><td>The group facilitator utilizes the individual's strengths, preferences, and interests. The group facilitator can:</td><td>44%</td></tr>
<tr><td>5.a</td><td>The group provider utilizes one of the individual's strengths, preferences and/or interests.</td><td>44%</td></tr>
<tr><td>5.b</td><td>The group provider correctly identifies at least one of the individual's strengths, preferences and/or interests and the provider can state how and when it was last used in the group.</td><td>41%</td></tr>
</table>

Comparative data showed mixed changes for compliance since the last review as follows:</td></tr>
</table>

	Previous period	Current period
Mean compliance rate		
5.	29%	44%
Compliance rate in last month of period		
5.a	42%	*18%

*This datum is for November 2008. MSH did not present audit data for December 2008 and January 2009. Item 5.b is a new sub-indicator and has no previous data for comparison.

This monitor reviewed nine charts (CF, GD, JCY, JVM, KDL, KJE, KRD, LJ and LJS). Appropriate strengths were stated in the intervention sections in three of the WRPs in the charts (CF, JVM and LJ), while the interventions in the remaining six WRPs (GD, JCY, KDL, KJE, KRD and LJS) failed to include any strengths/preferences/interests or the stated strengths/preferences/interests were poor and not ones the facilitator can apply in the Mall sessions to motivate the individual to achieve his/her objectives.

WRPTs continue to have difficulty writing appropriate strengths specific to the intervention that facilitators could use to motivate individuals in their groups to achieve their objectives/goals. To improve compliance, MSH plans to increase discipline-specific monitoring and mentoring of PSR facilitators and address low compliance at the departmental level.

Current recommendation:
Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual and that the facilitators are aware of these.

C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue to undertake the clinical case formulation as a team rather than by assigning the task to a team member or to non-team members, and ensure that the documentation in the Present Status 6section reflects the practice. **Findings:** This monitor observed three WRPCs during this tour (AMP, EM and LS). In all cases, the core team members presented their findings relative to their areas of practice. However, in a number of cases the findings were not thoroughly discussed. The WRPTs spent too much time in the initial items of section B, leaving very little time for some of the more important areas (for example, discharge barriers). The monthly reviews were more like seven-day and fourteen-day reviews. **Recommendations 2 and 3, September 2008:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities. **Findings:** MSH's response to this recommendation is "WRPTs are not consistently including the individual's vulnerabilities in the case formulation," and "The WRPTs are not consistently recording changes in the individuals' vulnerabilities to mental illness, substance abuse, and readmission due to relapse in the Present Status section, and thus not following through in the focus, objectives and interventions." This monitor reviewed nine charts (CDJ, DAC, GM, HDF, JA, KFB, KRD, PDF and RS). The individual's vulnerabilities were documented in the case

formulation section in four of the WRPs in the charts (DAC, GM, KFB and PDF) and where appropriate the vulnerabilities were updated in the subsequent WRPs; this was not the case in the remaining five WRPs (CDJ, HDF, JA, KRD and RS).

Recommendation 4, September 2008:
Continue to train the substance abuse facilitators using the stage model from the training manual.

Findings:
In November 2008, MSH hired a new Coordinator of Substance Abuse and Recovery (SAR) Services and trained the Coordinator on the DMH SAR treatment program plan of improvement. MSH also hired three Psychiatric Technicians who received the same training as the Coordinator. The newly hired Coordinator has reviewed and revised the SAR Course Outlines and Lesson Plans for the Pre-Contemplation, Contemplation, Preparation, and Action stages of the SA curriculum to align with the proposed DMH Substance Abuse Treatment Program Plan of Improvement. MSH plans to roll out the revised SAR treatment program and curricula at the next Mall cycle, and train staff who have not received the required training.

Recommendation 5, September 2008:
Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

Findings:
Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance using a 16% sample of the WRPs due for the review month (August 2008 to January 2009):

3.	*The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the*	53%

	individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate	

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	77%	53%
Compliance rate in last month of period		
3.	50%	62%

According to MSH, all individuals are not assigned to WRAP groups in Focus 11 because WRPTs did not understand the nature and purpose of WRAP. To improve compliance, Social Work services is to develop and implement a new curriculum and progress tracking system for WRAP groups and ensure that WRPTs assign all individuals to WRAP groups.

Current recommendations:

1. Continue to undertake the clinical case formulation as a team rather than by assigning the task to a team member or to non-team members, and ensure that the documentation in the Present Status section reflects the practice.
2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
3. Update the Present Status section of the individual's WRP to reflect the current status of these vulnerabilities.
4. Continue to train the substance abuse facilitators using the stage model from the training manual.
5. Provide groups regarding the purpose of Wellness Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. • Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** MSH continues to assess cognitive levels of individuals via the Integrated Assessment: Psychology Section upon admission of the individual and via cognitive assessments when warranted based on the individual's change of functioning. In addition, MSH has taken steps to improve the cognitive assessment, and assignment of individuals to PSR Mall groups according to their cognitive levels, including the identification of 125 individuals diagnosed with cognitive and/or developmental impairment, DCAT-restructured PSR service delivery by way of enhanced reinforcement schedule and staffing resources to maximize individuals' learning opportunities, and the standardization of materials and programs for individuals with cognitive limitations. Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed its compliance using a 1% sample of the Mall group facilitators WRPs due for the review month (August to January 2009): 16. *Material is presented in a manner consistent with each individual's cognitive strengths and limitations. The group facilitator can:* 67% 16.a *Identify a cognitive strength and limitation of a group participant, and* N/A 16.b *Describe how the cognitive strength and limitation* N/A

	was taken into account by the facilitator during the group.	

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
16.	26%	67%
Compliance rate in last month of period		
16.	30%	100%

The sub-indicators are new and do not have data for comparison. MSH should increase the sample size audited.

Barriers to compliance include that PSR Services has not received all the required discipline-specific assessment data and that WRPTs sometimes fail to align the available data with the individuals' objectives and interventions and assigned Mall groups.

To improve compliance, PSR Services is working with the appropriate leadership and disciplines to achieve the following: establish a database and reporting system for discipline-specific assessment data, increase the number of Spanish groups, integrate the BY CHOICE system into the treatment and community activities, use the CASAS data identify areas of educational weakness and develop training protocols for groups providers to improve their competency on teaching strategies, meet with the Neuropsychology team and DCAT leadership to establish cut-off criteria for specialized treatment programs, including the STAR and Cognitive Rehabilitation programs, develop standardized criteria for specialized group placements, and improve the tracking and monitoring of the data on PSR treatment non-adherence.

		Current recommendations: 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. • Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. • Use the data from monthly Mall Progress Notes in the WRP review process. **Findings:** MSH's Mall Progress Note system is not fully automated. This process is expected to be in full compliance when the WaRMSS MAPP2 module is completed and implemented. The table below showing the required number of progress notes for each program (N), the number of progress notes received by the WRPTs from each program (n), and the mean compliance (%C) is a summary of the facility's data:

	P1	P2	P3	P5	P6	Mean
N	304	648	1736	1680	656	1005
n	137	460	955	756	492	560
%C	45	71	55	45	75	58

MSH's mean compliance to completing Mall Progress Notes and making them available to WRPTs showed progress, going from a mean of 39% from the previous review period to a mean of 58% during this review period.

This monitor reviewed six charts (BB, DAC, EGW, NB, RMB and SB). Four of the charts (BB, EGW, NB and RMB) contained a fair number of the required Mall progress notes, one (DAC) had only two Mall progress notes, and one (SB) did not contain any Mall progress notes. Three of the WRPs (BB, DAC, and EGW) in the charts containing Mall progress notes had reviewed and referenced the Mall progress notes in the Present Status section of the individual's WRP.

To improve performance and compliance, MSH will increase monitoring and mentoring of this process at the program, WRPT, and facilitator levels.

Other findings:
A review of records of 20 individuals (BJW, DEM, DM, FR, GSZ, IR, JJS, JLH, JS, KF, KS, MAB, PA, PMH, RD, RLH, RM, SC, TDR and VLA) receiving Rehabilitation Therapy Services (including PSR Mall groups and direct treatment) to assess compliance with C.2.i.vii found eighteen records (BJW, DEM, DM, FR, GSZ, IR, JJS, JS, KF, KS, MAB, PA, PMH, RD, RLH, SC, TDR and VLA) in partial compliance and two records (JLH and RM) not in compliance.

Current recommendations:
1. Ensure that all group and individual therapy providers provide the

		WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Continue the current practice of providing Mall services for five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. • Provide groups as needed by the individuals and written in the individuals' WRPs. • Add new groups as the needs are identified in new/revised WRPs. **Findings:** MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered. The following table showing the census (N) for the review month (August 2008 to January 2009), the hours of services offered per week for each month, and the hours of participation under each category is a summary of the data:

	8/08	9/08	10/08	11/08	12/08	1/09	Mean
N	699	678	681	666	648	625	666
0-5 hrs/wk	43	27	54	31	24	87	43

6-10 hrs/wk	15	23	50	155	44	137	66
11-15 hrs/wk	56	100	248	313	314	176	199
16-20+ hrs/wk	585	528	329	167	266	226	358

MSH's PSR Services has expanded the number of Mall groups offered to accommodate the needs of the individuals in its facility, including eight groups conducted in Spanish.

Barriers to compliance include: PSR Mall service staff is awaiting the discipline-specific assessment data to develop more focused groups for the individuals; MSH continues to conduct WRPC and other activities during Mall hours, negatively impacting Mall service delivery; PSR Mall Service is experiencing difficulty in adding and/or scheduling Mall groups due to staffing shortage; and PSR Mall Service identified shortcomings in the physical space to provide sufficient services according to the individuals' assessed needs.

To improve compliance, PSR Mall Service plans to stabilize Program III, restructure Program V Mall services to align with the rest of the facility, restructure MAPP data reporting, establish a database and reporting system for discipline-specific assessment data to PSR Services, increase the number of groups provided in Spanish, establish a database and reporting system regarding individuals' progress through discipline- and content-specific curricula and reanalyze participation data relative to provider data.

Current recommendations:

1. Continue the current practice of providing Mall services for five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each

		individual or two hours a day when the individual is in school, except days falling on state holidays; 2. Provide groups as needed by the individuals and written in the individuals' WRPs. 3. Add new groups as the needs are identified in new/revised WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH did not have any bed bound individuals during this monitor's visit to the SNF units. Observation in the unit, interview with the staff, and documentation in the charts found that staff transports individuals with limited mobility in wheelchairs when needed. MSH has had five individuals designated as bed-bound during this review period. The table below with the individuals'/program and the hours of services delivered for each month of the review period (August 2008 to January 2009) is a summary of the data.

Monthly Hours of Active Treatment Delivered							
Individual (Program)	8/08	9/08	10/08	11/08	12/08	1/09	Mean
DC/VI	28	39	34	45	35	30	33.5
DE/VI	16	46	16	2	7	8	16
JP/VI	36	45	1	28	15	13	23
LB/VI	20	27	16	22	19	10	19
SB/VI	33	39	42	48	48	25	39

This monitor's documentation review (Mall group scheduled/delivered and chart review for hours attended) found that MSH offered services to

		individuals in bed-bound status based on their availability, health status and willingness to participate. This monitor's findings from chart reviews of three individual's (DE, DC, and JP) designated as bed-bound are in agreement with the facility's data. PSR Services is to work with Program VI staff to standardize groups and develop specific materials and training programs for bed-bound individuals'. **Current recommendation**: Continue current practice.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. • Ensure that Mall groups and individual therapies are cancelled rarely, if ever. **Findings:** According to the Mall Director, once the discipline-specific data is received and analyzed, and WRPTs better trained, the Mall group offerings will be more specific to the individuals' needs, including their cognitive, medical, and physical and functional status. MSH evaluated the number of hours of services scheduled against the number completed. The table below showing the number of hours of services scheduled (N) for each month of the review period (August 2008 to January 2009), the number of hours of services not completed (n), and

the percent cancelled (%C) is a summary of the data:

	8/08	9/08	10/08	11/08	12/08	1/09	Mean
N	44,772	44,683				35,487	41,647
n	2,606	5,499				4,188	4,098
%C	6	12				12	10

As shown in the table above, MSH did not present data for October to December 2008. A mean of 10% of the scheduled Mall groups had been cancelled for the remaining three months of this review period.

According to the Mall Director, PSR Services' analysis of the data on Mall group cancellations found that the actual number of cancellations was underreported. MSH will correct the understanding so that the data pulled from MAPP report is correct.

Recommendation 3, September 2008:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
MSH's data as shown in the table below shows that none of the disciplines facilitated the minimum number of hours of Mall groups.

Discipline	Hours Scheduled/Week	Hours Provided
Psychiatry	95	56 (59%)
Psychology	232	173 (75%)
Social Work	272	210 (77%)
Rehab Therapy	372	282 (76%)
Nursing	515	338 (66%)
Other	119	45 (38%)*

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

Findings:
As shown in the table below, the administrators and support staff also did not facilitate the minimum of one hour of Mall groups required of them.
<table>
<tr><th>Discipline</th><th>Hours Scheduled</th><th>Hours Provided</th></tr>
<tr><td>Administration</td><td>57</td><td>38 (67%)</td></tr>
</table>
Insufficient number of providers and inconsistent participation by providers causes the PSR Mall staff to cancel the scheduled groups or find stand-in providers who often are not well prepared. Documentation review found that the Medical Director had sent notification to the Psychiatry staff that they provide only four hours of Mall services per week.

Current recommendations:
1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.
3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.
4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
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<tr>
<td>C.2.i.xi</td>
<td>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</td>
<td>Current findings on previous recommendations:</td>
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</table>

Recommendations 1 and 2, September 2008:

- Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.
- Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

Findings:

MSH has assigned Nursing Coordinators in each program as Enrichment/ Supplemental Activity Coordinators. MSH also developed and implemented a Facilitator Consultation process form to monitor and improve services. The Enrichment Activity data were reviewed at the monthly Program Director's meetings to track and monitor attendance and participation. Enrichment (Supplemental) data was reviewed monthly in the Hospital-wide Performance Improvement and Program Director meeting to assess for progress and improve services.

The table below showing the hours of Enrichment Activities scheduled for each month of this review period (N), the number of hours of activities offered (n), and the mean percentage compliance (%C) is a summary of the facility's data.

	8/08	9/08	10/08	11/08	12/08	1/09	Mean
N	18	33	25	22	25	23	25
n	13	14	15	13	16	15	14
%C	72	42	60	59	64	65	59

As the table above shows, MSH actually offers only about half of the activities scheduled (mean of 25 hours scheduled vs mean of 14 hours offered), with a mean of 60% attendance. These numbers remain about the same as from the previous review. According to the Mall Director, the data are unreliable because of incorrect data entry and insufficient

		staffing during the NOC shift. Nevertheless, MSH has made improvements in other areas including responding to individuals' requests for Enrichment Activities, for example the requests for additional activities through the council meetings were developed and implemented, attendance rosters have been developed and used to track attendance, and Rehabilitation Therapists have conducted training of activity providers. MSH has added more than 50 new enrichment activities to its program since the last review. A review of the activity schedules for units 401, 407, 409, and 415 found that the times did not clash with other known interruptions for the individuals to participate in them. To improve compliance, MSH will develop standardized methodology for all activities offered and monitor to ensure that the NOC shift data is accurate. Program Directors will be responsible for ensuring accurate NOC shift data entry and will review offerings monthly and report to the Clinical Administrator actions taken to ensure that activities to enhance the individuals' quality of life are offered. **Current recommendations**: 1. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.

Findings:
This monitor reviewed six charts (BB, DAC, EGW, NB, RMB and SB). Only the milieu intervention documented in one chart (SB) was appropriate to the active intervention. In the remaining five (BB, DAC, EGW, NB and RMB) there were no milieu interventions or the milieu interventions documented were not aligned with the active interventions. For example, the milieu intervention for BB requires the unit staff to encourage the individual to participate in Mall groups; however the active intervention was not designed to encourage BB to attend the Mall groups because BB is not non-adherent.

Recommendation 2, September 2008:
Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.

Findings:
In the previous review MSH used item 12 (*Staff are observed discussing Mall activities with individuals*) from the Therapeutic Milieu Observation Monitoring Form. This item directly addresses this recommendation. However, for this review the facility used items 1-10 from the DMH Therapeutic Milieu Monitoring Form, to assess its compliance by observing interaction between staff and individuals on the units. The table below with its indicators and mean compliance is a summary of the facility's data.

1.	*During the 30-min observation, there is more staff in the milieu than in the nursing station.*	78%
2.	*There is some staff interacting (e.g., engaged in conversation or activity) with individuals.*	82%
3.	*There is evidence of a unit recognition program.*	53%
4.	*The posted unit rules reflect recovery language and principles.*	66%
5.	*The bulletin boards have any postings, literature, or*	55%

	materials that reflect religious or cultural activities.	
6.	*Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.*	100%
7.	*Staff is observed actively engaged with the individuals.*	92%
8.	*Staff interacts with individuals in a respectful manner.*	99%
9.	*Situations involving privacy occurred and they were properly handled.*	98%
10.	*If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.*	89%

Comparison of the data between this and the previous reviews is not possible because of the changes in the monitoring items. According to MSH, fluctuations in compliance data across the items were due to inconsistent applications of monitoring tool instructions. To improve compliance, MSH will increase Program Management involvement and monitoring of the therapeutic milieu and address areas of low compliance at the departmental level. MSH also will ensure that staff understand the requirements and reinforce it during Nursing Shift change, and implement the DMH Nursing Task Force policies.

Current recommendations:

1. Ensure that all WRPs have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff know what the individuals are learning in the Malls and individual therapies and reinforce their learning in all settings.

C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with	**Current findings on previous recommendations:**

generally accepted professional standards of care.

Recommendations 1 and 2, September 2008:

- Track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

Findings:

The BMI categories, the number of individuals in each BMI category, and the number and percentage of individuals assigned to exercise groups is a summary of the facility's data:

BMI Level	Individuals in each category	Individuals assigned to exercise groups	Percentage assigned
25 - 30	208	124	60%
31 - 35	131	80	61%
36 - 40	51	39	77%
>40	25	15	60%

The table above shows an increase in the number of individuals in each BMI category compared to the previous review period. The total number of individuals reported with BMI greater than 25 was 290 in the previous review period and 415 in the current period. The percentage of individuals in each category assigned to exercise groups showed mixed changes in comparison with the previous review. MSH should ensure that all individuals, and especially those in the higher categories of BMI, are enrolled in exercise programs.

MSH identified WRPTs' failures to write Focus 6 objectives as the main barrier to compliance. To improve compliance, the Medical Director and MSH's Director of Professional Education will to work with PSR Services to design and implement Metabolic Syndrome groups, establish minimum criteria for exercise groups, define Focus 6 group targets, and increase the number of medical staff providing active treatments.

		Compliance: Partial. **Current recommendations**: 1. Track and review participation of individuals in scheduled group exercise and recreational activities. 2. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment. **Findings:** MSH used the DMH C2k Family Therapy Auditing Form to evaluate compliance: 1. *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.* — 64% 1.a *General family education in the primary or preferred language of the family is provided to the family, either in person or by mail.* — NA 1.b *There is documentation in the 30-day Psychosocial Assessment, the SW assessed the family's ability and willingness to be involved in the individual's recovery, and* — NA 1.c *The Social Worker identified and documented potential barriers to the family's involvement in the individual's recovery.* — NA 2. *Long-Term: Efforts to involve the family, and* — 57%

	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.	
2.a	*There is documentation in the Present Status section of efforts to involve the family in the individual's WRPC and Recovery.*	NA
2.b	*In the individual's WRP, Focus 11 contains an objective that prepares the individual for his or her role within their family system, and*	NA
2.c	*There is documentation in the Present Status section that the identified barriers have decreased or there is evidence of continuing efforts to decrease the barriers.*	NA

MSH audited only the main indicators for items 1 and 2, excluding sub-indicators. According to the Chief of Social Work, after analysis, MSH recognized that the short form had been used to audit this recommendation. The short form included only the main indicators. There is no data for comparison between this review and the previous review.

Documentation review (list of individuals with assessed needs for Family Therapy) and interview of the Chief of Social Work found that MSH has provided services to a large number of individuals identified as needing family therapy/education. For example, four families participate in the individuals' WRPCs (Program 410), a number of families are attending family therapy groups at the facility, and SW staff makes regular phone contacts when families are unable to visit due to distance or health reasons. It appears that poor documentation is adversely affecting the facility's compliance with this recommendation. MSH should ensure that WRPTs document these family therapy/education/supports provided to

		the individuals. To improve compliance, MSH will implement the long version of MH-C 9086 that contains both the indicators and sub-indicators, increase the number of Supervising social work staff to improve coverage facility-wide, and develop family education materials on mental health, diagnosis, and treatment. **Compliance:** Partial. **Current recommendation**: Complete the needs assessments for all individuals and provide needed services as indicated by the needs assessment.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement. **Findings:** Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on an average sample of 22% of individuals with at least one diagnosis listed on Axis III who have a WRP due each month for the review period (August 2008 - January 2009). The following table outlines the indicators with corresponding mean compliance rates: 1. *All medical conditions listed in Axis III are included on the Medical Conditions Form.* 73% 2. *The WRP includes each medical condition listed on the Medical Conditions Form 42.* 49% 3. *There is an appropriate focus statement for each* 50%

	medical condition or diagnosis.	
4.	*There is an appropriate objective for each medical condition or diagnosis.*	15%
5.	*There are appropriate interventions for each objective.*	8%

MSH's data indicated overall increases in compliance with the exception of item 4:

	Previous period	Current period
Mean compliance rate		
1.	55%	73%
2.	39%	49%
3.	43%	50%
4.	18%	15%
5.	6%	8%
Compliance rate in last month of period		
1.	55%	84%
2.	38%	44%
3.	42%	52%
4.	18%	6%
5.	6%	7%

A review of 40 individuals' WRPs (AEE, AER, APQ, BB, BJW, BTM, CLW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JEF, JLA, JLG, JLW, JRF, KS, LAD, LEL, LES, LEY, LJS, LLW, MKC, MLD, MMS, PA, PAL, RDA, RO, RRA, RRR, RS, SL, SRC and TG) found that there has been little improvement in this area from the last review. The problematic areas continue to include inadequate, inappropriate and non-meaningful nursing objectives and interventions, which were found in most of the WRPs reviewed. Also, there were a number of medical conditions that were not listed on the

		Axis III diagnoses in the WRPs. Some issues identified on the admission and integrated nursing assessments were not integrated into the WRPs. In addition, there was very little evidence in the IDNs that interventions listed in the WRPs were actually being implemented, despite the fact the implementation of nursing interventions is part of the nursing process and standards of nursing practice. In three of four WRPCs observed by this monitor (Program I, Unit 410, Program V, Unit 405, and Program VI, Units 418 and 419), a number of the objectives and interventions were not appropriate; however, the nursing staff and the team progressed through the WRPC process without initiating modifications. The barriers to compliance identified by the facility with regard to this requirement included inconsistencies with the WRPTs writing objectives that are measurable, observable and/or behavioral for issues in Focus 6. Also, many of the objectives are not written in terms of what the individual will learn. In addition, the interventions listed in the WRPs frequently do not include the symptoms to be monitored due to some nurses not having adequate knowledge and experience in developing interventions for some medical conditions. Although MSH identified and trained RN mentors, they were not available to train RNs during this review period due to time constraints. Also, MSH indicated that a new staff member began conducting the audits during this review period. A number of individuals have multiple open Focus 6 problems and if one objective or intervention is not written according to the WRP manual, compliance must still be rated as a "NO" for compliance. MSH's plan of correction includes continuing training to ensure that all nurses can demonstrate the ability to write appropriate objectives and to identify the specific nurses who are having difficulty writing objectives and interventions correctly. The Health Service Specialists have been assigned to assist nurses on each unit in writing appropriate objectives

		and interventions. Also, the RNs are being provided one-on-one training sessions regarding the WRPs and are expected to appropriately modify existing plans. Additionally, the program management coordinators have been collaborating with the unit psychiatrists to update the WRPs, including appropriate objectives and interventions. These strategies should increase the quality of nursing objectives and interventions and thus the compliance rates regarding this requirement. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement plan of correction to increase compliance with this requirement. 2. Ensure that interventions in WRPs are being implemented as directed. 3. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	Not applicable. MSH does not serve children or adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in C.2.o.

	clinically indicated.	**Findings:** Same as in C.2.o. **Compliance:** Partial. **Current recommendation**: Same as in C.2.o.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement the Substance Abuse Treatment Program Plan of Improvement in all four facilities. **Findings:** MSH recently hired a new Coordinator of Substance Abuse and Recovery (SAR) Services, and three Psychiatric Technicians. The new Coordinator had reviewed and revised the Course Outlines and Lesson Plans for the Pre-Contemplation, Contemplation, Preparation, and Action stages of the SA curriculum to align with the proposed DMH Substance Abuse Treatment Program Plan of Improvement. The Coordinator and Psychiatric Technicians received training on the DMH Substance Abuse Treatment Program Plan of Improvement. MSH will implement the DMH Substance Abuse Treatment Program and new curricula by the next Mall cycle. Currently, MSH cares for 379 individuals with SA diagnoses. Twenty SAR groups were offered during this review period, serving a total of 263 individuals. This monitor noted, from a number of chart reviews, that WRPTs failed to assign PC 1370 individuals with SA problems to PSR services. WRPTs should ensure that all individuals with SA diagnoses are

		assigned to a SAR group, since the individual has a SA problem and the facility has trained facilitators and SAR groups to help them. **Recommendation 2, September 2008:** Provide process and clinical outcome data regarding substance recovery services, including comparative data when these data are available. **Findings:** MSH did not present outcome data. The new SAR Coordinator at MSH has redesigned and streamlined the process and clinical outcome data collection, and plans to work with PSR Services to develop SA Group parameters. According to the Coordinator, SAR staff will track outcomes on weekly, monthly and quarterly bases using newly designed forms and systems. SAR staff also will use SOCRATES A and D for pre- and post-testing to assess alcohol and substance abuse awareness and collect relevant stage of change data, administer follow-up assessments using the Addiction Severity Index-5 (ASI-5) at the Contemplation stage to confirm and document previous diagnosis, and to assess further treatment needs with regard to SAR Services and collateral skills development. **Recommendation 3, September 2008:** Provide results of competency-based training of SR providers. **Findings:** Review of MSH's SAR provider training data found that all providers facilitating SA services had been trained using the Velasquez et al. (2001) Therapy Manual, SAMHSA TIP #35 and SAMHSA TIP #21. According to the Mall Director and the SAR Coordinator, DMH has proposed a DMH Substance Abuse Treatment Program Plan of Improvement for the four hospitals.

Recommendations 4 and 5, September 2008:

- Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).

Findings:

Using the DMH Substance Abuse Auditing Form, MSH evaluated its compliance using a 17% sample of all individuals with a Substance Abuse diagnosis:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	74%
2.	*There is an appropriate focus statement listed under Focus 5.*	92%
3.	*There is at least one objective related to the individual's stage of change.*	74%
4.	*There are interventions that are appropriately linked to the active objective(s).*	67%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.*	58%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	47%

Comparative data indicated mixed changes in compliance from the previous review period as follows:

	Previous period	Current period
Mean compliance rate		
1.	69%	74%
2.	95%	92%
3.	93%	74%
4.	92%	67%
5.	93%	58%
6.	36%	47%
Compliance rate in last month of period		
1.	98%	81%
3.	100%	81%
4.	100%	78%
5.	100%	57%
6.	50%	59%

This monitor reviewed the charts of seven individuals who were diagnosed with substance use disorders. The review found compliance in one chart (KS) and partial compliance in six (AMP, BNJ, JCY, JHT, JM, and RNM). The main deficiencies involved missing or insufficient integration of the issue in the case formulation, especially in the Present Status section; poor construction of the discharge criteria; and improper linkage of the stages of change to the objectives and interventions.

MSH attributed its data variability in the table above to WRPTs' inconsistency in assigning individuals to Substance Abuse interventions, writing SA objectives and interventions, and reviewing substance abuse and relapse progress. The facility expects that the implementation of the DMH Substance Abuse Treatment Program and new curricula in the next Mall cycle will result in improved compliance.

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

Current recommendations:
1. Monitor this requirement using Clinical Chart and Substance Abuse Audit Forms based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</td>
</tr>
<tr>
<td>C.2.p</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.

Findings:
According to the PSR Mall staff, MSH did not implement the DMH revised form (MH-C 9104) in November 2008. Using items 1-14 from the DMH Mall Facilitator Observation Monitoring Form, MSH evaluated its compliance using a 1% sample of all the Mall group providers in the review months (August 2008 to January 2009). The table below showing the indicators and sub-indicators with their corresponding mean compliance is a summary of the data:
<table>
<tr><td>1.</td><td>The session starts and ends within five minutes of the designated starting and ending time.</td><td>47%</td></tr>
<tr><td>2.</td><td>The facilitator greets participants to begin the session.</td><td>52%</td></tr>
<tr><td>3.</td><td>The facilitator reviews work from the prior session.</td><td>35%</td></tr>
<tr><td>4.</td><td>The facilitator introduces the day's topic and goals.</td><td>54%</td></tr>
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</table>

5.	*The facilitator shows a familiarity with the lesson plan, either verbally or as demonstrated during the group session.*	47%
6.	*The facilitator makes an attempt to engage each participant during the group.*	81%
7.	*The facilitator attempts to keep all participants on task during the session.*	81%
8.	*The facilitator's shows a presentation style that keeps some/all participants attentive and interested during the session.*	65%
9.	*The facilitator attempts to test the participants' understanding.*	67%
10.	*The facilitator presents information in a manner appropriate to the functioning level of the participants.*	59%
11.	*The facilitator summarizes the work done in the session.*	62%
12	*The facilitator/co-facilitator uses at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.*	83%
13.	*The room is arranged in a way that is as conducive to learning as possible.*	75%
14.	*Lesson is available and followed:*	37%
14.a	*The facilitator has the lesson plan available during the group.*	n/a
14.b	*The lesson plan is followed in the group.*	n/a

Data comparison is not applicable as MSH's data presentation for the previous review period represented only one discipline (Rehabilitation Therapy). In addition, the audit data and formatting is different.

As the table above shows, less than half of the Mall groups observed had

		lesson plans (item 14). Facilitators generally failed to apply standard methodology in their Mall facilitation such as reviewing work from prior sessions and introducing the day's topics and goals (items 3 and 4). It is discouraging to think that the providers were unfamiliar with the lesson plans (47%, item 5), which has contributed to their not addressing the individual's functioning levels (59%, item 10). It is encouraging to see that the facilitators employed a variety of instructional techniques (item 12) and engaged the individuals during the sessions (item 6). This monitor observed a number of Mall groups (Acceptance and Commitment, Substance Recovery, Coping Skills, and Medical Health and Wellness). The facilitators were prepared with lesson plans and activity material. The facilitators were active in facilitating the groups. The facilitators used language appropriate to the individuals' functioning levels (for example, the facilitators in the "Coping Skills" group, in which most of the individuals were at the challenged level), engaged the individuals and reinforced them for their participation. Ten individuals were attending the Coping Skills group; the roster had 24 individuals, but five other individuals not on the roster were regularly attending this group. Mean attendance in these groups was 42%. A number of facilitators reported that individuals in their groups displayed a range of cognitive functioning with different primary/preferred languages and were not benefiting from the groups. For example, the Medical Health and Wellness group had one individual (who was on 1:1) whose functioning level was much lower than most of the others in the group and in addition he was unable to sit with the others and was constantly moving about, which posed a distraction to other group participants. According to the PSR Mall staff, group roster, progress notes, and facilitator monitoring is not conducted by the discipline monitors/ auditors. To improve compliance, MSH will fully implement the DMH Mall Facilitator Observation Monitoring Form (MH-C 9104). MSH will increase monitoring and mentoring at the discipline, Program, and facilitator levels

		and address low compliance during performance evaluations. As disciplines write their own lesson plans for the Mall groups along with the training competency on those plans, provider training will be streamlined. **Compliance:** Partial. **Current recommendation**: Monitor the competency of all group facilitators and therapists in providing rehabilitation services, and specify what the training entailed, the total target population, the sample reviewed, and how competency was measured.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendations 1-4, September 2008:** • Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum. • Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. • Ensure that training includes all of the five stages of change. • Implement the review system and show data derived from the remedial training. **Findings:** According to the Mall Director, there was a Statewide MAPP system crash that affected MSH's data analysis. MSH also did not have a Substance Abuse Recovery Service Coordinator during this review period and did not conduct any Substance Abuse Recovery provider training during this review period. The table below showing the number of Substance Abuse Recovery Providers and co-providers (N), the number of certified SAR providers

<table>
<tr>
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<td>and co-providers (n), and the percentage of certified providers (%C) is a summary of the facility's data:

<table>
<tr><th colspan="8">Substance Abuse Group Facilitators and Co-Facilitators</th></tr>
<tr><th></th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Mean</th></tr>
<tr><td>N</td><td>56</td><td>56</td><td>x</td><td>x</td><td>x</td><td>41</td><td>51</td></tr>
<tr><td>n</td><td>56</td><td>56</td><td>x</td><td>x</td><td>x</td><td>41</td><td>51</td></tr>
<tr><td>%C</td><td>100</td><td>100</td><td>x</td><td>x</td><td>x</td><td>100</td><td>100</td></tr>
</table>

The table above shows an absence of data from October to December, 2008, due to a Statewide MAPP system crash. The available data as seen in the table above shows that all Substance Abuse Recovery providers and co-providers were trained.

MSH plans to continue the training of providers and monitoring of their competency in providing Substance Abuse Recovery Services, and to ensure that WRPTs assign individuals with Substance Abuse diagnoses to PSR services with appropriate objectives and interventions.

Compliance:
Partial.

Current recommendations:
1. Ensure that all group facilitators complete the substance abuse training curriculum as per MSH training curriculum.
2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum.
3. Ensure that training includes all of the five stages of change.
4. Implement the review system and show data derived from the remedial training.
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</tr>
<tr>
<td>C.2.r</td>
<td>Transportation and staffing issues do not preclude individuals from attending appointments.</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

Recommendations 1 and 2, September 2008:

- Review reasons for cancellations and assess and correct factors contributing to such events.
- Complete and implement the Medical Scheduler.

Findings:

The table below is a summary of the facility's data:

Missed Appointments Monitoring – Medical Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
Aug 2008	1387	296(21%)	1 staffing 6 transportation 289 other
Sep 2008	1510	297(20%)	3 staffing 2 transportation 292 other
Oct 2008	1410	295(21%)	9 staffing 0 transportation 286 other
Nov 2008	1138	241(21%)	1 staffing 0 transportation 240 other
Dec 2008	1613	267(17%)	4 staffing 0 transportation 263 other
Jan 2009	526	279(53%)	6 staffing 0 transportation 273 other

As shown in the table above, cancellations range from 17% and 53% per month. The cancellation for January 2009 (53%) is very high. Staffing and transportation are not typically significant contributors to

		cancellations. MSH should continue to identify the reasons and minimize if not eliminate the other reasons contributing to the high rate of cancellations. MSH is awaiting DMH's Statewide Medical Scheduling System to address this recommendation and implement the Medical Scheduler. **Compliance:** Partial. **Current recommendations**: 1. Review reasons for cancellations and assess and correct factors contributing to such events. 2. Complete and implement the Medical Scheduler.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. • Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. • Develop and implement monitoring systems that address all of the required elements. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 16% of the WRPs due each month during the review period (August 2008 to January 2009): 10. *Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that* — 80%

	individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.	
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.*	83%
10.c	*All interventions are offered at the cognitive functioning level of the individual*	83%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	89%	80%
Compliance rate in last month of period		
10.	94%	79%
10.a	94%	82%
10.c	94%	76%

Data presented in the table in C.2.p. for item 10 (*The facilitator presents information in a manner appropriate to the functioning level of the participants*) also indicates that facilitators continue to have difficulty presenting information at the cognitive levels of the individuals in their groups. This could be a function of the facilitator's skills, the heterogeneity of the groups, and assignment of individuals to groups

		unsuitable to the individual's cognitive functioning. According to MSH, the decline in compliance was due to improper application of the definition of cognitive levels. To improve compliance, MSH plans to increase discipline-specific monitoring and mentoring of WRPTs and address areas of low compliance at the departmental level. Facilitators are to be trained to use specific teaching strategies to target deficits in learning as identified by CASAS educational and discipline-specific psychodiagnostic data. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Continue to develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure positive clinical outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

Findings:
MSH is using the DMH WRP Clinical Chart Auditing Form as the monitoring tool to evaluate the process outcomes and positive clinical outcomes of treatment and/or rehabilitation services, as well as to audit the alignment of Mall activities with the elements in the individual's WRP. This tool adequately addresses all the elements in the recommendations.

Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 16% of WRPs due each month during the review period (August 2008 to January 2009):

11.	*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)*	6%
11.a	*Each objective is observable, measurable and behavioral.*	36%
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.*	85%
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP.*	54%
11.d	*If the individual has not made progress on an objective in two months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	28%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	67%

Comparative data showed general decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
11.	18%	6%
Compliance rate in last month of period		
11.	18%	10%
11.a	46%	51%
11.b	100%	77%
11.c	67%	36%
11.d	35%	29%
11.e	73%	90%

This monitor reviewed 20 charts (BB, CF, DAC, DG, DS, EGW, GR, JCY, JF, KDL, KJE, KS, LAD, LJS, MMS, NB, PF, RMB, SB and TG). The groups and individual therapies in fifteen of the WRPs in the charts (BB, SB, DAC, EGW, RMB, NB, JVM, KRD, GF, LJS, JCY, JF, CF, MMS, and KJE) were linked directly to the foci, objective, and interventions specified in the WRP with five of them revising the objectives and interventions based on the individual's progress or lack thereof. Seven of the WRPs (BB, DS, JF, KS, NB, RMB and TG) contained all or most of the required Monthly Mall Progress Notes for the active treatments in the individual's WRP, and only one (BB) had reviewed and addressed the information in the Mall progress notes.

MSH identified as barriers to compliance the facts that WRPTs are not writing objectives in a behavioral and/or observable manner and utilizing Mall progress notes when assessing individuals' progress or lack thereof.

To improve compliance, MSH will increase discipline-specific monitoring and mentoring. MSH will also monitor and mentor WRPTs to use the PSR

		Mall Progress notes in progress assessment and objective/ intervention modifications. **Compliance:** Partial. **Current recommendations**: 1. Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof 2. Ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. • Provide data regarding providers of this education by discipline and hours of education. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The following table showing the Mall terms, the number of individuals identified as needing the education, and the number of individuals receiving the education is a summary of the facility's data:

Individuals Needing and Provided WRP Education Groups During the Current and Prior Three Mall Terms				
	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
Individuals with identified need	469	590	X	278
Individuals receiving service	469	590	X	278

As the table above shows, all individuals with the identified need received the education in the first quarter 2009 Mall term. MSH did not present data for the fourth quarter 2008 Mall term.

The table below shows the number of WRAP groups scheduled and held, and the number of individuals' scheduled.

Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (January 2008 to March 2009,	
Sessions scheduled	19
Sessions held	19
Percentage held	100%
Number of individuals scheduled	278
Number of individuals attended at least one group per month	X
Percentage attendance	X

As the table above shows, 100% of the scheduled groups were held. MSH did not present data on the number of individuals attending at least one group per month or on the attendance rate.

To improve compliance, MSH will increase discipline involvement and self-monitoring of WRP education groups and address areas of low compliance

		at the department level. MSH also will implement sponsor materials obtained from ASH. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. 2. Provide data regarding providers of this education by discipline and hours of education. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Provide data regarding number of individuals in need for this education and number and hours of education provided to meet this need. Clarify the method used in needs assessment. **Findings:** The facility has yet to establish a mechanism to identify individuals in need of medication education groups. The following table illustrates the number of these groups offered during the current and three previous Mall terms. The facility did not report data for October-December 2008 due to problems with the MAPP system.

Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009
55 (91 hrs)	52 (87 hrs)	X	24 (49 hrs)

Recommendation 2, September 2008:
Provide data regarding providers of this education by discipline and hours of education.

Findings:
MSH reported that during the January-March 2009 Mall term, 100% of medication education groups were facilitated by psychiatrists or trained nursing staff.

Recommendation 3, September 2008:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
The facility reported that it intends to finalize and implement standardized medical education group curricula for the next Mall term.

Compliance:
Partial.

Current recommendations:
1. Develop a mechanism to identify individuals in need of Medication Education Groups.
2. Provide data regarding number of:
   a. Individuals in need of Medication Education Groups;
   b. Number of individuals scheduled for Medication Education Groups;
   c. Number of Medication Education Groups offered; and
   d. Hours (per week) of Medication Education Groups.

C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement a system of trigger notifications and tracking of response by the WRPTs. **Findings:** MSH uses the monthly trigger report built into the current trigger reporting system. The Psychology WRPT members attend the trigger meetings through which the WRPTs are notified. MSH has conducted training of the WRPT members concerning the need to develop alternative strategies when trigger is met. The facility has not implemented a system to track the WRPT's response to the notification of the trigger data. According to the Enhancement Plan Coordinator, information on committee meetings' reviews and responses on triggers are entered into a database. This information is reviewed on a weekly basis by the WRPTs, and the discipline chiefs also receive the database. **Recommendation 2 and 3, September 2008:** • Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. • Provide data regarding: a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.

		Findings: MSH did not present data to these recommendations. MSH did not have the staff to provide the services needed to non-adherent individual'. MSH only recently (January 2009) hired three staff to provide Narrative Restructuring Therapy (NRT). Additional barriers to compliance include analysis of attendance/non-adherent data based on percentage of hours scheduled rather than percentage of hours provided and the lack of a standardized program at MSH to motivate individuals to participate in Mall groups. To improve compliance, MSH will train the newly hired staff to provide NRT and provide the therapy facility-wide and ensure that WRPT response to triggers is tracked. **Compliance:** Partial. **Current recommendations**: 1. Implement a system of trigger notifications and tracking of response by the WRPTs. 2. Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups. 3. Provide data regarding: a. All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers); b. The number of individuals receiving these interventions; and c. The number of individuals who trigger non-adherence to WRP in the key indicators.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. MSH has made further progress in the finalization of diagnoses listed as NOS, deferred and/or rule out. 2. MSH has achieved substantial compliance with the requirement regarding initial medical assessments. 3. MSH has made further progress in the quality of the admission and integrated psychiatric assessments. 4. MSH has provided adequate CME programs to address a range of relevant topics including needs of individuals suffering from neuropsychiatric disorders. 5. MSH has improved the timeliness of the weekly psychiatric reassessments. **Summary of Progress on Psychological Assessments:** 1. MSH has maintained and improved upon compliance in all aspects of psychological assessments. 2. MSH has significantly increased the number of psychological, assessments (a total of 390 assessments) in various domains including Focused Assessments, Neuropsychological Assessments, Cognitive/Academic Assessments, and Integrated Assessments: Psychology Section **Summary of Progress on Nursing Assessments:** 1. MSH has made significant progress in ensuring that each section of the Nursing Admission and Integrated Assessments is completed and will be focusing training and auditing on improving the quality of the assessments. 2. The timeliness of the Nursing Admission Assessments has remained in substantial compliance.

		Summary of Progress on Rehabilitation Therapy Assessments: 1. Quality of D.4 admission and focused assessments has improved. 2. Data analysis based on requisite audit samples for each area of D.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Assessments:** 1. Timeliness and quality of D.5 Nutrition assessments has continued to improve across all assessments types. 2. Data analysis based on requisite audit samples for each area of D.5 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Social History Assessments:** MSH has maintained the level of progress achieved at the time of the last review in some elements and made some progress in other elements, but overall did not make any significant improvement since the last review. **Summary of Progress on Court Assessments:** MSH has achieved substantial compliance with the requirements regarding court reports for individuals admitted under PC 1026 and PC 1370.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Bala Gulasekaram, MD, Chief of Psychiatry 2. Behnam Behnam, MD, Chief of Professional Education 3. Michael Barsom, MD, Medical Director Reviewed: 1. The charts of the following 37 individuals: AB, AC, AM, APQ, BMY, CB, CN, CP, DE, DMW, EA, EWC, FPR, GWB, IIG, JGH, JR, LEY, LB, MD, MG, NB, OH, PAS, RJA, RLH, RR, RRR, RS, RU, RWL, SD, SM, SS, TMC, TME and YH 2. MSH list of all individuals with their diagnoses and medication regimens 3. MSH CME Program: Dementia 4. MSH CME Program: Assessment of Cognitive Disorders 5. DMH streamlined Monthly Psychiatry Progress note Template 6. DMH Admission Psychiatric Assessment Auditing Form 7. MSH Admission Psychiatric Assessment summary data (August 2008 to January 2009) 8. DMH Integrated Psychiatric Assessment Auditing Form 9. MSH Integrated Psychiatric Assessment Auditing summary data (August 2008 to January 2009) 10. MSH Admission Medical Assessment Auditing Form 11. MSH Admission Medical Assessment Auditing summary data (August 2008 to January 2009) 12. DMH Monthly Physician Progress Note (PPN) Auditing Form 13. MSH Monthly PPN Auditing summary data (August 2008 to January 2009) 14. DMH Weekly PPN Auditing Form 15. MSH Weekly PPN Auditing summary data (August 2008 to January 2009)

<table>
<tr><td></td><td></td><td>16. DMH Physician Transfer Note Auditing Form
17. MSH Physician Transfer Note Auditing summary data (August 2008 to January 2009)</td></tr>
<tr><td>D.1.a</td><td>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.</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:

- Continue to monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample.
- Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:

MSH used the DMH Admission Assessment, Integrated Assessment: Psychiatry Section and Monthly Physician Progress Note auditing forms to assess compliance (August 2008 to January 2009). The average samples were 95% (of admission assessments), 77% (of integrated assessments) and 21% (of monthly notes for individuals who had been hospitalized for more than 90 days), respectively. The following tables summarize the data:

<table>
<tr><th colspan="3">Admission Assessment</th></tr>
<tr><td>4.</td><td>Admission diagnosis is documented.</td><td>96%</td></tr>
<tr><td>4.a</td><td>Admission diagnoses Axis I-V are addressed</td><td>99%</td></tr>
<tr><td>4.b</td><td>DSM-IV diagnosis consistent with history and presentation</td><td>97%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period:

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

Integrated Assessment		
2.b	*Statements from the individual are included, if available.*	98%
2.d	*Diagnosis and medications given at previous facility are included*	85%
7.	*Includes diagnostic formulation*	84%
8.	*Includes differential diagnosis*	77%
9.	*Includes current psychiatric diagnoses*	80%

Comparative data showed mixed changes in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
2.d	47%	85%
7.	77%	84%
8.	56%	77%
9.	92%	80%
Compliance rate in last month of period		
2.d	39%	100%
7.	67%	97%
8.	47%	80%
9.	83%	80%

Monthly PPN		
3.b	*Current diagnoses (evidence is present to support changes, if applicable, Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.)*	96%
3.b.1	*The note includes the 5-axis diagnosis and this is consistent with the current presentation and*	97%

	recent developments	
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	56%
3.b.3	*Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution*	50%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Other findings:
Chart reviews by this monitor found that the facility has made further progress in correcting the deficiencies in the admission and integrated psychiatric assessments. However, some deficiencies persisted (see other findings of D.1.c.ii, D.1.c.iii and D.1.f) that must be corrected to achieve substantial compliance with this section.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing forms, based on at least 20% samples.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The facility has maintained current practice. All psychiatrists at the facility have successfully completed at least three years of psychiatry residency training in a program approved by the Accreditation Council for Graduate Medical Education. The facility reported that all psychiatrists are continually encouraged to obtain board certification. The facility currently has 36 psychiatrists who provide direct clinical services. This is consistent with 39 during the previous review. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide the number of allocated and filled FTEs relevant to this indicator.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Provide documentation, without identification of individual practitioners, of performance improvement/corrective actions that were implemented to address trends/patterns in the physician quality profile data.

		Findings: MSH reported that supervising physicians (Senior Psychiatrists, Chief of Psychiatry, Medical Staff President and Medical Director) review performance data with each individual physician. The facility reported that practitioner-specific patterns and trends in performance are contained within the Physician Performance Profiles and are included in the discussion with practitioners. The facility reported that a systemic trend (inadequate documentation of the monitoring for potential adverse medication effects in at-risk populations) was noted through review of the Physician Performance Profiles. The Chief of Professional Education facilitated the development and implementation of guidelines for the use of benzodiazepine and anticholinergic medications as corrective actions. **Compliance:** Partial. **Current recommendation:** Describe and specify the indicators and process used in the current reprivileging system.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.

		Findings: This recommendation was not addressed during the review period. **Recommendations 2 and 3, September 2008:** • Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The facility did not provide data on initial medical assessments for this cell. Rather, the data presented was reflective of the initial psychiatric assessments. The mean compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. The sub-indicators and facility's analysis are listed as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals. The review found compliance in nine charts (CP, EA, OH, PAS, RR, RU, SD, SM and SS) and partial compliance in one (CN). There was evidence of consistent implementation of the DMH revised template for the admission medical assessment. This template provided correction of the previously noted deficiencies in the plan of care. **Compliance:** Partial.

		Current recommendations: 1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Continue to monitor completeness of the admission medical examination within the specified time frame and follow-up regarding incomplete items on the examination, based on at least a 20% sample. 3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.c.i.1	a review of systems;	98%.
D.1.c.i.2	medical history;	99%.
D.1.c.i.3	physical examination;	98%.
D.1.c.i.4	diagnostic impressions; and	99%.
D.1.c.i.5	management of acute medical conditions	99%, compared to 87% during the last review period.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure full implementation of the new DMH template for the Admission Psychiatric Assessment. **Findings:** MSH has implemented the DMH template for admission psychiatric assessments.

		Recommendations 2 and 3, September 2008: • Continue to monitor the Admission Psychiatric Assessment using the DMH standardized instrument. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** MSH used the DMH Admission Psychiatric Assessment Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 95% of the admissions each month. Comparative data indicated maintenance of compliance greater than 90% from the previous review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS) The review found compliance in seven charts (CN, EA, OH, PAS, RR, RU and SM) and partial compliance in three (CP, SD and SS). Overall, the facility has made significant progress in this area since the last review period, including evidence of consistent implementation of the DMH revised template for the admission psychiatric assessment. However, in order to reach substantial compliance with this requirement, further improvement is needed to resolve the following deficiencies: 1. The assessment did not address the individual's thought process (SS). 2. The assessment did not include specific information regarding the nature of visual hallucinations (SD). 3. The assessment did not include information regarding the individual's

<table>
<tr><td></td><td></td><td>insight (CN).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</td></tr>
<tr><td>D.1.c.ii.1</td><td>psychiatric history, including a review of presenting symptoms;</td><td>
<table>
<tr><td>2.</td><td>Psychiatric history, including review of presenting symptoms</td><td>93%</td></tr>
<tr><td>2.a</td><td>Identifying data including legal status</td><td>100%</td></tr>
<tr><td>2.b</td><td>Discharge diagnosis and condition</td><td>97%</td></tr>
<tr><td>2.c</td><td>Reason for admission and chief complaint</td><td>99%</td></tr>
<tr><td>2.d</td><td>History of present illness</td><td>99%</td></tr>
<tr><td>2.e</td><td>Psychiatric history</td><td>98%</td></tr>
<tr><td>2.f</td><td>Substance abuse history</td><td>99%</td></tr>
<tr><td>2.g</td><td>Allergies</td><td>99%</td></tr>
<tr><td>2.h</td><td>Current medications</td><td>99%</td></tr>
</table>
The facility reported a mean compliance rate of 93% compared to 81% during the last review period.
</td></tr>
<tr><td>D.1.c.ii.2</td><td>complete mental status examination;</td><td>97%.</td></tr>
<tr><td>D.1.c.ii.3</td><td>admission diagnoses;</td><td>96%.</td></tr>
</table>

<table>
<tr><td>D.1.c.ii.4</td><td>completed AIMS;</td><td>98%.</td></tr>
<tr><td>D.1.c.ii.5</td><td>laboratory tests ordered;</td><td>100%.</td></tr>
<tr><td>D.1.c.ii.6</td><td>consultations ordered; and</td><td>99%.</td></tr>
<tr><td>D.1.c.ii.7</td><td>plan of care.</td><td>
<table>
<tr><td>8.</td><td>Plan of care</td><td>90%</td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>93%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>83%</td></tr>
<tr><td>8.c</td><td>Special precautions to address risk factors as indicated</td><td>92%</td></tr>
</table>
The mean compliance rate for the main indicator increased to 90% from 84% during the previous review period.
</td></tr>
<tr><td>D.1.c.iii</td><td>within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</td><td>
Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:
• Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument.
• Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).

Findings:
MSH used the DMH Integrated Assessment Psychiatry Section Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 77% of the integrated assessments due each month. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.
</td></tr>
</table>

		The mean compliance rates for the other requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of 10 individuals who were admitted during this review period (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS). Overall, the reviews found further improvement in the timeliness and quality of the integrated assessments. However, there continue to be some deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. One assessment (PAS) did not include a chief complaint and there was no explanation for this omission. 2. The assessment of SS did not include a statement regarding presence or absence of current suicidal ideations, intent or plan in the mental status examination. 3. The mental status examination of SD included inadequate assessment of perceptual disturbances despite the documented history of recent command hallucinations. 4. The chart of OH included inadequate assessment of the individual's memory without justification. 5. There was no assessment of insight and judgment in the chart of EA. 6. The cognitive examination was not completed in the chart of RU due to the individual's inability to cooperate with testing, but the examination was not completed at a later date when the individual's status improved. 7. The mental status examinations often included generic findings regarding the individual's insight and judgment without specific information to justify the findings (OH, PAS, RR, SD and SS). 8. The diagnostic formulation was inadequate in a few assessments (CN and SS). 9. One assessment did not include a plan of care to address a non-

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<td>specified diagnosis of cognitive impairment and the simultaneous prescription of a combination of high risk medications that can worsen this condition (SM).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.</td>
</tr>
<tr>
<td>D.1.c.iii.
1</td>
<td>psychiatric history, including a review of present and past history;</td>
<td>
<table>
<tr><td>2.</td><td>Psychiatric history, including a review of present and past history.</td><td>84%</td></tr>
<tr><td>2.a</td><td>Identifying data including legal status.</td><td>99%</td></tr>
<tr><td>2.b</td><td>Statements from the individual are included, if available.</td><td>98%</td></tr>
<tr><td>2.c</td><td>Chief complaint</td><td>97%</td></tr>
<tr><td>2.d</td><td>Diagnosis and medications given at previous facility are included.</td><td>85%</td></tr>
<tr><td>2.e</td><td>Effectiveness of medications from previous facility is included</td><td>88%</td></tr>
<tr><td>2.f</td><td>Past psychiatric history is documented including a review of pertinent physical exam status.</td><td>95%</td></tr>
</table>

Comparative data showed improvements in compliance since the previous review as follows:
</td>
</tr>
</table>

	Previous period	Current period
Mean compliance rate		
2.	36%	84%
Compliance rate in last month of period		
2.	31%	100%
2.a	83%	100%
2.b	97%	100%
2.c	100%	100%
2.d	39%	100%
2.e	50%	100%
2.f	77%	100%

D.1.c.iii.2

psychosocial history;

3.	*Psychosocial history is documented.*	71%
3.a	*Developmental history*	92%
3.b	*Family history*	98%
3.c	*Educational history*	93%
3.d	*Religious and cultural influences*	78%
3.e	*Occupational history*	93%
3.f	*Marital status*	90%
3.g	*Sexual history*	78%
3.h	*Legal history*	93%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
3.	37%	71%

	Previous period	Current period
Compliance rate in last month of period		
3.	53%	100%
3.a	96%	100%
3.b	83%	100%
3.c	92%	100%
3.d	72%	100%
3.e	83%	100%
3.f	86%	100%
3.g	68%	100%
3.h	72%	100%

D.1.c.iii.3

mental status examination;

4.	*Complete mental status examination is documented*	51%
4.a	*Attitude/cooperation*	98%
4.ba	*General appearance*	100%
4.c	*Motor Activity*	99%
4.d	*Speech*	98%
4.e	*Mood/affect*	95%
4.f	*Thought process/content*	98%
4.g	*Perceptual alterations*	98%
4.h	*Fund of general knowledge*	72%
4.i	*Abstraction ability*	68%
4.j	*Judgment*	61%
4.k	*Insight*	75%
4.l	*MMSE*	84%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
4.	34%	51%
Compliance rate in last month of period		
4.	17%	60%
4.a	97%	100%
4.b	94%	100%
4.c	97%	100%
4.d	81%	100%
4.e	81%	87%
4.f	86%	100%
4.g	89%	100%
4.h	86%	100%
4.i	67%	73%
4.j	44%	87%
4.k	74%	100%
4.l	67%	93%

The facility's data analysis identified particular deficits in assessment of insight, judgment and abstract thinking. As a corrective action, medical administration staff provided in-service training to admission psychiatrists and their supervisors on these areas. MSH also implemented the CAF to provide individualized feedback to practitioners.

D.1.c.iii.4	strengths;	92%.
D.1.c.iii.5	psychiatric risk factors;	

6.	*Psychiatric risk factors are documented*	61%
6.a	*Risk for suicide*	87%
6.b	*Risk for self-injurious behavior*	76%

6.c	*Risk factors for seclusion (medical and emotional)*	88%
6.d	*Risk factors for restraint (medical and emotional)*	88%
6.e	*Risk for aggression*	96%
6.f	*Risk for fire setting*	82%
6.g	*Risk for elopement*	82%
6.h	*Risk for victimization*	78%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
6.	39%	61%
Compliance rate in last month of period		
6.	39%	80%
6.a	69%	87%
6.b	54%	93%
6.c	83%	93%
6.d	83%	93%
6.e	83%	100%
6.f	89%	100%
6.g	70%	100%
6.h	95%	100%

The facility reported that as a result of audit data analysis, medical administration staff provided in-service training to admission psychiatrists on guidelines for all risk assessments. MSH also implemented the CAF to provide individualized feedback to practitioners.

D.1.c.iii.6	diagnostic formulation;	84%, compared to 77% during the last review period. The rate for the last month of this review period was 87% compared to 67% during the

<table>
<tr><td></td><td></td><td>last review period.

MSH reported that review of audit data identified two psychiatrists with low compliance in the areas of diagnostic formulation, differential diagnosis and diagnostic consistency with history and current presentation. Senior Psychiatrists and Medical Administration provided enhanced mentoring to these staff during this review period.</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>77%, compared to 56% during the last review period. The rate for the last month of this review period was 80% compared to 47% during the last review period.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>80%, compared to 92% during the last review period. The rate for the last month of this review period was 80% compared to 81% during the last review period.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td>57%</td></tr>
<tr><td>10.a</td><td>Current target symptoms</td><td>82%</td></tr>
<tr><td>10.b</td><td>Specific medications to be used</td><td>96%</td></tr>
<tr><td>10.c</td><td>Dosage titration schedules, if indicated</td><td>80%</td></tr>
<tr><td>10.d</td><td>Adverse reactions to monitor for</td><td>63%</td></tr>
<tr><td>10.e</td><td>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</td><td>64%</td></tr>
<tr><td>10.f</td><td>Response to medications since admission, if applicable including PRN and Stat medications.</td><td>92%</td></tr>
<tr><td>10.g</td><td>Medication consent issues were addressed.</td><td>96%</td></tr>
</table>
Comparative data showed improvements in compliance since the previous review as follows:
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>10.</td><td>16%</td><td>57%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>14%</td><td>87%</td></tr>
<tr><td>10.a</td><td>51%</td><td>100%</td></tr>
<tr><td>10.b</td><td>94%</td><td>93%</td></tr>
<tr><td>10.c</td><td>64%</td><td>100%</td></tr>
<tr><td>10.d</td><td>25%</td><td>86%</td></tr>
<tr><td>10.e</td><td>50%</td><td>71%</td></tr>
<tr><td>10.f</td><td>67%</td><td>100%</td></tr>
<tr><td>10.g</td><td>97%</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>D.1.c.iii.
10</td><td>management of identified risks.</td><td>62%, compared to 61% during the last review period. The rate for the last month of this review period was 80% compared to 37% during the last review period.</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;</td><td>Current findings on previous recommendations:

Recommendation 1, September 2008:
Continue medical education programs to improve diagnostic accuracy, including assessment of cognitive and other neuropsychiatric disorders. Provide information regarding affiliations of instructors and attendees.

Findings:
During the review period MSH offered 14 CME trainings. Two were related to cognitive and neuropsychiatric disorders. A summary follows:</td></tr>
</table>

Date	Title	Speaker/ affiliations	Attendees
8/13/08	Management of Acute Agitation	M. Makhinson, MD, PhD/ UCLA	43
8/27/08	New Updates in Schizophrenia	M. Valenceria, MD/ USC	29
10/18/08	Neuroleptic Extra-Pyramidal Side Effects	B. Behnam, MD/ MSH & Loma Linda University	47
10/22/08	Provision of Medical Care	M. Barsom, MD/ MSH & UCLA	44
10/29/08	Metabolic Syndrome	B. Behnam, MD/ MSH & Loma Linda University	39
11/12/08	Extra-Pyramidal Side Effects: Tardive Dyskinesia & Neuroleptic Malignant Syndrome	B. Behnam, MD/ MSH & Loma Linda University	37
11/19/08	Individualizing Evidence Based Medicine in T. Ketter, MD the Treatment of Bipolar Disorder	T. Ketter, MD/ Stanford University	38
12/10/08	Seizure Disorders	B. Behnam, MD/ MSH & Loma Linda University	37
12/17/09	Schizophrenia: Optimizing Patient Medication	R. Bera, MD/ University of California Irvine	30

	Adherence for Improved Outcomes	(UCI)	
01/14/09	Suicide	B. Behnam, MD/ MSH & Loma Linda University	31
01/21/09	Medical Malpractice in a Hospital Setting	K. Sharma, MD/ USC	43
01/28/09	Assessment of Cognitive Disorders	T. Oskaragoz, PhD/MSH	42
02/11/09	Dementia	B. Behnam, MD/ MSH & Loma Linda University	32

Recommendation 2, September 2008:
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.

Findings:
MSH did not provide data related to the number of individuals with Rule Out, Deferred or NOS diagnoses.

Other findings:
This monitor found that the number of individuals who have received diagnoses listed as NOS for three or more months has decreased further since the last review. However, the charts of several individuals who continued to have these diagnoses contained deficiencies in the documentation of efforts to finalize the diagnosis, as indicated, the assessment of the cognitive impairments, as indicated and/or alignment of the diagnostic information in the current WRP with the corresponding

<table>
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<td>psychiatric progress notes. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following table outlines the chart reviews:

<table>
<tr><th>Initials</th><th>Diagnosis</th></tr>
<tr><td>AC</td><td>Psychotic Disorder NOS</td></tr>
<tr><td>AM</td><td>Dementia NOS</td></tr>
<tr><td>APQ</td><td>Dementia NOS and Psychotic Disorder NOS</td></tr>
<tr><td>LEY</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>NB</td><td>Mood Disorder, NOS and Eating Disorder NOS</td></tr>
<tr><td>PAS</td><td>Psychotic Disorder NOS</td></tr>
<tr><td>RJA</td><td>Cognitive Disorder, NOS</td></tr>
<tr><td>RS</td><td>Psychotic Disorder NOS</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Continue medical education programs to improve diagnostic accuracy and subsequent treatment, including:
a. Assessment of cognitive and other neuropsychiatric disorders and
b. Selecting modes of treatment based upon neuropsychological status.
2. Provide information regarding affiliations of instructors and attendees for each medical education program.
3. 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.</td>
</tr>
<tr>
<td>D.1.d.ii</td>
<td>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Same as in D.1.a.</td>
</tr>
</table>

		Findings: Same as in D.1.a. **Compliance:** Partial. **Current recommendation**: Same as in D.1.a.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in D.1.i. **Findings:** Same as in D.1.i. **Compliance:** Partial. **Current recommendation**: Same as in D.1.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Continue current practice. • Provide information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review of justification and results of this review.

		Findings: MSH reported that it had continued its practice. The facility indicated that at the time of the review, no individual had received "no diagnosis" on Axis I. **Other findings:** Chart reviews by this monitor found no evidence of "no diagnosis" listed on Axis I. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review of justification and results of this review.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Continue to monitor this requirement and provide separate data for weekly and monthly notes. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period). **Findings:** MSH used the DMH Weekly Physician Progress Note (PPN) Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 59% of individuals with a length of admission less than 60 days. The following summarizes the data:

1.	*The reassessments are completed weekly for the first 60 days on the admission units:*	80%
1.a	*There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.*	83%
1.b	*The note must contain the subjective complaint, objective findings, assessment and plan of care*	95%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	76%	80%
Compliance rate in last month of period		
1.	77%	78%
1.a	77%	78%
1.b	100%	100%

MSH also used the DMH Psychiatry Monthly PPN Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 30% of individuals with a length of admission greater than 90 days. The mean compliance rate reported for this review period was 71%, compared to 66% during the last review. The rate for the last month of this review period was 78% compared to 73% during the last review period.

Other findings:
This monitor reviewed the charts of 10 individuals who were admitted during this review period (CN, CP, EA, OH, PAS, RR, RU, SD, SM and SS). The review focused on the timeliness of the weekly notes. The review

		found compliance in eight charts (CN, CP, PAS, RR, RU, SD, SM and SS) and partial compliance in two (EA and OH). This monitor also reviewed the charts of 10 other individuals who were admitted during this review period (DE, EWC, FPR, GWB, JGH, MD, RJA, RLH, TMC and YH). This review focused on the timeliness of the monthly notes. The review found compliance in nine charts (DE, EWC, GWB, JGH, MD, RJA, RLH, TMC and YH) and partial compliance in one (FPR). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** MSH used the DMH Psychiatry Monthly PPN Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The

		average sample was 21% of the individuals with a length of admission greater than 90 days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. Comparative data are listed, as appropriate. **Recommendation 3, September 2008:** Ensure correction of the deficiencies cited by this monitor above. **Findings:** The facility did not report corrective actions in addition to implementation of the CAF. **Other findings:** This monitor reviewed the charts of 12 individuals (AB, CB, DE, EWC, GWB, JGH, JR, MD, RJA, RLH, TMC and YH). The review found that MSH has made further progress in the implementation of the facility's template for the monthly notes. However, the facility still falls short of substantial compliance regarding this requirement due to persistent deficiencies in the content of documentation. The main deficiencies were noted in the following areas: 1. Documentation of specific symptoms that required various trials of pharmacotherapy during the interval; 2. Documentation of different medication trials attempted during the interval; 3. Documentation of relevant abnormal laboratory findings; 4. Updates of diagnosis and treatment strategies based on relevant clinical and laboratory findings; and 5. Review of risks and benefits of treatment relevant to actual developments in the individual's status. This monitor also reviewed the charts of six individuals who have experienced the use of seclusion and/or restraints during this review

		period (AB, BMY, DMW, RR, RWL and TME). The review assessed the use of PRN/Stat medication prior to seclusion and/or restraints (as documented in the orders and progress notes). The review found that a pattern of deficiencies still existed in the following areas: 1. Prescription of PRN medications for specified behavioral indications (RWL and TME); 2. Documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications; 3. The development and implementation of behavioral guidelines for some individuals who were refractory to current medication trials; and 4. The documentation of a face-to-face assessment by a psychiatrist within 24 hours of the administration of Stat medications to inform future management. The above review is also relevant to the requirements in D.1.f.vi and F.1.b. **Compliance:** Partial. **Current recommendations**: 1. Streamline the current format for the monthly psychiatric reassessments to ensure proper focus on relevant clinical and laboratory findings. 2. Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

<table>
<tr><td>D.1.f.i</td><td>significant developments in the individual's clinical status and of appropriate psychiatric follow up;</td><td>
<table>
<tr><td>2.</td><td>Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms</td><td>91%</td></tr>
<tr><td>2.a</td><td>Subjective complaints are documented.</td><td>98%</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented</td><td>98%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>98%</td></tr>
<tr><td>2.d</td><td>Progress towards objectives in the WRP.</td><td>98%</td></tr>
<tr><td>2.e</td><td>The mental status exam is documented</td><td>98%</td></tr>
<tr><td>2.f</td><td>The individual's legal status and any change in legal status, if applicable.</td><td>97%</td></tr>
<tr><td>2.g</td><td>Current status of medical problems and treatment are documented</td><td>97%</td></tr>
<tr><td>2.h.1</td><td>The lab/diagnostic tests and consults for relevant medical conditions are documented and follow-up provided as indicated</td><td>96%</td></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic Guidelines)</td><td>97%</td></tr>
</table>
The facility reported a mean compliance rate of 91% compared to 82% during the last review period.
</td></tr>
<tr><td>D.1.f.ii</td><td>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;</td><td>
<table>
<tr><td>3.</td><td>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</td><td>83%</td></tr>
<tr><td>3.a</td><td>The MMSE is completed and documented in the progress note.</td><td>85%</td></tr>
<tr><td>3.b</td><td>The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.</td><td>96%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data showed an increase in mean compliance since the previous review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>72%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>72%</td><td>89%</td></tr>
<tr><td>3.a</td><td>72%</td><td>91%</td></tr>
<tr><td>3.b</td><td>97%</td><td>95%</td></tr>
</table></td></tr>
<tr><td>D.1.f.iii</td><td>Analyses of risks and benefits of chosen treatment interventions;</td><td>
<table>
<tr><td>4.</td><td>Analyses of risks and benefits of chosen treatment interventions</td><td>90%</td></tr>
<tr><td>4.a</td><td>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>91%</td></tr>
<tr><td>4.b</td><td>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>93%</td></tr>
<tr><td>4.c</td><td>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</td><td>93%</td></tr>
</table>
The facility reported a mean compliance rate of 90% compared to 87% during the last review period.</td></tr>
<tr><td>D.1.f.iv</td><td>Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;</td><td>
<table>
<tr><td>5.</td><td>Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to</td><td>95%</td></tr>
</table></td></tr>
</table>

	reduce risks	
5.a	*There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.*	96%
5.b	*The monthly note identifies specific risk behaviors including triggers during the interval period.*	95%
5.c	*If applicable, treatment is modified to minimize risk.*	93%

The facility reported a mean compliance rate of 95% compared to 83% during the last 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;

6.	*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*	77%
6.a	*Rationale for current psychopharmacology plan including analysis of risks and benefits.*	89%
6.b	*There is a description of any side effects caused by medications, including sedation and cognitive impairment.*	86%
6.c	*The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.*	93%
6.d	*Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives*	97%

Comparative data showed modest improvement in compliance since the

previous review as follows:

	Previous period	Current period
Mean compliance rate		
6.	75%	77%
Compliance rate in last month of period		
6.	81%	90%
6.a	88%	95%
6.b	94%	94%
6.c	94%	98%
6.d	99%	98%

D.1.f.vi

Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and

7.	*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*	84%
7.a	*Describes the rationale/specific indications for all PRN orders.*	89%
7.b	*Reviews the PRNs and Stats during the interval period.*	91%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	73%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	80%

Comparative data showed improvements in compliance since the previous review as follows:

		Previous period	Current period
		Mean compliance rate	
		7.	74%	84%
		Compliance rate in last month of period	
		7.	60%	94%
		7.a	87%	96%
		7.b	73%	95%
		7.c	47%	90%
		7.d	38%	92%

D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	8.	*Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated.*	90%
		8.a	*There is a description in the note of the response to non-pharmacologic treatment.*	96%
		8.b	*If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.*	82%
		8.c	*There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.*	91%
		8.d	*There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.*	98%

<table>
<tr><td></td><td></td><td>The facility reported a mean compliance rate of 90% compared to 84% during the last review period.</td></tr>
<tr><td>D.1.g</td><td>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</td><td>

Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:

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

Findings:

MSH used the DMH Physician Inter-Unit Transfer Note Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 50% of all individuals transferred between WRPTs each month. The following summarizes the data:

<table>
<tr><td>1.</td><td>Psychiatric course of hospitalization,</td><td>46%</td></tr>
<tr><td>2.</td><td>Medical course of hospitalization,</td><td>59%</td></tr>
<tr><td>3.</td><td>Current target symptoms,</td><td>96%</td></tr>
<tr><td>4.</td><td>Psychiatric risk assessment,</td><td>70%</td></tr>
<tr><td>5.</td><td>Current barriers to discharge,</td><td>93%</td></tr>
<tr><td>6.</td><td>Anticipated benefits of transfer.</td><td>85%</td></tr>
</table>

Comparative data showed improvements in compliance since the previous review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>22%</td><td>46%</td></tr>
<tr><td>2.</td><td>39%</td><td>59%</td></tr>
<tr><td>3.</td><td>78%</td><td>96%</td></tr>
</table>

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

4.	35%	70%
5.	72%	93%
6.	58%	85%
Compliance rate in last month of period		
1.	43%	68%
2.	44%	78%
3.	93%	100%
4.	72%	100%
5.	96%	100%
6.	64%	100%

Based on review of the audit data, MSH reported it implemented the following corrective actions:

1. The facility implemented a Transfer Note Template that contains all the required elements.
2. The facility designated a Senior Psychiatrist to monitor transfer notes and provide feedback (from the CAF) to the practitioner as appropriate.

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this reporting period. The following table outlines the reviews:

Initials	Date of transfer
CP	01/09/09
IIG	01/13/09
LB	01/08/09
MG	08/28/08
RRR	01/08/09
TME	10/02/08

		The reviews found partial compliance in charts reviewed. Overall, the assessments were more timely and comprehensive than in the previous review. However, the following deficiencies must be corrected to achieve substantial compliance with this requirement: 1. Several assessments did not include any information regarding the anticipated benefits of the transfer or indicated that the transfer occurred only for administrative reasons, without any explanation of the reason that the receiving unit was selected for that individual (LB, MG and RRR). 2. The assessment of RRR failed to address current target symptoms or outline barriers to discharge. 3. One assessment listed the type of PRN and/or Stat medications used in the transferring unit, but no information was provided as to effectiveness and/or efficacy in order to guide future care (LB). 4. One assessment included generic reference to current target symptoms. This reference did not provide useful information to ensure continuity of care based on the current status of the individual (IIG). This assessment as well as few other assessments (e.g. TME) did not provide information regarding the reason for transfer other than "continuity of care." 5. The assessments included important information regarding the individual's non-adherence to the WRP, but there was no information regarding alternative strategies that may be attempted by the receiving unit to improve the individual's motivation to participate (LB). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Physician Inter-Unit

		Transfer Note Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

2. Psychological Assessments		
		Methodology: Interviewed: 1. Aaron Baker, PsyD, Acting Senior Psychologist 2. Alex Guerrero, PsyD, PBS Team Leader 3. Ashvind Singh, PhD, Psychologist 4. Cynthia Lusch, Clinical Administrator 5. Darren Sush, PsyD, PBS Team Leader 6. Edwin Poon, PhD, Senior Psychologist 7. Erich Mullen, PT, PBS Team Member 8. Gretchen Hunt, BY CHOICE Coordinator 9. Jon Fogel, PhD, DCAT Leader 10. Kathleen Fitzpatrick, PhD, Acting Senior Psychologist 11. Ken Layman, Treatment Enhancement Coordinator 12. Kevin Buckheim, Mall Coordinator for Programs 1 and 2 13. Michael Cooper, PhD, Coordinator Psychology Specialty Services 14. Mina Guirguis, PsyD, Acting Senior Psychologist 15. Richard Hartley, PhD, Senior Psychologist 16. Sharon Smith Nevins, Executive Director 17. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 18. Siobhan Donovan, PsyD, Psychologist 19. Swati Roy, PhD, Chief of Psychology Reviewed: 1. The charts of the following 43 individuals: AB, AE, AF, BA, BMY, CG, CH, CSZ, DB, DY, ER, EV, FTG, GM, HD, JA, JC, JDS, JF, JM, JO, JOM, JR, JS, KB, KS, LJM, LS, MC, MCL, MMR, NB, NOS, OH, OO, RA, RD, RO, RT, SW, TVM, VN and WH 2. Functional assessments developed and implemented in the last six months 3. Integrated Assessments: Psychology Section 4. List of completed DSM-IV-TR checklists

		5. List of individuals undertaking psychological assessments 6. List of individuals whose primary/preferred language is other than English 7. List of individuals with diagnostic uncertainties 8. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 9. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 10. Neuropsychological assessments completed in the last six months 11. Observations Data of Psychologists Performing Integrated Assessments: Psychology Section 12. Psychological Assessment Auditing Form 13. Psychological Assessment Mentoring Form 14. Psychological Assessments completed in the last six months 15. Structural assessments developed and implemented in the last six months <u>Observed</u>: 1. Demonstration of MSH MAPP Reporting Portal 2. PSR Mall group: Acceptance and Commitment 3. PSR Mall group: Coping Skills 4. PSR Mall group: Medical Health and Wellness 5. PSR Mall group: Substance Recovery 6. WRPC (Program III, unit 415) for monthly review of AMP 7. WRPC (Program V, unit 405) for 14-day review of EM 8. WRPC (Program V, unit 411) for monthly review of LS
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue the practice of orienting new staff to the manual.

	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.	**Findings:** MSH had hired six new psychologists during this review period. The six psychologists received training on assessment procedures, EP issues, and service-related information using the DMH WRP Manual and the DMH Psychology Manual. MSH, in concert with other State hospitals and with approval from the DMH, has developed and implemented the appropriate and necessary standardized psychological assessments and protocols necessary to conduct assessments of the individuals in the facility. In addition, MSH has purchased assessment instruments in other languages (such as Spanish) so as to assess individuals in their primary/preferred languages. Documentation review found that as part of their training, new staff is observed conducting psychological assessments to evaluate their competency. **Compliance:** Substantial. **Current recommendation**: Continue the practice of orienting new staff to the manual.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the individuals under 22 years of age who eligible for assessment during this review period (August 2008 to January 2009):

		1. *Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (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.* — 94% Compliance is less than 100% because one individual refused to participate and subsequently has been discharged from the facility. Comparative data indicated maintenance of compliance greater than 90% from the previous review period. This monitor reviewed charts of seven individuals 22 years and below (DB, ER, JA, JO, MMR, SW and TVM), who by law should have received the cognitive and academic assessments within 30 days of admission unless comparable testing had been performed within one year of admission. The documentation showed that two of the individuals (JO and SW) had high school educations and did not need the evaluations. The remaining five individuals had their evaluations conducted in a timely manner. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

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Findings:
The table below showing the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent is a summary of the facility's data.

<table>
<tr><td>1.a</td><td>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</td><td>34</td></tr>
<tr><td>1.b</td><td>Number of psychologists who meet the hospital's credentialing and privileging requirements</td><td>34</td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking psychological assessments</td><td>34</td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>34</td></tr>
</table>

According to the Chief of Psychology, focused assessments are conducted by WRP psychologists, and the practicum students only conduct cognitive screening as part of the Integrated Assessments: Psychology Section (IAPS).

Compliance:
Substantial.

Current recommendation:
Continue current practice.

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<tr>
<td>D.2.d</td>
<td>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</td>
<td>

Compliance:
Substantial.

</td>
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</table>

<table>
<tr>
<td>D.2.d.i</td>
<td>expressly state the clinical question(s) for the assessment;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>3.</td><td>Expressly state the clinical question(s) for the assessment.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed seven focused assessments (EV, JDS, JF, JS, KB, MC and RD. All seven expressly stated the clinical question(s) for the assessment. This monitor also noted that the recommendations made in the focused assessments were incorporated into the individuals' WRPs, for example JS.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>D.2.d.ii</td>
<td>include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due
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<table>
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<td>each month of this review period (August 2008 to January 2009):

<table>
<tr><td>4.</td><td>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed seven focused assessments (EV, JDS, JF, JS, KB, MC and RD). All seven focused assessments included findings that addressed the clinical question(s), and also included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested intervention priorities useful to the individual's WRPT.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.d.iii</td>
<td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>5.</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</td><td>100%</td></tr>
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</table>

		Comparative data indicated maintenance of compliance greater than 90% from the previous review period. This monitor reviewed eight focused assessments (AF, EV, JDS, JF, JOM, KB, MC and RD). All eight focused assessments indicated whether individual or group therapy would benefit the individual and the recommendations were aligned with their findings. **Current recommendation**: Continue current practice.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009): 6. *Be based on current, accurate, and complete data.* 100% Comparative data indicated maintenance of compliance greater than 90% from the previous review period. This monitor reviewed ten focused assessments (AF, BA, EV, JDS, JF, JOM, JS, KB, MC and RD). All ten focused assessments were based on current, accurate and complete data. The assessments included the individual's identification information, relevant sources of information, behavioral observations, and statements on the validity of the assessment.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.v</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>7.</td><td>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed nine focused assessments (BA, EV, JDS, JF, JOM, JS, KB, MC and RD). All nine focused assessments addressed the need for behavioral supports or interventions, or whether a full Positive Behavior Support plan was required.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.vi</td><td>include the implications of the findings for interventions;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.</td></tr>
</table>

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<td>
Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>8.</td><td>Include the implications of the findings for interventions</td><td>100%</td></tr>
</table>

This monitor reviewed nine focused assessments (AF, BA, EV, JDS, JR, JS, KB, MC and RD). All nine focused assessments included implications of the findings for interventions, and the recommended interventions were aligned with the findings. The monitor also found that the recommendations made in the focused assessments were incorporated in the individuals' WRPs (for example, AF, JS and KB).

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

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>9.</td><td>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</td><td>100%</td></tr>
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</tr>
</table>

<table>
<tr><td></td><td></td><td>This monitor reviewed eight focused assessments (BA, EV, JDS, JF, JOM, KB, MC and RD). All eight focused assessments indicated if there were unresolved issues, and when there were unresolved issues, a determination was made on the steps to be taken to address the issue.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.d.viii</td><td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Focused Psychology Assessments due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>10.</td><td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</td><td>100%</td></tr>
</table>

This monitor reviewed ten focused assessments (AF, BA, EV, JDS, JF, JOM, JS, KB, MC and RD). All 10 focused assessments used assessment tools and techniques appropriate for the individuals assessed. All of the assessments reviewed included statements of confidentiality. The instruments used were appropriate for addressing the clinical questions and the instruments were from the DMH Clinical Indicator List of approved instruments.</td></tr>
</table>

		Current recommendation: Continue current practice.
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.	The court monitor had no previous recommendations as the requirements of this cell had been met at the time of the previous tour. **Compliance:** Substantial.
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:	**Compliance:** Substantial.
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Integrated Assessments: Psychology Section due each month of this review period (August 2008 to January

<table>
<tr>
<td></td>
<td></td>
<td>2009):

<table>
<tr><td>12.</td><td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed the Integrated Assessments: Psychology Section for seven individuals (AE, DB, HD, JM, JOM, KS and LS). All seven of them were completed in a timely manner.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.2.f.i.1</td>
<td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Integrated Assessments: Psychology Section due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>This monitor reviewed seven charts (AE, DB, HD, JM, JOM, KS and LS). All seven Integrated Assessments: Psychology Section in the charts discussed the individual's behaviors, and signs and symptoms corresponding to the individual's psychiatric diagnoses.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.2.f.i.2</td><td>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance using 100% of the Integrated Assessments: Psychology Section due each month of this review period (August 2008 to January 2009):

<table>
<tr><td>14.</td><td>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed seven charts (AE, DB, HD, JM, JOM, KS and LS). All seven Integrated Assessments: Psychology Section in the charts provided accurate and sufficient information regarding the individual's psychological functioning useful for WRP rehabilitation service needs.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Ensure accurate evaluation of psychological functioning that informs the WRPT of the individual's rehabilitation service needs.</td></tr>
<tr><td>D.2.f.ii</td><td>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</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance using 100% of active PBS plans during this review period (August 2008 to January 2009):

<table><tr><td>5.</td><td>PBS assessments include structural and functional assessments, and as necessary, functional analysis</td><td>100%</td></tr></table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Structural and functional assessments were conducted prior to PBS plan development and implementation for all eight PBS plans reviewed (AB, BMY, CG, CH, DY, LS, MCL and WH). The overall quality of the assessments has improved. PBS team members are routinely collaborating with other disciplines. Areas for further improvement include: a) data collection and analysis when the target behavior will not be exhibited across the full range of typical daily routines, b) data analysis on the target behavior's cycle, strength, and patterns, and c) data collection and analysis on the replacement behavior/alternate behavior or skills to be taught.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:
Ensure appropriate structural and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</td></tr>
<tr><td>D.2.f.iii</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, MSH assessed its compliance regarding diagnostic categories lacking sufficient information based on a 100% sample of the integrated assessments conducted during this review period (August 2008 to January 2009):

<table>
<tr><td>17.</td><td>Rule-out</td><td>100%</td></tr>
<tr><td>18.</td><td>Deferred</td><td>100%</td></tr>
<tr><td>19.</td><td>No diagnosis</td><td>100%</td></tr>
<tr><td>20.</td><td>NOS diagnosis</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance greater than 90% from the previous review period for all items.

This monitor reviewed nine charts of individuals with one or more diagnostic categories without sufficient information with unresolved clinical questions in their WRPs (GM, JM, JOM, LJM, NB, NOS, OH, OO and RT). All nine Integrated Assessments: Psychology Section in the charts had follow-up assessments, including the completed DSM-IV-TR checklists, to clarify the diagnostic categories.

Current recommendation:
Continue current practice.</td></tr>
</table>

D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, MSH analyzed its compliance based on a 100% sample of the individuals admitted during this review period (August 2008 to January 2009) whose primary/preferred language is other than English: 21.a — *Number of individuals who needed assessment during the evaluation period whose primary language was not English* — 11 21.b — *Of those in 21.a, number of individuals who were assessed in their primary language* — 9 22.a — *Of those in 21.a, number of individuals who could not be assessed* — 2 22.b — *Of those in 22.a, number of individuals who had plans developed to meet their assessment needs* — 2 23. — *Of those in 22.b, number of individuals whose plans for assessment were implemented* — 2 As shown in the table above, MSH conducted all assessments in the individuals' primary/preferred languages. This monitor reviewed charts of eight individuals (AB, CSZ, FTG, JC, JOM, RA, RO and VN) whose primary/preferred language was something other than English. All eight individuals had their assessments conducted in their preferred/primary language. MSH used a variety of options to conduct the assessments in the individual's preferred language (for

		example, AT&T language interpreter, ASL, and staff who could speak the individual's preferred language including Spanish, Vietnamese, and Russian). **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Alfred Johnson, RN, Program I 2. Ania Sobolewska, RN, Health Service Specialist, NP, C 3. Aubri Griffis, Acting Nursing Coordinator 4. Aurora Hendricks, Nurse Administrator 5. Estela D. Millan, RN, Program I 6. Fiora S. Yballe, RN, Program I 7. Kasia Kolansinski, RN, Health Service Specialist 8. Paul Bernoulli, RN, Program I 9. Shu Wang, WRP Mentor 10. Vicenta Gonzalez, RN, Program V Reviewed: 1. MSH's progress report and data 2. Inter-Rater Reliability for Admission Nursing Assessment for August-December 2008 3. MSH's audits for 40 Nursing Admission/Integrated Assessments 4. Admission and Integrated assessments and WRPs for the following 40 individuals: AEE, AER, APQ, BB, BJW, BTM, CLW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JEF, JLA, JLG, JLW, JRF, KS, LAD, LEL, LES, LEY, LJS, LLW, MKC, MLD, MMS, PA, PAL, RDA, RO, RRA, RRR, RS, SL, SRC and TG Observed: 1. WRPC for KS, Program I, Unit 410 2. WRPC for VWS, Program V, Unit 405 3. WRPC for MD, Program VI, Unit 418 4. WRPC for AB, Program VI, Unit 419

D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 99% mean sample of admissions each month for the review period (August 2008 – January 2009). The following table outlines the indicators with corresponding mean compliance rates (items for D.3.a.ii-a.ix are found in the corresponding cells below):

1.	*A description of presenting conditions*	99%
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete.*	100%
1.b	*Any key descriptor box identified that has an impact on the individual is elaborated on in the narrative description in the summary of presenting conditions, or there are no key descriptor boxes identified that need elaboration in the narrative section.*	99%

Comparative data indicated an increase in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	90%	99%

Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on an 88% mean sample of admissions each month for the review period (August 2008 – January 2009). The following table outlines the indicators with corresponding mean compliance rates (items for D.3.a.ii-a.ix are found in the corresponding cells below):

1.	*The Present Status of the Integrated Assessment: Nursing Section is complete or there is documentation that the individual is non-adherent with the interview.*	98%

Comparative data indicated an increase in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	72%	98%

A review of admission assessments for 40 individuals (AEE, AER, APQ, BB, BJW, BTM, CLW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JEF, JLA, JLG, JLW, JRF, KS, LAD, LEL, LES, LEY, LJS, LLW, MKC, MLD, MMS, PA, PAL, RDA, RO, RRA, RRR, RS, SL, SRC and TG) found that MSH has shown overall improvement in completing the sections of the assessments and a majority of the assessments included more descriptive Summaries of Presenting Conditions. However, when reviewing the content and quality of the Nursing assessments, there were a number of issues that did not support a rating of substantial compliance. There were a number of inconsistencies and discrepancies noted within the assessment information without a comment or explanation provided by the nurse completing the assessment. In addition, a number of goals did not accurately reflect the information found in the assessments. A number of assessments noted that the individual had experienced rashes from particular medications.

		However, additional information such as where the rash occurred or how it was resolved was not included. When vital signs were recorded as abnormal, there was no indication that they were retaken. Many questions were answered with "Yes" or "No" with no additional information provided. For example, the assessment noted "Yes" an individual could read, yet there was no mention that he read well in Spanish and not well in English. If memory problems were identified on the assessment, there was no indication if the memory deficits were long-term, short-term or both. It is essential to address these issues in a Nursing assessment; this type of information is also pertinent when developing the individual's WRP. A review of 40 integrated assessments for the above-referenced 40 individuals found the same problematic issues as those identified in regard to the Nursing admission assessments. Again, the sections of the integrated assessments were completed but the clinical relevance of the questions was rarely adequately addressed. A review of all 40 audits for these Nursing Admission/Integrated Assessments indicated that the auditors had identified some similar content and quality issues in the comment sections of the audits but still rated the item as being "in compliance." A discussion about this with the auditors indicated that they were aware of some of the problems with quality, but were auditing only based on "completion" of an item as directed by the DMH audit tool since the word "quality" is not included. Generally accepted standards of Nursing practice dictate that Nursing assessments contain quality information. Also, an interview with the Medical Director confirmed that although Nursing and Psychiatry conduct joint admission assessments at MSH, psychiatrists and psychologists do not read the Nursing admission/integrated assessments and provide no feedback or training regarding the clinical relevance of the information being gathered. It was agreed that now that staff are completing the assessments, the focus for training and auditing will be on the quality of the content.

		MSH has made significant progress in ensuring that each section of the Nursing Admission Assessment is completed. However, there is an overall lack of understanding regarding what type of clinical information should be addressed in the Admission and Integrated Assessments. Discussion with a number of RNs who conduct the admission/integrated assessments indicated that they saw the process as a question and answer session and stated they felt they were "not allowed" to comment on anything more than the questions on the forms. A better understanding of the clinical relevance of the questions contained in the admission and integrated assessment is needed for nursing to complete quality assessments to attain substantial compliance. **Current recommendations**: 1. Provide training using interdisciplinary staff such as Psychiatry and Psychology to Admission RNs and Nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated nursing assessments. 2. Ensure auditors' compliance ratings for Nursing admission/integrated assessments reflect quality; not just completion. 3. Continue to monitor this requirement.

D.3.a.ii	current prescribed medications;	Admission Assessments

2.	*All medications the individual is currently taking on admission to this facility are documented, or there is documentation that medication records are not available, or the "no medications" box is checked.*	98%

Comparative data indicated an increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	92%	98%

Integrated Assessments

2.	*The medication management section is complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.*	98%

Comparative data indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	72%	98%

<table>
<tr>
<td>D.3.a.iii</td>
<td>vital signs;</td>
<td>
<u>Admission Assessments</u>

<table>
<tr><td>3.</td><td>Vital signs are documented, or there is documentation that the individual was non-adherent.</td><td>100%</td></tr>
</table>

Comparative data showed maintenance of compliance from the previous review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>98%</td><td>100%</td></tr>
</table>

<u>Integrated Assessments</u>

<table>
<tr><td>3.</td><td>Vital signs are documented, or there is documentation that the individual was non-adherent.</td><td>95%</td></tr>
</table>

Comparative data indicated a significant increase in compliance from the previous review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>73%</td><td>95%</td></tr>
</table>
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<tr>
<td>D.3.a.iv</td>
<td>allergies;</td>
<td>
<u>Admission Assessments</u>

<table>
<tr><td>4.</td><td>Allergies</td><td>99%</td></tr>
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Comparative data indicated maintenance of compliance from the previous
</td>
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<table>
<tr>
<td></td>
<td></td>
<td>review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>96%</td><td>99%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>96%</td></tr>
</table>
Comparative data indicated a significant increase in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>74%</td><td>96%</td></tr>
</table>
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</tr>
<tr>
<td>D.3.a.v</td>
<td>pain;</td>
<td><u>Admission Assessments</u>
<table>
<tr><td>5.</td><td>The pain assessment is complete</td><td>98%</td></tr>
</table>
Comparative data indicated an increase in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>93%</td><td>98%</td></tr>
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<tr>
<td></td>
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<td>
<u>Integrated Assessments</u>

5.	*The pain assessment is complete*	92%

Comparative data indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
5.	58%	92%
</td>
</tr>
<tr>
<td>D.3.a.vi</td>
<td>use of assistive devices;</td>
<td>
<u>Admission Assessments</u>

6.	*The functional assessment and assistive devices section is complete, or the "no concerns," "no conditions" or "none" box is checked.*	98%

Comparative data indicated an increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
6.	91%	98%

<u>Integrated Assessments</u>

6.	*The update assistive devices use or need section is complete, or the "no problems noted" box is checked.*	97%
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<td></td>
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<td>Comparative data indicated a significant increase in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>76%</td><td>97%</td></tr>
</table>
</td>
</tr>
<tr>
<td>D.3.a.vii</td>
<td>activities of daily living;</td>
<td><u>Admission Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>100%</td></tr>
</table>
Comparative data indicated an increase in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>90%</td><td>100%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td>7.</td><td>Activities of daily living</td><td>94%</td></tr>
</table>
Comparative data indicated a significant increase in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>60%</td><td>94%</td></tr>
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<tr>
<td>D.3.a.viii</td>
<td>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</td>
<td>
<u>Admission Assessments</u>

8.	*The "Risks/Alerts Requiring Immediate Nursing Interventions" section is completed, or the "none known" box is checked.*	99%

Comparative data indicated an increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
8.	90%	99%

<u>Integrated Assessments</u>

8.	*The "Risks/Alerts Requiring Immediate Nursing Interventions" section is completed, or the "none known" box is checked.*	97%

Comparative data s indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
8.	61%	97%
</td>
</tr>
<tr>
<td>D.3.a.ix</td>
<td>conditions needing immediate nursing interventions.</td>
<td>
<u>Admission Assessments</u>

9.	*Immediate nursing intervention(s) implemented during*	99%
</td>
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</table>

		the admission process are documented, or the "none known" box is checked.

Comparative data indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
9.	79%	99%

Integrated Assessments

9.	*Immediate nursing interventions implemented since completion of the "Admission Assessment" are documented, or the "none known" box is checked.*	91%

Comparative data indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
9.	48%	91%

D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH's Nursing Department Policy and Procedures and practices

		demonstrate the consistent use of the Wellness and Recovery Model for Nursing. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** No data was provided by MSH addressing competency training regarding nursing assessments. Review of licensure data verified that all of the 220 RNs employed at MSH during the review period were licensed. **Other findings:** Although MSH did not provide competency training regarding Admission/Integrated Assessment, the findings in D.3.a.i indicated a lack of competency, especially in the area of the clinical relevance of the assessments. While compliance rates have increased in all the areas regarding the completion of the assessments, the lack of quality of the assessments suggests the need for additional training in this area. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding competency training regarding nursing assessments.

<table>
<tr><td></td><td></td><td>2. See D.3.a.i.
3. Review and revise training material regarding Nursing Admission/Integrated Assessments to ensure that the clinical relevance of the questions is included.
4. Continue to monitor this requirement.</td></tr>
<tr><td>D.3.d</td><td>Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:</td><td>Compliance:
Partial.</td></tr>
<tr><td>D.3.d.i</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
<table><tr><td>12.</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission.</td><td>100%</td></tr></table>
Comparative data showed maintenance of compliance for this item from the previous review period:

<table><tr><td></td><td>Previous period</td><td>Current period</td></tr><tr><td colspan="3">Mean compliance rate</td></tr><tr><td>12.</td><td>99%</td><td>100%</td></tr></table>
Findings:
A review admission assessments for 40 individuals (AEE, AER, APQ, BB, BJW, BTM, CLW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JEF, JLA, JLG, JLW, JRF, KS, LAD, LEL, LES, LEY, LJS, LLW, MKC, MLD, MMS, PA, PAL, RDA, RO, RRA, RRR, RS, SL, SRC and TG) found that one was incomplete</td></tr>
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<table>
<tr><td></td><td></td><td>(CPP) and one was not timely completed (JRF).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.3.d.ii</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on an 88% mean sample of admissions each month for the review period (August 2008 – January 2009). (Item 13.b reflects data for only January 2009 since this item was not included on tool used for data collection for August-December 2008.) The following table outlines the indicators with corresponding mean compliance rates:

<table>
<tr><td>13.</td><td>Further Nursing Assessments</td><td>82%</td></tr>
<tr><td>13.a</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within 7 days of admission.</td><td>85%</td></tr>
<tr><td>13.b</td><td>The Integrated Nursing Assessment is completed between (3) to (5) days of admission</td><td>95%</td></tr>
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Comparative data indicated a modest increase in compliance from the previous review period:</td></tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>13.</td><td>78%</td><td>82%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>13.</td><td>81%</td><td>84%</td></tr>
<tr><td>13.a</td><td>81%</td><td>85%</td></tr>
<tr><td>13.b</td><td>N/A</td><td>95%</td></tr>
</table>

The barrier to compliance was a lack of understanding of the assessment requirements by two of 37 RNs in January 2009. The plan of action includes individual mentoring of the RNs by an HSS.

A review of integrated assessments for 40 individuals (AEE, AER, APQ, BB, BJW, BTM, CLW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JEF, JLA, JLG, JLW, JRF, KS, LAD, LEL, LES, LEY, LJS, LLW, MKC, MLD, MMS, PA, PAL, RDA, RO, RRA, RRR, RS, SL, SRC and TG) found that 14 were not timely completed (AEE, BB, CPP, EAB, FM, LAD, LES, LEY, MKC, MMS, PA, RDA, RO and SRC).

Compliance:
Partial.

Current recommendation:
Continue to monitor this requirement.
</td>
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<tr>
<td>D.3.d.iii</td>
<td>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.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, September 2008:
Ensure reliability of auditing data.

Findings:
MSH indicated that the inter-rater agreement data for this reporting
</td>
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		period was 96%. However, based on discussion with a WRPT mentor regarding WRPCs observed by both the reviewer and mentor, there were some significant discrepancies in rating appropriate team participation. **Recommendation 2, September 2008:** Continue to monitor this requirement. **Findings:** MSH's data from the DMH WRP Observation Monitoring Form did not address the item; Nursing assessments are reviewed at every scheduled WRP meeting (the RN communicates clinically relevant findings). In addition, the data provided was based on a 12% mean sample of WRPCs observed during the review months. This sample size needs to be increased to 20%. In observations of four WRPCs (Program I, Unit 410; Program V, Unit 405; and Program VI, Units 418 and 419), this reviewer found that one WRPC (Unit 410) demonstrated good information provided by the RN and PT. The RN and PT at the WRPC observed on Unit 405 provided good information; however, the team maintained an objective that the individual clearly had met. The WRPCs observed on Units 418 and 419 demonstrated not only a lack of review of assessment data by the RN and PT, but inaccurate data that was provided for two individuals who spoke languages other than English. **Current recommendations**: 1. Ensure that audit data accurately reflects the quality of the reviews at the WRPCs in relation to appropriate interventions and outcomes for the individuals. 2. Provide appropriate data for this requirement. 3. Increase sample size to 20%. 4. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Andrea Cirota, Supervising Rehabilitation Therapist 2. Asha Vij, Occupational Therapist 3. Donna Gilland, Assistant Clinical Administrator 4. Jack McClary, Supervisor of Vocational Services 5. Jamie Critie, Supervising Rehabilitation 6. Lisa Adams, Supervising Rehabilitation Therapist 7. Mari Cobb, Rehabilitation Therapy Chief 8. Marion Paclibar, Physical Therapist 9. Rebecca McClary, Rehabilitation Therapy Program Assistant 10. Terez Henson, Supervising Rehabilitation Therapist 11. Troy Zelones, Physical Therapist Reviewed: 1. DMH Rehabilitation Therapy IA-RTS audit data for August 2008 - January 2009 2. Focused assessment audit data for August 2008 - January 2009 for Vocational Rehabilitation, Occupational Therapy, CIPRTA, and Physical Therapy 3. MSH Plan for Vocational Services Systems and Processes 4. List of individuals who had IA-RTS assessments from August 2008 - January 2009 5. Records of the following 12 individuals who had IA-RTS assessments from August 2008 - January 2009: CM, EDM, ERM, JWR, LB, LJ, LJS, PM, RDA, RM, SET and TW 6. List of individuals with Vocational Rehabilitation assessments in August 2008 - January 2009 7. Records of the following 12 individuals who had Vocational Rehabilitation Assessments from August 2008 - January 2009: BB, BH, CDJ, CPP, DLN, JJS, JLA, JLG, JLS, MAO, MEB and SW

		8. List of individuals with Physical Therapy assessments in August 2008 - January 2009 9. Records of the following eight individuals with Physical Therapy assessments in August 2008 - January 2009: ALH, FR, KG, MAB, SB, TG, TMC and WOS 10. List of individuals with Occupational Therapy assessments in August 2008 - January 2009 11. Records of the following five individuals with Occupational Therapy assessments in August 2008 - January 2009: BJW, DEM, KDL, PMH and TP 12. List of individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessments in August 2008 - January 2009 13. Records of the following individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessments in August 2008 - January 2009: GSZ, PA and RLH 14. List of individuals who had type D.4.d assessments from August 2008 - January 2009 15. Records of the following 11 individuals who had type D.4.d assessments from August 2008 - January 2009: AC, AE, BLW, CAS, DR, HL, JC, MEB, RD, SHP and SL 16. Rehabilitation Therapy training binder reviewed on site by Rob Schaufenbil, with findings reported via teleconference
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals continue to be consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and EP requirements.

		Findings: The DMH Rehabilitation Therapy Services Manual was implemented on 1/7/09 via Special Order 138. The manual will be updated as procedures and processes change according to performance improvement and accepted standards of practice. **Recommendation 2, September 2008:** Revise and implement the proposed Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals. **Findings:** The Vocational Services screening tool was revised and implemented at MSH on 10/1/08. The facility reported that 39/39 RT staff were trained to competency on materials related to the revised Vocational Rehabilitation Screening tool from 10/15/08 to 1/28/09. The training was verified by review of raw data from training rosters and training post-tests. **Recommendation 3, September 2008:** Ensure that admission IA-RTS assessments are completed by more than one assessment team (to be selected from the pool of current admissions therapists), and that unit Rehabilitation Therapists perform type D.4.d assessments. **Findings:** On 9/18/08, all unit-based Rehabilitation Therapists began to perform type D.4.d conversion assessments. On 1/1/09, the pool of available therapists for completing IA-RTS assessments was expanded, though the facility continues to use only one primary team of four admissions therapists to complete assessments. The process does not appear to be efficient and timeliness of assessment

		completion has been impacted by vacancies in admission unit RT positions due to illness and vacation, which are not filled. The facility needs to restructure the current process to ensure that more than one team of therapists is completing assessments, that vacancies on admissions units are filled, and that each team of two therapists has one therapist from the individual's admission unit. **Recommendation 4, September 2008:** Utilize standardized assessments (e.g., CASAS) when available as part of the Vocational Rehabilitation focused assessments as clinically indicated. **Findings:** This recommendation has not been met. Currently, Vocational Instructors are employed under the Golden Vista School and not the Rehabilitation Therapy/Vocational Services department. All Vocational Instructors and Vocational Services staff qualified to perform assessments are not currently completing VRAT assessments, and are not integrated under one department. A plan outlining the process for completing VRAT assessments, which includes the use of standardized tests as clinically indicated, has been developed but is pending implementation. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to restructure the process by which admission assessments are completed to ensure compliance with timeliness and quality of IA-RTS admission assessments. 2. Use standardized assessments (e.g., Careerscope) to supplement the findings of the Vocational Rehabilitation focused assessments as clinically indicated.

<table>
<tr><td></td><td></td><td>3. Recruit and retain Speech Language Pathology staff so that focused Speech Therapy assessments can be completed as clinically indicated.</td></tr>
<tr><td>D.4.b</td><td>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</td><td>

Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 98% of Integrated Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 208 out of 213). The following table outlines the indicators with corresponding mean compliance rates:

<table>
<tr><td>1.</td><td>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</td><td>77%</td></tr>
<tr><td>1.a</td><td>The assessment was completed within five calendar days of the individual's admission, and</td><td>88%</td></tr>
<tr><td>1.b</td><td>Filed in the medical record.</td><td>90%</td></tr>
</table>

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

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

	Previous period	Current period
Mean compliance rate		
1.	35%	77%
Compliance rate in last month of period		
1.	30%	75%
1.a	30%	85%
1.b	48%	95%

The facility attributed less than substantial compliance with timeliness to staffing shortage on the RIAT (RT admissions assessment team) due to illness, vacations and holidays.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of August 2008 - January 2009 (total of 49). The following table outlines the indicators with corresponding mean compliance rates:

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

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

	Previous period	Current period
Mean compliance rate		
1.	44%	100%

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 25). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	80%
1.a	*The assessment was completed within five calendar days of the individual's admission, and*	100%
1.b	*Filed in the medical record.*	80%

Comparative data indicated a decline in compliance for item 1.b from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	80%
1.a	100%	100%
1.b	100%	80%

The facility attributed less than substantial compliance with 1.b to a filing error by Physical Therapy staff.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of August 2008 - January 2009 (total of eight). The following table outlines the indicators with corresponding mean compliance rates:

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

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of five). The following outlines the indicator with corresponding mean compliance rates:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	60%
1.a	*The assessment was completed within five calendar days of the individual's admission, and*	100%
1.b	*Filed in the medical record.*	60%

Comparative data indicated a decline in compliance for item 1.b from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	60%
1.a	100%	100%
1.b	100%	60%

The facility attributed less than substantial compliance with 1.b to a filing error.

The facility does not currently have a Speech Therapist on-site to perform focused Speech Therapy assessments as needed.

Other findings:
A review of the records of 12 individuals (CM, EDM, ERM, JWR, LB, LJ, LJS, PM, RDA, RM, SET and TW) to assess compliance with timeliness of IA-RTS assessments found all records in compliance.

A review of the records of eight individuals (CDJ, CPP, JJS, JLA, JLG, MAO, MEB and SW) to assess compliance with timeliness of Vocational Rehabilitation assessments found all records in compliance.

A review of the records of five individuals (ALH, FR, KG, TG and WOS) to assess compliance with timeliness of Physical Therapy assessments found four records in compliance (FR, KG, TG and WOS) and one record not in compliance (ALH).

A review of the records of five individuals (BJW, DEM, KDL, PMH and TP) to assess compliance with timeliness of Occupational Therapy assessments found all records in compliance.

		A review of the records of three individuals (GSZ, PA and RLH) to assess compliance with timeliness of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found all records in compliance. **Compliance:** Partial. **Current recommendation:** Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 98% of Integrated Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 208 out of 213). The following table outlines the indicators with corresponding mean compliance rates: 2. *Is accurate and comprehensive as to the individuals functional abilities;* 47% 2.a *Identifying information is fully documented* 100%

2.b	*Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented*	89%
2.c	*Structured assessment activities and pertinent information related to setting/time are listed*	83%
2.d	*Leisure and enrichment profile items are completed*	93%
2.e	*Functional observation items are completed for [all pertinent sections]*	60%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	14%	47%
Compliance rate in last month of period		
2.	52%	30%
2.a	93%	100%
2.b	86%	100%
2.c	86%	44%
2.d	93%	90%
2.e	59%	45%

The facility attributed less than substantial compliance to therapists failing to proofread documents prior to submission and leaving items blank or incomplete.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of August 2008 - January 2009 (total of 49). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	92%
2.a	*Identifying information is fully documented*	100%
2.b	*Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24-hour admission assessment), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented.*	98%
2.c	*Educational background items are completed.*	98%
2.d	*Employment history items are completed.*	100%
2.e	*Personal grooming and appearance items are completed.*	100%
2.f	*All physical functioning items are completed and specific functional measurements are documented if appropriate.*	96%
2.g	*All standardized assessments, as indicated.*	*

*No data was provided for this cell by the facility as no standardized assessments were used, regardless of clinical indication.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	18%	92%

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 8). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	100%
2.a	*Identifying information is fully documented*	100%
2.b	*Onset date completed*	100%
2.c	*Previous pertinent clinical assessments, WRPs and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	100%
2.d	*Prior level of functioning completed including equipment owned*	100%
2.e	*Pertinent medical history completed, including precautions.*	100%
2.f	*Current functional abilities are addressed including:*	100%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	45%	100%

Auditing of focused assessments is not currently done in vivo, and thus the validity of facility audit data for focused Occupational Therapy assessments is questionable at this time.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Physical Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 25). The following table outlines the indicators with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	56%
2.a	*Identifying information is fully documented*	100%
2.b	*Diagnosis*	96%
2.c	*Functional PT diagnosis*	100%
2.d	*Onset date*	100%
2.e	*Age*	96%
2.f	*Chief complaint/mechanism of injury*	100%
2.g	*Past Medical History*	100%
2.h	*Prior level of function*	100%
2.i	*Special precautions*	92%
2.j	*Orientation*	63%

Comparative data showed improvement in compliance or maintenance of compliance at or greater than 90% for all items except 2.j since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	16%	56%
2.a	7%	100%
2.b	81%	96%
2.c	97%	100%
2.d	94%	100%
2.e	100%	96%
2.f	19%	100%
2.g	91%	100%
2.h	97%	100%
2.i	97%	92%
2.j	91%	63%

Comparative data for compliance rates in the last months of the previous and current review periods were not provided by the facility, nor were an analysis of barriers to compliance or a proposed action plan.

Auditing of focused assessments is not currently done in vivo, and thus the validity of facility audit data for focused Physical Therapy assessments is questionable at this time.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of five). The following outlines the indicator with corresponding mean compliance rates:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	60%
2.a	*Identifying information is fully documented*	100%
2.b	*Previous POST evaluations, Vocational evaluations, WRPs plans and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	100%
2.c	*Pertinent medical history completed, including precautions*	100%
2.d	*Prior level of functioning in all areas is addressed, including adaptive equipment*	60%
2.e	*Current functional abilities are addressed, as indicated*	80%

Comparative data showed improvement in compliance or maintenance of compliance greater than 90% for all sub-items except 2.e. since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	50%	60%
2.a	100%	100%
2.b	100%	100%
2.c	100%	100%
2.d	50%	60%
2.e	100%	80%

Comparative data for compliance rates in the last months of the previous and current review periods were not provided by the facility.

		Recommendation 2, September 2008: Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria. **Findings:** The facility provided no data regarding this recommendation. **Other findings:** A review of the records of 12 individuals (CM, EDM, ERM, JWR, LB, LJ, LJS, PM, RDA, RM, SET and TW) to assess compliance with D.4.b.i in IA-RTS assessments found ten records in substantial compliance (CM, EDM, ERM, JWR, LJ, LJS, PM, RDA, SET and TW) and two records in partial compliance (LB and RM). A review of the records of 12 individuals (BB, BH, CDJ, CPP, DLN, JJS, JLA, JLG, JLS, MAO, MEB and SW) to assess compliance with D.4.b.i in Vocational Rehabilitation assessments found all records in partial compliance. An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive description of the individual's functional ability in terms of vocational skills and areas of function. A review of the records of eight individuals (ALH, FR, KG, MAB, SB, TG, TMC and WOS) to assess compliance with D.4.b.i in Physical Therapy assessments found all records in substantial compliance. A review of the records of five individuals (BJW, DEM, KDL, PMH and TP) to assess compliance with D.4.b.i in Occupational Therapy assessments found two records in substantial compliance (DEM and TP) and three records in partial compliance (BJW, KDL and PMH). A review of the records of three individuals (GSZ, PA and RLH) to assess compliance with D.4.b.i in Comprehensive Integrated Physical

		Rehabilitation Therapy focused assessments found two records in substantial compliance (PA and RLH) and one record in partial compliance (GSZ). **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 98% of Integrated Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 208 out of 213). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	64%
3.a	*The functional status is described for Physical Functioning*	86%
3.b	*The functional status is described for Social Functioning*	78%
3.c	*The functional status is described for Life Skills*	73%

4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	70%
4.a	*A description of the skills and supports necessary to live in the setting in which she/he will be placed, and*	73%
4.b	*A discussion of possible progression/steps towards this level of independence.*	84%

Comparative data indicated improvement in mean compliance from the previous review period but mixed changes in compliance from the last month of the previous review period to the last month of the current review period:

	Previous period	Current period
Mean compliance rate		
3.	36%	64%
3.a	58%	86%
3.b	43%	78%
3.c	43%	73%
4.	27%	70%
4.a	35%	73%
4.b	40%	84%
Compliance rate in last month of period		
3.	38%	42%
3.a	95%	68%
3.b	52%	63%
3.c	43%	58%
4.	90%	50%
4.a	90%	50%
4.b	90%	88%

The facility attributed a decrease in compliance to the additional therapists trained to perform assessments.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of August 2008 - January 2009 (total of 49). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	98%
4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	100%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	49%	98%
4.	34%	100%

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 8). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	100%

4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 76% of Physical Therapy assessments due each month for the review period of August 2008 - January 2009 (19 out of 25). The following table outlines the indicators with corresponding mean compliance rates:

3.	*Identifies the individual's current functional status, and*	95%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	70%	95%
4.	67%	100%

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 5). The following table outlines the indicators with corresponding mean compliance rates:

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

Comparative data showed maintenance of compliance greater than 90% from the previous review period.

Recommendation 2, September 2008:
Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.

Findings:
The facility provided no data regarding this recommendation.

Other findings:
A review of the records of 12 individuals (CM, EDM, ERM, JWR, LB, LJ, LJS, PM, RDA, RM, SET and TW) to assess compliance with D.4.b.ii in IA-RTS assessments found 11 records in substantial compliance (CM, EDM, ERM, JWR, LJ, LJS, PM, RDA, RM, SET and TW) and one record in partial compliance (LB).

A review of the records of 12 individuals (BB, BH, CDJ, CPP, DLN, JJS, JLA, JLG, JLS, MAO, MEB and SW) to assess compliance with D.4.b.ii in Vocational Rehabilitation assessments found two records in substantial compliance (BB and DLN) and ten records in partial compliance (BH, CDJ, CPP, JJS, JLA, JLG, JLS, MAO, MEB and SW). An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive description of the individual's functional status and skills and supports needed to transfer to the next level of care. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii

		compliance and the level of compliance noted in record review. A review of the records of eight individuals (ALH, FR, KG, MAB, SB, TG, TMC and WOS) to assess compliance with D.4.b.ii in Physical Therapy assessments found seven records (ALH, FR, KG, SB, TG, TMC and WOS) in partial compliance and one record not in compliance (MAB). An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive description of the individual's functional status and skills and supports needed to transfer to the next level of care. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii compliance and the level of compliance noted in record review. A review of the records of five individuals (BJW, DEM, KDL, PMH and TP) to assess compliance with D.4.b.ii in Occupational Therapy assessments found all records in partial compliance. An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive description of the individual's functional status and skills and supports needed to transfer to the next level of care. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii compliance and the level of compliance noted in record review. A review of the records of three individuals (GSZ, PA and RLH) to assess compliance with D.4.b.ii in Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found all records in partial compliance. An area of identified deficiency that the facility should focus on in order to improve compliance is that assessments do not consistently provide a comprehensive description of the individual's functional status and skills and supports needed to transfer to the next level of care. A discrepancy was noted between audit data provided by the facility regarding D.4.b.ii compliance and the level of compliance noted in record review.

		Current recommendations: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. 2. Ensure that adequate auditing and training in response to auditing results occurs in regards to D.4.b.ii criteria for focused assessments, and ensure that data is reliable and valid.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 98% of Integrated Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of 208 out of 213). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	94%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	96%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's*	94%

	non-verbal status it is stated as such.	
6.	*Strengths, and:*	89%
6.a	*The individual's strengths for engaging in wellness activities are identified*	96%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	89%
7.	*Motivation for engaging in wellness activities*	82%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	96%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	91%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	87%

Comparative data showed improvement in mean compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	74%	94%
6.	60%	89%
7.	39%	82%
Compliance rate in last month of period		
5.	83%	90%
6.	86%	85%

7.	79%	75%

Using the DMH Vocational Rehabilitation Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Vocational Rehabilitation assessments due each month for the review period of August 2008 - January 2009 (total of 49). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	98%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	98%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	100%
6.	*Strengths, and:*	100%
6.a	*The individual's strengths for engaging in wellness activities are identified*	100%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	100%
7.	*Motivation for engaging in wellness activities*	69%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	86%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	96%
7.c	*Motivation may include both direct quotes from the*	88%

	individual as well as the therapist's assessment of the individual's motivation	

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	59%	98%
6.	48%	100%
7.	13%	69%

Comparative data for item 7 for the last months of the previous and current review periods was not provided.

Using the DMH Occupational Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Occupational Therapy assessments due each month for the review period of August 2008 - January 2009 (total of eight). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	100%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	100%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	100%
6.	*Strengths, and:*	100%
6.a	*The individual's strengths for engaging in wellness*	100%

	activities are identified	
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	100%
7.	*Motivation for engaging in wellness activities*	75%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	100%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	N/A
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	75%

Comparative data showed improvement in compliance or maintenance of compliance greater than 90% since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	100%	100%
6.	91%	100%
7.	20%	75%
Compliance rate in last month of period		
7.	0%	100%
7.a.	100%	100%
7.b	0%	N/A
7.c	50%	100%

Using the DMH Physical Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 92% of Physical Therapy assessments due each month for the review period of August 2008 - January 2009 (23 out of 25). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	70%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	91%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	74%
6.	*Strengths, and:*	75%
6.a	*The individual's strengths for engaging in wellness activities are identified*	92%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	75%
7.	*Motivation for engaging in wellness activities*	88%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	96%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	N/A
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	92%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	94%	70%
6.	76%	75%
7.	30%	88%
Compliance rate in last month of period		
6.	50%	0%
6.b	50%	0%
7.	0%	100%
7.a	100%	100%
7.b	0%	N/A
7.c	0%	100%

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Tool, MSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of August 2008 - January 2009 (total of five). The following table outlines the indicators with corresponding mean compliance rates:

5.	*Identifies the individual's life goals,*	100%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	100%
5.b	*Direct quotes in the individual's own words are used*	100%

	or if quotes are not used as a result of individual's non-verbal status it is stated as such.	
6.	*Strengths, and:*	100%
6.a	*The individual's strengths for engaging in wellness activities are identified*	100%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	100%
7.	*Motivation for engaging in wellness activities*	100%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	100%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	N/A
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	100%

Comparative data showed improvement in or maintenance of compliance greater than 90% since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	100%	100%
6.	50%	100%
7.	50%	100%

		Recommendation 2, September 2008: Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria. **Findings:** The facility provided no data regarding this recommendation. **Other findings:** A review of the records of 12 individuals (CM, EDM, ERM, JWR, LB, LJ, LJS, PM, RDA, RM, SET and TW) to assess compliance with D.4.b.iii in IA-RTS assessments found eleven records in substantial compliance (CM, EDM, ERM, JWR, LJ, LJS, PM, RDA, RM, SET and TW) and one record in partial compliance (LB). A review of the records of 12 individuals (BB, BH, CDJ, CPP, DLN, JJS, JLA, JLG, JLS, MAO, MEB and SW) to assess compliance with D.4.b.iii in Vocational Rehabilitation assessments found all records in substantial compliance. A review of the records of eight individuals (ALH, FR, KG, MAB, SB, TG, TMC and WOS) to assess compliance with D.4.b.iii in Physical Therapy assessments found six records in substantial compliance (ALH, FR, KG, MAB, SB and TG) and two records in partial compliance (TMC and WOS). A review of the records of five individuals (BJW, DEM, KDL, PMH and TP) to assess compliance with D.4.b.iii in Occupational Therapy assessments found all records in substantial compliance. A review of the records of three individuals (GSZ, PA and RLH) to assess compliance with D.4.b.iii in Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found all records in substantial compliance.

		Current recommendation: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible. **Findings:** According to facility report, 9/9 Rehabilitation staff therapists requiring training received training to competency on materials for the Integrated Assessment: Rehabilitation Therapy Section on 9/29/08, 10/17/08, 11/07/08, 12/09/08, and 1/15/09. The training was verified by review of raw data from training rosters and training post-tests. With regard to the revised IA-RTS policy, 40/41 Rehabilitation Therapists requiring training were trained to competency on 12/17/08, 12/18/08, 12/29/08, 1/2/08, 1/6/08, 1/7/08, 1/9/08, 1/15/08, 1/21/08, and 1/22/08. The training was verified by review of raw data from training rosters and training post-tests. According to facility report, 3/3 Vocational Rehabilitation staff members who are performing Vocational Rehabilitation assessments received competency-based training on the Vocational Rehabilitation Assessment on 1/5/09 and were trained to competency. This training was verified by review of raw data from training roster and training post-tests. The Physical Therapist who is performing Physical Therapy assessments received competency-based training on the Physical Therapy focused assessment on 10/6/08 and was trained to competency. This training was

		verified by review of raw data from training roster and training post-test. The Occupational Therapy staff member (1/1) who is performing Occupational Therapy assessments received competency-based training on the Occupational Therapy focused assessment on 12/10/08 and was trained to competency. This training was verified by review of raw data from training roster and training post-tests. Three out of three POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments received training to competency on materials related to the Comprehensive Integrated Physical Rehabilitation Therapy focused assessment on 12/15/08. This training was verified by review of raw data from training roster and training post-tests. **Recommendation 2, September 2008:** Implement a system by which to provide feedback and mentoring to staff based on analysis of audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments). **Findings:** This recommendation has been partially met in terms of Vocational assessments, but it does not appear that adequate mentoring to ensure compliance with focused assessments is occurring at this time. **Recommendation 3, September 2008:** Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.

		Findings: This recommendation has been partially met. A schedule for recommended CEU courses was developed in September 2008. **Other findings**: Currently, the system for mentoring therapists based on audit results is done retroactively, with no proactive training or mentoring to therapists prior to submission of assessments. **Compliance:** Partial. **Current recommendation**: Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that all individuals admitted to MSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months. **Findings:** According to facility report, 191 out of 191 type D.4.d assessments were completed during the review period. At this time, the facility reports that all conversion assessments have been completed. **Other findings:** A review of the records of 11 individuals (AC, AE, BLW, CAS, DR, HL, JC, MEB, RD, SHP and SL) who were reported to have received type D.4.d IA-RTS assessments showed that all records had evidence of completed

		assessments. Five records (AC, AE, HL, JC and SL) were in found to be substantial compliance and six records (BLW, CAS, DR, MEB, RD and SHP) were in partial compliance in regards to assessment quality. **Compliance:** Partial. **Current recommendation**: Same as in D.4.b.i, D.4.b.ii and D.4.b.iii.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Chris Marshall, Director of Nutrition Services 2. Geovanne Dimas, Assistant Director of Nutrition Services 3. Portia Salvacion, Assistant Director of Nutrition Services 4. Virginia Tovar, Assistant Director of Nutrition Services Reviewed: 1. Nutrition Care Monitoring audit data for August 2008 - January 2009 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from August 2008 - January 2009 for each assessment type 3. Records of the following six individuals with type D.5.a assessments from August 2008 - January 2009: AMB, BMT, ITJ, JC, JMA and OH 4. Records of the following two individuals with type D.5.c assessments from August 2008 - January 2009: CC and PA 5. Records of the following five individuals with type D.5.d assessments from August 2008 - January 2009: JKW, LL, MMA, RU and WOS 6. Records of the following five individuals with type D.5.e assessments from August 2008 - January 2009: ADF, JC, LD, SC and VPN 7. Records of the following five individuals with type D.5.f assessments from August 2008 - January 2009: BA, JLG, JM, NB and PAF 8. Records of the following seven individuals with type D.5.g assessments from August 2008 - January 2009: JS, KAR, LAC, LB, MWM, PW and TBM 9. Records of the following eight individuals with type D.5.i assessments from August 2008 - January 2009: AMP, CRT, DD, DLH, FTR, IPF, JB and RR 10. Records of the following five individuals with type D.5.j.i assessments from August 2008 - January 2009: BTM, BU, CJ, CL and MCL

<table>
<tr><td></td><td></td><td>11. Records of the following 10 individuals with type D.5.j.ii assessments from August 2008 - January 2009: CB, CPB, CSR, DCE, FMR, JA, MJA, RLF, SMR and TR
12. Nutrition Services Policy and Procedure 4107: Clinical Nutrition Charting</td></tr>
<tr><td>D.5.a</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period of August 2008 - January 2009 (total of 19). The following table outlines the indicators with corresponding mean compliance rates:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>86%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
<tr><td>9.</td><td>Progress is monitored, measured, and evaluated</td><td>100%</td></tr>
</table></td></tr>
</table>

		10. *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* — 100% 11. *Recommendations are appropriate and complete* — 100% 12. *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* — 100% 13. *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* — 100% 14. *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* — 100% 15. *Assessment utilizes approved abbreviations* — 100% 16. *Assessment is concise* — 100% 17. *Assessment is legible* — 100% 18. *Each page of the assessment is signed* — 100% Comparative data indicated maintenance of compliance greater than 90% for items 2-18 and a decrease in compliance for item 1 from 94% in the previous review period to 86% in the current review period. **Other findings:** A review of the records of six individuals (AMB, BMT, ITJ, JC, JMA and OH) to assess compliance with Nutrition type D.5.a assessment criteria found four records in substantial compliance (AMB, BMT, ITJ and JC) and two records in partial compliance (JMA and OH). **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of	Not applicable—MSH does not have a medical/surgical unit.

	admission.	
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c assessments due each month for the review period of August 2008 - January 2009 (total of three). The following table outlines the indicators with corresponding mean compliance rates:

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

	date of next review. Include NST in comment	
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	NA
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance greater than 90% for items 1-17 (as applicable) and an increase in compliance for item 18 from 80% in the previous review period to 100% in the current review period.

Other findings:
A review of the record of two individuals (CC and PA) to assess compliance with Nutrition type D.5.c assessment criteria found both records in substantial compliance.

Compliance:
Unable to determine at this time due to small sample size.

Current recommendation:
Continue current efforts to achieve compliance.

D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, 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	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its

	comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period of August 2008 - January 2009 (total of 54). The following table outlines the indicators with corresponding mean compliance rates:

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

		18. *Each page of the assessment is signed* 100% Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items. **Other findings:** A review of the records of five individuals (JKW, LL, MMA, RU and WOS) to assess compliance with Nutrition type D.5.d assessment criteria found all records in substantial compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period of August 2008 - January 2009 (total of 42). The following table outlines the indicators with corresponding mean compliance rates: 1. *Assessment is completed on time per policy* 100% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 100% 4. *Estimated daily needs for nutrients specified are* 100%

	appropriate	
5.	*Assessment utilizes findings from subjective and objective data100%*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	NA
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items.

Other findings:
A review of the records of five individuals (ADF, JC, LD, SC and VPN) to assess compliance with Nutrition type D.5.e assessment criteria found four records in substantial compliance (ADF, JC, SC and VPN) and one record in partial compliance (LD).

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

Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
<tr><td>D.5.f</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period of August 2008 - January 2009 (total of seven). The following table outlines the indicators with corresponding mean compliance rates:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>97%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
</table></td></tr>
</table>

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

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1, 3-8, 11-13, and 15-18. Compliance for items 2 and 10 increased from 80% in the previous review period to 100% in the current review period. Items 9 and 14 were not relevant.

Other findings:
A review of the records of five individuals (BA, JLG, JM, NB and PAF) to assess compliance with Nutrition type D.5.f assessment criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g assessments due each month for the review period of August 2008 - January 2009 (total of 104). The following table outlines the indicators with corresponding mean compliance rates:

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

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

Comparative data showed maintenance in compliance greater than 90% in all items from the previous review period.

Other findings:
A review of the records of seven individuals (JS, KAR, LAC, LB, MWM, PW and TBM) to assess compliance with Nutrition type D.5.g assessment criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 36% of all Nutrition Type D.5 Assessments due each month for the review period of August 2008 - January 2009 (501 out of 1379) to assess compliance with D.5.h. The facility found that 99% (weighted mean) of Nutrition admission

		assessments audited had evidence of a correctly assigned NST level. Comparative data showed maintenance of compliance greater than 90% from the previous review period. **Other findings:** A review of records of 53 individuals (ADF, AMB, AMP, BA, BMT, BTM, BU, CB, CC, CJ, CL, CPB, CRT, CSR, DCE, DD, DLH, FMR, FTR, IPF, ITJ, JA, JB, JC, JCY, JKW, JLG, JM, JMA, JS, KAR, LAC, LB, LD, LL, MCL, MJA, MMA, MWM, NB, OH, PA, PAF, PW, RLF, RR, RU, SC, SMR, TBM, TR, VPN and WOS) to assess compliance with D.5.h found all records in compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 22% of Nutrition Type D.5.i assessments due each month for the review period of August 2008 - January 2009 (206 out of 932). The following table outlines the indicators with corresponding mean compliance rates: 1. *Assessment is completed on time per policy* 99% 2. *All required subjective concerns are addressed* 93% 3. *All pertinent objective nutrition information is* 91%

	accurately addressed	
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	99%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	99%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	98%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	94%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	100%
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	99%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items except item 7, for which compliance increased from 88% in the previous review period to 99% in the current review period.

		Other findings: A review of the records of eight individuals (AMP, CRT, DD, DLH, FTR, IPF, JB and RR) to assess compliance with Nutrition type D.5.i assessment criteria found seven records in substantial compliance(AMP, CRT, DD, FTR, IPF, JB and RR) and one record in partial compliance (DLH). **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop and implement a formal system to log and track incoming referrals. **Findings:** A system to log and track incoming referrals was developed and the Nutrition Services Policy and Procedure 4107: Clinical Nutrition Charting was revised to reflect the process. **Recommendation 2, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D5j.i. Assessments due each month for the review period of August 2008 - January 2009 (total of 10). The following table outlines the indicators with corresponding mean compliance rates:

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

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for all items except items 4 and 10,

		for which compliance increased from 81% and 87% respectively in the previous review period to 100% in the current review period. **Other findings:** A review of the records of five individuals (BTM, BU, CJ, CL and MCL) to assess compliance with Nutrition type D.5.j.i assessment criteria found four records in substantial compliance (BTM, BU, CL and MCL) and one record in partial compliance (CJ). **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 36% of Nutrition Type D.5.j.ii assessments due each month for the review period of August 2008 - January 2009 (87 out of 235). The following table outlines the indicators with corresponding mean compliance rates:

1.	*Assessment is completed on time per policy*	99%
2.	*All required subjective concerns are addressed*	99%
3.	*All pertinent objective nutrition information is accurately addressed*	100%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%

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

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all items.

Other findings:
A review of the records of 10 individuals (CB, CPB, CSR, DCE, FMR, JA, MJA, RLF, SMR and TR) to assess compliance with Nutrition type D.5.jii assessment criteria found nine records in substantial compliance (CB, CPB, DCE, FMR, JA, MJA, RLF, SMR and TR) and one record in partial compliance (CSR).

		Compliance: Substantial. **Current recommendation**: Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Cynthia Lusch, Clinical Administrator 2. Donnie Yoo, Supervising Social Worker 3. Ken Layman, Treatment Enhancement Coordinator 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Sharon Nevins, Executive Director 6. Shirin Karimi, LCSW, Chief of Social Work 7. Terry Garcia, LCSW, Supervising Social Worker Reviewed: 1. Charts of the following 21 individuals: AEE, BTM, CR, EB, JB, JC, JG, JKW, JVM, JW, KL, KVM, LD, LEL, MKC, MMS, PAL, RR, SL, SRC, and TM 2. Discharge Planning and Community Integration Audit Tool 3. DMH Integrated Assessment: Social Work Section Instructions 4. DMH Social History Assessment Monitoring Form 5. DMH WRP Discharge Planning and Community Integration Auditing Form 6. Integrated Assessments: Social Work Section 7. List of individuals assessed to need family therapy 8. Social History Assessments 9. WRP Documentation Worksheet Observed: 1. Demonstration of MSH MAPP2 Reporting Portal 2. PSR Mall group: Acceptance and Commitment 3. PSR Mall group: Coping Skills 4. PSR Mall group: Medical Health and Wellness 5. PSR Mall group: Substance Recovery 6. WRPC (Program III, unit 415) for monthly review of AMP

<table>
<tr><td></td><td></td><td>7. WRPC (Program V, unit 405) for 14-day review of EM
8. WRPC (Program V, unit 411) for monthly review of LS</td></tr>
<tr><td>D.6.a</td><td>Is, to the extent reasonably possible, accurate, current and comprehensive;</td><td>

Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that the 5-Day Integrated Assessment and the 30-Day Social History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive.

Findings:
Using the DMH Social History Integrated Assessments Form, NSH assessed its compliance based on an average sample of 100% of the Integrated Assessments due each month during the review period (August 2008 to January, 2008):

<table>
<tr><td>1.</td><td>Is, to the extent reasonably possible, accurate</td><td>95%</td></tr>
<tr><td>2.</td><td>Current, and</td><td>59%</td></tr>
<tr><td>2.a</td><td>Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.</td><td>92%</td></tr>
<tr><td>2.b</td><td>Includes behavioral observations since the time of admission, and</td><td>66%</td></tr>
<tr><td>2.c</td><td>Provides adequate information regarding the individual's current psychosocial functioning.</td><td>85%</td></tr>
<tr><td>3.</td><td>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.</td><td>97%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90%

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from the previous review period for items 1 and 3, and decline in compliance for item 2 as follows:

	Previous period	Current period
Mean compliance rate		
2.	75%	59%
Compliance rate in last month of period		
2.	91%	95%
2.a	100%	100%
2.b	100%	95%
2.c	89%	100%

A review of 15 charts (AEE, BTM, JB, JC, JG, JVM, JW, KL, LEL, MKC, MMS, PAL, SL, SRC and TM) found that 14 of the 15 Integrated Assessments: Social Work Section contained within the charts were current, accurate, and comprehensive.

A review of another 15 charts (AEE, BTM, JB, JG, JVM, JW, KL, LEL, MKC, MMS, PAL, RR, SL, SRC and TM) to evaluate the timeliness, accuracy, and completeness of the 30-day Social History Assessments found that nine of the 30-day assessments in the charts met compliance, and the remaining six (JVM, JW, KL, LEL, MKC and RR) had one or more deficits (for example, MKC was untimely and JVM was incomplete).

MSH did not present data for the 30-Day Psychosocial Assessments for this recommendation.

According to the Chief of Social Work, a barrier to compliance is that behavioral observation was not included as an item in the Integrated Assessments and therefore the Social Work staff conducting the assessments were not including behavior observation data. The revised version of the Integration Assessment tool includes a section for

		behavioral observations. The Social Work chief has seen improvement since the revised assessment was implemented. **Other findings:** Two supervising social workers have left the Social Work department. The Chief of Social Work is covering the tasks of the two social workers with assistance from the remaining Supervising Social Work staff. MSH had hired three levels-of-care Social Work staff, but the facility still has a vacancy for four level-of-care staff. **Compliance:** Partial. **Current recommendation**: Ensure that the 5-Day Integrated Assessment and the 30-Day Social History Assessment are, to the extent reasonably possible, accurate, current, and comprehensive.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments. **Findings:** Using the Social History Assessment Monitoring Form, NSH assessed its compliance based on an average sample of 95% of the 30-day Social History Assessments due each month during the review period (August 2008 to January, 2008): 4. *Expressly identifies factual inconsistencies among sources.* 99% 5. *Resolves or attempts to resolve inconsistencies.* 98%

		6. *Explains the rationale for the resolution offered.* 98% Comparative data showed maintenance of compliance greater than 90% from the previous review period for all items. This monitor reviewed nine charts (BTM, JVM, JW, LEL, MKC, PAL, SL, SRC and TM). Seven of the 30-day Social History Assessments in the charts (BTM, JW, LEL, MKC, SL, SRC and TM) addressed the factual inconsistencies and where factual inconsistencies were identified, appropriate resolutions were offered, and the remaining two (JVM and PAL) did not. **Compliance:** Partial. **Current recommendation**: Ensure that factual inconsistencies are addressed in the 30-Day Social History Assessments.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. **Findings:** Using the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of all Integrated Assessments: Social Work Section due each month during the review period (August 2008 to January, 2008): 7. *Is included in the 7-day integrated assessment* 87% 7.a *The assessment was completed within five calendar* 89%

	days of the individual's admission, and	
7.b	*Filed in the medical record.*	99%

Comparative data showed modestly mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	90%	87%
Compliance rate in last month of period		
7.	77%	100%
7.a	77%	100%
7.b	100%	100%

This monitor reviewed nine charts (BTM, JVM, JW, LEL, MKC, PAL, SL, SRC and TM). All nine Integrated Assessments in the charts were timely and were made available to the WRPTs before the seven-day conference.

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

Findings:
Using the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a mean sample of 95% of the 30-Day Psychosocial Assessments due each month during the review period (August 2008 to January 2009):

8.	*Fully documented by the 30th day of the individual's admission.*	53%
8.a	*Competed no earlier than the first work day after the 7-day WRPC and no later than the 30th*	53%

	calendar day after admission	
8.b	*Filed in the medical record.*	99%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	72%	53%
Compliance rate in last month of period		
8.	76%	62%
8.a	75%	62%
8.b	100%	100%

Five (PAL, TM, JG, CR, and LD) of the eight (CR, EB, JG, JKW, LD, MKC, PAL and TM) 30-day Social History Assessments in the charts were timely and available to the WRPTs before the 30th day

According to the Chief of Social Work, shortage of staffing, especially in unit 405, made timely completion of the assessments difficult. Unit 405 accounts for the majority of the 30-Day Assessments generated by the facility. To improve compliance, the facility will seek to fill the vacancies and to make unit 405 a priority in terms of staffing.

Compliance:
Partial.

Current recommendations:
1. Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC.
2. Ensure that all 30-day social histories are completed and available to the individual's WRPT members by the thirtieth day of admission.

<table>
<tr>
<td>D.6.d</td>
<td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td>
<td>

Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

Findings:
Using the DMH Social History Assessment Monitoring form, MSH analyzed its compliance based on a 100% sample of all Integrated Assessments: Social Work Section due each month during the review period (August 2008 to January 2009):

<table>
<tr><td>10.</td><td>Educational status</td><td>96%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Nine (BTM, JW, KVM, LEL, MKC, PAL, SL, SRC and TM) of the Integrated Assessments: Social Work Section in the ten charts reviewed (BTM, JW, KL, KVM, LEL, MKC, PAL, SL, SRC and TM) included the individual's educational status.

Using the DMH Social History Assessment Monitoring form, MSH also analyzed its compliance based on a mean sample of 95% of the 30-Day Psychosocial Assessments due each month during the review period (August 2008 to January 2009):

<table>
<tr><td>10.</td><td>Educational status</td><td>14%</td></tr>
<tr><td>10.a</td><td>Education includes recommendations for learning accommodations and testing, or states if none are needed, and</td><td>12%</td></tr>
<tr><td>10.b</td><td>Discusses the impact of the individual's education on his/her Wellness and Recovery.</td><td>94%</td></tr>
</table>

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

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	43%	14%
Compliance rate in last month of period		
10.	20%	4%
10.a	28%	4%
10.b	80%	94%

Four of the (AEE, JB, JG and MMS) of the 30-day Social History Assessments of the six charts reviewed (AEE, JB, JG, KL, MMS and RR) included the individual's educational status. However, none of them included recommendations for learning accommodations and testing or noted that none are needed, or discussed the impact of the individual's education on the individual's Wellness and Recovery services.

According to the Chief of Social Work, the instructions in the monitoring tool had the indicator for the individual's educational history, but not the educational implications for services. The tool has been adjusted to include the educational implications for services.

Compliance:
Partial.

Current recommendation:
Ensure that social histories reliably inform the individual's WRPT about the individual's relevant social factors and educational status.

7. Court Assessments		
		Methodology: Interviewed: 1. David Niz, Chief, Forensic Psychiatry 2. Michael Barsom, MD, Medical Director Reviewed: 1. Charts of six individuals (DMS, FA, FN, JN, SA and SR) who were admitted under PC 1026 2. Charts of six individuals (CM, DJG, JR, KDS, RJ and SG) who were admitted under PC 1370 3. DMH PC 1026 Report Auditing Form 4. DMH PC 1026 Report Auditing Form Instructions 5. MSH PC 1026 Report Auditing summary data (August 2008 to January 2009) 6. DMH PC 1370 Report Auditing Form 7. DMH PC 1370 Report Auditing Form Instructions 8. MSH PC 1370 Report Auditing summary data (August 2008 to January 2009) 9. Forensic Review Panel (FRP) meeting minutes (October 29 and November 25, 2008 and January 28, 2009)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Substantial.

D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period). **Findings:** MSH used the DMH PC 1026 Court Report Monitoring Form to assess compliance (August 2008 to January 2009). The facility reviewed 100% of the court reports during this reporting period. The mean compliance rate for this period was 100%, compared to 95% during the last review period. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1026 (DMS, FA, FN, JN, SA and SR). The review found compliance in five charts (DMS, FN, JN, SA and SR) and partial compliance in one (FA). **Current recommendation**: Continue to monitor this requirement and provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the past period).
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** The mean compliance rate reported by the facility was 96%, compared to 93%) during the last review period.

		Other findings: Chart reviews by this monitor found compliance in all charts reviewed. **Current recommendation**: Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** MSH used the DMH PC 1026 Court Report Monitoring Form to assess compliance (August 2008 to January 2009). The facility reviewed 100% of the court reports during this reporting period. The mean compliance rate for this period was 100%, compared to 95% during the last review period. **Other findings:** This monitor found compliance in two charts (FA and SA) and partial compliance in four (DMS, FN, JN and SR). In order to improve compliance with this requirement, the facility needs to ensure that this assessment is not limited to the psychiatric symptoms that preceded the instant offense but should also include psychosocial triggers of dangerous behavior. The assessment of these triggers should be informed by the WRPT's experience in working with the individual, as clinically appropriate. **Current recommendation**: Same as above.
D.7.a.iv	acceptance of mental illness and understanding of the need	**Current findings on previous recommendation:**

<table>
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<td>for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
<td>
Recommendation, September 2008:
Same as above.

Findings:
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>14.</td><td>Individual's acceptance of mental illness</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's understanding of the need for treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Individual's adherence to treatment</td><td>97%</td></tr>
</table>

Comparative data indicated that MSH has maintained compliance greater than 90% from the previous review period for each indicator.

Other findings:
This monitor found compliance in five charts (DMS, FA, FN, JN and SA) and partial compliance in one (SR).

Current recommendation:
Same as above.
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<tr>
<td>D.7.a.v</td>
<td>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Same as above.

Findings:
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>17.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>100%</td></tr>
<tr><td>18.</td><td>Individual's recognition of precursors and warning</td><td>97%</td></tr>
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		signs and symptoms (that may mediate) future dangerous acts Comparative data indicated maintenance of compliance greater than 90% from the previous review period for both indicators. **Other findings:** Chart reviews by this monitor found compliance in all charts reviewed. **Current recommendation**: Same as above.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 99%, compared to 90% during the last review). **Other findings:** This monitor found compliance in all charts reviewed. **Current recommendation**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above.

		Findings: The facility reported a mean compliance rate of 99%, compared to 95% during the last review). **Other findings:** This monitor found compliance in all charts to which this requirement was applicable (DMS, FN and JN). **Current recommendation**: Same as above.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 100%, compared to 94% during the last review period. **Other findings:** This monitor found compliance in five charts (FA, FN, JN, SA and SR) and partial compliance in one (DMS). **Current recommendation**: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above.

		Findings: MSH reported a mean compliance rate of 94%, compared to 70% during the last review period. **Other findings:** This monitor found compliance in all charts reviewed. **Current recommendation**: Same as above.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the 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:	**Compliance:** Substantial.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as D.7.a.i (as applicable to PC 1370). **Findings:** The facility assessed compliance using the DMH PC 1370 Court Report

		Monitoring Form (August 2008 to January 2009). The mean compliance rate was 95%, compared to 94% during the last review period. **Other findings:** This monitor reviewed the charts of six individuals (CM, DJG, JR, KDS, RJ and SG) who were admitted under PC 1370. All six were in compliance. **Current recommendation**: Same as D.7.a.i (as applicable to PC 1370).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** MSH reported a mean compliance rate of 99%, compared to 97% during the last review period. **Other findings:** This monitor found compliance in all charts reviewed. **Current recommendation**: Same as above.
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	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** MSH reported the following mean compliance rates for each indicator regarding this requirement:

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<table>
<tr><td>14.</td><td>Description of any progress or lack of progress</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's response to treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Current relevant mental status</td><td>98%</td></tr>
<tr><td>17.</td><td>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</td><td>99%</td></tr>
</table>

Comparative data indicated that MSH has maintained compliance greater than 90% from the previous review period for each indicator.

Other findings:
This monitor found compliance in all charts reviewed.

Current recommendation:
Same as above.
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<tr>
<td>D.7.b.iv</td>
<td>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Same as above.

Findings:
MSH reported a mean compliance rate of 96%, compared to 84% during the last review period.

Other findings:
This monitor found compliance in all charts reviewed.

Current recommendation:
Same as above.
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D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue current practice. **Findings:** **Recommendation 2, September 2008:** Provide information regarding any relevant training to FRP members, including the provider, frequency and the content of training. **Findings:** MSH has continued its practice. The following is a summary of current status and training activities since the last review: 1. Members of the FRP have reviewed 100% of court reports and provided written feedback, via emails, to the WRPTs upon review. 2. The FRP Chair has presented sample report deficiencies and required corrections during medical staff monthly meetings and provided face-to-face training sessions to authors of reports that did not meet requirements. 3. During the fall of 2008, members of the FRP provided the following series of forensic lectures to forensic psychiatry fellows as a pilot training project: a. Mentally disordered offenders (11/5/08); b. Dangerousness evaluations and community readiness (11/12/08); c. Involuntary medication in the Penal Code setting (11/19/08); d. Incompetent to stand trial (12/3/08); e. Malingering and psychosis (12/10/08); and f. Criminal responsibility (12/17/08) 4. The facility plans to provide a similar training series to the medical staff beginning in July 2009 through September 2009.

		5. The FRP Chair provided an in-service (11/12/08) to the Department of Social work regarding 1026 commitments and dispositional options. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Provide information regarding any relevant training to FRP members and WRPTs, including the provider, frequency and the content of training.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendations:** **Recommendations 1-3 September 2008:** • Continue current practice. • Provide information on the membership of the FRP and attendance by members during the review period. • Clarify information to address the required participation by the Facility Director or designee in the FRP. **Findings:** Review of minutes of the FRP panel during this reporting period showed that MSH has continued its practice and adequately addressed Recommendations 2 and 3. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: MSH has shown improvement relative to a number of EP requirements in comparison to the previous review. However, compliance still is at the partial stage in many of the areas.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Cynthia Lusch, Clinical Administrator 2. Donnie Yoo, Supervising Social Worker 3. Ken Layman, Treatment Enhancement Coordinator 4. Maribel Forbes, LCSW, Supervising Social Worker 5. Sharon Nevins, Executive Director 6. Shirin Karimi, LCSW, Chief of Social Work 7. Terry Garcia, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. Charts of the following 14 individuals: AEE, AP, AT, BNJ, CR, ERM, JC, JCY, JE, JG, JHT, JOM, LD, and MMS 2. Discharge Planning and Community Integration Audit Tool 3. DMH WRP Discharge Planning and Community Integration Auditing Form 4. Integrated Assessments: Social Work Section 5. List of individuals who met discharge criteria in the last six months 6. List of individuals who met discharge criteria but remain hospitalized 7. List of individuals assessed to need family therapy 8. PSR Mall Hours of Service by Discipline 9. Social History Assessments 10. WRP Documentation Worksheet 11. WRP Update Training "Social Work: The WRP and Discharge

		Planning" <u>Observed</u>: 1. Demonstration of MSH MAPP2 Reporting Portal 2. PSR Mall group: Acceptance and Commitment 3. PSR Mall group: Coping Skills 4. PSR Mall group: Medical Health and Wellness 5. PSR Mall group: Substance Recovery 6. BY CHOICE Incentive Store 7. Psychology Specialty Services Committee Meeting 8. WRPC (Program III, unit 415) for monthly review of AMP 9. WRPC (Program V, unit 405) for 14-day review of EM 10. WRPC (Program V, unit 411) for monthly review of LS
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. **Findings:** According to the Chief of Social Work, MSH conducted training on discharge-specific process, procedures, and appropriate documentation to WRPT members including the team Social Workers. Training also was conducted on the role and function of Social Work ("Social Work: The WRP and Discharge Planning") on October 1, 2008, with eight level-of-care SW staff (27% of the level-of-care SW staff); the training also included a 1:1 basis with Supervising Social Workers. Twenty-four Social Workers (80% of the Social Workers) also underwent a three-day training focusing on writing objectives and interventions led by Ken Layman, the Treatment Enhancement Coordinator. In October 2008, MSH created a WRP Documentation Worksheet that

provides discipline-specific guidelines for team members. In December 2008, 22 (73%) of the level-of-care Social Workers and their teams participated in Computer Lab training driven by the WRP Documentation Worksheet, with the Chief of Social Work and Supervising Social Workers on hand to answer questions and assist with the training. The Social Workers worked with Los Angeles Continuing Care Unit to find alternate placements for the expired 1370 commitment individuals. Programs I, II, and VI are now utilizing Full Service Partnership Program to discharge eligible individuals into community placements.

Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the WRPs due in the review month (August 2008 to January 2009):

4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement.*	56%

Comparative data indicated maintenance of mean compliance at 56% from the previous review period:

	Previous period	Current period
Mean compliance rate		
4.a	56%	56%
Compliance rate in last month of period		
4.a	52%	46%

Three (AEE, JE and JOM) of the six WRPs in the charts reviewed (AEE, CR, ERM, JE, JOM and LD) documented the individual's anticipated discharge setting and relevant skills for the anticipated setting.

Recommendation 2, September 2008:
Ensure appropriate linkage between each discharge criteria, focus of

hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the WRPs due in the review month (August 2008 to January 2009):

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	61%
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP; and*	73%
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective.*	71%

Comparative data indicated improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	51%	61%
Compliance rate in last month of period		
1.	61%	73%
1.a	71%	85%
1.b	74%	79%

This monitor reviewed six charts (AEE, CR, ERM, JE, JOM and LD). Proper linkage was noted between the discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy in five

		of the six WRPs in the charts. **Recommendation 3, September 2008:** Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. **Findings:** MSH referred this monitor to use the data in C2.d.vi for this recommendation. Upon review, this monitor determined that the indicators in C.2.d.vi are not aligned with this recommendation. This monitor reviewed six charts (AEE, CR, ERM, JE, JOM and LD). Two (CR and ERM) of the WRPs in the charts contained documentation indicating that discharge criteria and discharge status were discussed at the WRPC. **Recommendation 4, September 2008:** Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC. **Findings:** MSH referred this monitor to use the data in C.2.g.iii for this recommendation. Upon review, this monitor determined that the indicators in C.2.g.iii are not aligned with this recommendation. This monitor observed three WRPCs. Discharge criteria and discharge status were reviewed with the individual for one of them; discussion was cursory for one because the individual appeared psychotic and was not in a mood to listen or in a mental state to understand and participate in the discussion; and the discussion was incomplete and unsatisfactory in the other. To improve compliance, the SW discipline will shift to 1:1 trainings for

		existing employees and group computer lab training for new employees. The Quality Council will discuss systems issues related to the inclusion of information in the WRPs. **Compliance:** Partial. **Current recommendations**: 1. Ensure that anticipated discharge setting and relevant skills for that setting are developed at the first seven-day WRP. 2. Ensure appropriate linkage between each discharge criteria, focus of hospitalization and relevant PSR Mall groups or individual therapy (as needed) to achieve that discharge criteria. 3. Ensure that the discharge criteria and discharge status are reviewed and documented at each WRPC. 4. Ensure that the discharge criteria and discharge status are reviewed with the individual at each WRPC.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to November 2009):

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	61%
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are stated on the first page of the WRP; and*	73%
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective.*	71%

Comparative data showed progress in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	51%	61%
Compliance rate in last month of period		
1.	61%	73%
1.a	71%	85%
1.b	74%	79%

Four (AEE, AP, JOM and LD) of the eight WRPs in the charts reviewed (AEE, AP, CR, JE, JHT, JOM, LD and MMS) had identified strengths of the individuals for use to achieve the discharge goals. The remaining four (CR, JE, JHT and MMS) did not have strengths identified in the interventions or the quality of the stated interventions were poor. For example, Strength for MMS was stated as "Ms. S's ability to positively engage with others;" however, documentation in the present status section stated MMS to be "quiet and isolative" and having "minimal interaction with others." The same generic statement "Desire to leave the hospital" was given as a strength in multiple interventions and across foci for JHT, and was not individualized to the specific interventions.

<table>
<tr><td></td><td></td><td>Three (ERM, JOM, and JE) of the six WRPs in the charts reviewed (AEE, CR, ERM, JE, JOM and LD) had developed an objective using the individual's life goals.

Compliance:
Partial.

Current recommendations:
1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.
2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.</td></tr>
<tr><td>E.1.b</td><td>the individual's level of psychosocial functioning;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a 21% sample of all Quarterly and Annual WRPs due each month for the review period (August 2008 to January 2009):

<table>
<tr><td>2.</td><td>The individual's level of psychosocial functioning</td><td></td></tr>
<tr><td>2.a</td><td>The individual's level of psychosocial functioning is mentioned in the Present Status section of the WRP, and</td><td>97%</td></tr>
</table></td></tr>
</table>

		Comparative data indicated maintenance of compliance greater than 90% from the previous review period. Five (CR, ERM, JE, JHT and LD) of the ten WRPs in the charts reviewed (AEE, BNJ, CR, ERM, JCY, JE, JG, JHT, JOM and LD) had properly addressed the individual's functional status in the Present Status sections of their WRPs. **Compliance:** Partial. **Current recommendation**: Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. **Findings:** Using the DMH Discharge Planning and community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to January 2009): 3. *Any barriers preventing the individual from transitioning to more integrated environment,* 44%

	especially difficulties raised in previously unsuccessful placements.	
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.*	50%
3.b	*These barriers are listed in Focus 11, with appropriate objectives and interventions.*	54%

Comparative data showed progress in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	32%	44%
Compliance rate in last month of period		
3.	45%	46%
3.a	52%	52%
3.b	55%	56%

Four (AEE, ERM, JOM and LD) of the WRPs in the six charts reviewed (AEE, CR, ERM, JE, JOM and LD) contained documentation to show discussion of the individual's barriers to discharge and/or opened Focus 11 with an objective and interventions. The barriers to discharge were not discussed and/or a focus was not opened with relevant objective and interventions in the remaining two WRPs

This monitor observed three WRPCs. Discharge criteria and discharge status were reviewed with the individual in two of the WRPCs. However, difficulties with previously unsuccessful placements and/or difficulties expected with the anticipated discharge setting were not a topic of the discussion with the individuals.

		According to the SW staff, the WRPTs have yet to fully understand Focus 11. To improve compliance, MSH plans to train WRPT SW staff and increase their accountability in integrating Focus 11 into the WRP. MSH also plans to conduct Focus 11 training specific to each Penal Code and Civil Code hold. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Assess skills and supports deficits the individual may have for the intended placement. • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP at the next scheduled conference. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to November 2009):

4.	*The skills and supports necessary to live in the setting in which the individual will be placed.*	55%
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement*	56%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	83%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	52%	55%
Compliance rate in last month of period		
4.	52%	46%
4.a	52%	46%
4.b	90%	81%

Two (ERM and JOM) of the WRPs in the six charts reviewed (AEE, CR, ERM, JE, JOM and LD) had identified the skills and support that are needed for the individual to successfully transition to the next placement. The remaining four did not address all the elements in these recommendations.

Compliance:
Partial.

Current recommendations:
1. Assess skills and supports deficits the individual may have for the intended placement.
2. Assess the skills and supports that will be needed by the individual

<table>
<tr><td></td><td></td><td>for a successful transition to the identified setting.
3. Include these skills and supports in the individual's WRP at the next scheduled conference.</td></tr>
<tr><td>E.2</td><td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td><td>

Current findings on previous recommendations:

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

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to January 2009):

<table>
<tr><td>12.</td><td>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td><td>62%</td></tr>
<tr><td>12.a</td><td>The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge.</td><td>68%</td></tr>
<tr><td>12.b</td><td>The WRPT asks the individual if he or she is able to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to discharge criteria.</td><td>67%</td></tr>
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Comparative data showed mixed changes in compliance since the last review as follows:

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	Previous period	Current period
Mean compliance rate		
13.	66%	62%
Compliance rate in last month of period		
13.	59%	84%
13.a	73%	X
13.b	68%	X

According to the Chief of Social Work, data is not available for sub-indicators 13a and 13b for January 2009 because changes were made to the WRP observation audit form in December 2008.

Four (AEE, CR, ERM and JOM) of the six WRPs in the charts reviewed (AEE, CR, ERM, JE, JOM and LD) contained documentation that the individual actively participated in the discussion of his/her discharge criteria. Where appropriate, there was documentation that individuals did not understand, were confused, or chose not to participate in the discussion. For example, CR had questioned the validity of the tests and indicated that he did not think they pertained to him.

Recommendations 2 and 3, September 2008:

- Develop individualized and measurable discharge criteria.
- Prioritize objectives and interventions related to the discharge processes.

Findings:

This monitor reviewed seven charts (AEE, CR, ERM, JE, JOM, LD and MMS). Three of the WRPs in the charts (AEE, CR and ERM) had measurable objectives and interventions to address the individual's discharge criteria. The discharge criteria in the remaining four (JE, JOM, LD and MMS) were not objective or measurable, were not individualized, and/or did not prioritize objectives and interventions

		related to the discharge process. For example, JE's WRP did not address one or more discharge criteria in the objectives/intervention sections, and JOM's WRP did not have a Focus 7. According to the facility, a barrier to compliance is WRPT members' failure to ask for the individual's input into discharge matters. To improve compliance, MSH will ensure that WRPTs identify discharge criteria and prioritize them for interventions/services, and track and mentor WRPTs with low scores. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Develop individualized and measurable discharge criteria. 3. Prioritize objectives and interventions related to the discharge processes.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP. **Findings:** A review of six WRPs (AEE, BNJ, JC, JCY, JHT and MMS) found that three were acceptable with minor deficiencies, and three had major deficiencies and did not meet acceptable standards. The 6-Ps documentation and quality of the subsequent sections (foci, objectives, interventions, and discharge criteria) were not well developed and

		integrated for MMS (included incomplete statements and inconsistencies, objectives were not observable/measurable, interventions read like objectives, and had no focus for life goals). AEE's 6-Ps were not well integrated; barriers to discharge simply stated "he needs to complete his recovery plan," focus statement was incomplete, milieu interventions were not aligned with the active treatments, and interventions read like objectives. Some of the objectives and interventions for JHT were not achievable (for example losing weight, to go from a BMI of 32 to 27 in 90 days) given the nature, frequency, intensity, and duration of the activities recommended (and statement in the present status indicated that the individual gained five pounds recently). Barriers to discharge for BNJ were not well documented and lacked alignment between active treatments and milieu interventions. **Other findings:** This monitor reviewed a number of documents developed by the SW staff (WRP Update Training "Social Work: The WRP and Discharge Planning", and WRP Documentation Worksheet). These documents should assist WPRTs if they choose to read, understand, and apply the information. **Compliance:** Partial. **Current recommendation**: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:**

Recommendation, September 2008:
Write all objectives, including those dealing with discharge criteria, in behavioral and measurable terms.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to January 2009):

	Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	
6.	*Measurable interventions regarding these discharge considerations*	56%
6.a	*The interventions are aligned with their respective objectives, and*	95%
6.b	*All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.*	56%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	59%	56%

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>48%</td><td>60%</td></tr>
<tr><td>6.a</td><td>97%</td><td>98%</td></tr>
<tr><td>6.b</td><td>48%</td><td>60%</td></tr>
</table>

The objectives and interventions in two (JCY and JG) of the WRPs from six charts reviewed (AEE, BNJ, JCY, JG, JHT and MMS) had observable/measurable objectives, active interventions aligned with the objectives, and milieu interventions that were aligned with the active interventions. The remaining four did not. For example, some of the stated interventions read more like objectives (e.g. "Ms. S will be from complications of hypertension," "Mr. E will have normal chest x-ray"), some objectives were observable and measurable but unrealistic (e.g. BMI decrease from 32 to 27 in 90 days), and some milieu interventions were not aligned with the active interventions.

Compliance:
Partial.

Current recommendation:
Write all objectives, including those dealing with discharge criteria, in behavioral and measurable terms.
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<tr>
<td>E.3.b</td>
<td>the staff responsible for implement the interventions; and</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:
• Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted.
• Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.
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Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 21% of the Quarterly and Annual WRPs due each month during the review period (August 2008 to January 2009):

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<tr><td>7.</td><td>The interventions specify the name(s) of specific staff responsible for implementing each one</td><td>92%</td></tr>
</table>

Comparative data indicated improvement in compliance from 81% in the previous review period.

Six (AEE, CR, ERM, JG, JOM and LD) of eight WRPs reviewed (AEE, CR, ERM, JCY, JE, JG, JOM and LD) had documented the staff member responsible for each intervention. In three of the WRPs reviewed (JCY, JG and JOM), the staff identified in the intervention sections also matched the staff listed in the Mall schedules.

According to the Mall Director, the alignment will be automatically fixed and compliance improved when MAPP2 is rolled out.

Compliance:
Partial.

Current recommendations:
1. Ensure that for each intervention in the Mall or for individual therapy, the name of the staff member responsible is noted.
2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.

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<tr>
<td>E.3.c</td>
<td>The time frames for completion of the interventions.</td>
<td>

Current findings on previous recommendation:

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Recommendation, September 2008:
For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 20% of the Quarterly and Annual WRPs due each month for the review period (August 2008 to January 2009):

	Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	
8.	*The time frames for completion of interventions*	79%
8.a	*The frequency of the interventions are specified*	79%
8.b	*The duration of the interventions are specified.*	79%

Comparative data showed modest changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	80%	79%
Compliance rate in last month of period		
8.	84%	85%
8.a	84%	85%
8.b	84%	85%

		Four (ERM, JE, JOM and LD) of the six WRPs reviewed (AEE, CR, ERM, JE, JOM and LD) referenced the appropriate time frame for the next scheduled review. **Compliance:** Partial. **Current recommendation**: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Partial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Reduce the overall number of individuals still hospitalized after referral for discharge has been made. **Findings:** The list reviewed by this monitor of individuals referred for discharge but still hospitalized contained a total of 57 individuals. Thirty-eight individuals are awaiting discharge on the Los Angeles County "Alternate Level of Care (ALOC) placement. The reasons for the 38 individuals' continued presence at MSH include lack of suitable placement for medically fragile individuals, pending charges, denial of consent by conservators, and waiting for interview by the Los Angeles Continuing Care. Seven individuals are awaiting placement to other counties in California, and the primary barrier to discharge for these individuals is

		the availability of placement settings. Twelve forensic individuals with CONREP recommendations on the list have to contend with lack of placement, denial by CONREP, and battles between the DA and the individuals' attorneys on a number of issues. Documentation review and SW staff interviews found that the SW staff continues to advocate for the individuals' discharge despite a number of external barriers, especially with issues dealing with CONREP. **Current recommendation**: Reduce the overall number of individuals still hospitalized after referral for discharge has been made.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure and document that individuals receive adequate assistance when they transition to the new setting. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, MSH analyzed its compliance based on a mean sample of 12% of the Quarterly and Annual WRPs due each month for the review period (August 2008 to January 2009): *Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:* 10. *Individuals receive adequate assistance in transitioning to the new setting. (E4b)* — 43% 10.a *The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and* — 77%

10.b	*Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.*	43%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	50%	43%
10.a	66%	77%
10.b	53%	43%
Compliance rate in last month of period		
10.	67%	38%
10.a	75%	83%
10.b	67%	39%

One (ERM) of the six WRPs reviewed (AT, CR, ERM, JE, JOM and LD) indicated the assistance needed by the individual and/or the assistance provided to the individual when transitioning to the discharge setting.

To improve compliance, MSH is focusing on one-to-one training with staff showing low compliance and the provision of weekly and real-time responses to poorly written documents.

Current recommendation:
Ensure and document that individuals receive adequate assistance when they transition to the new setting.

E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of cell E.5 and sub-cells are not presently applicable to MSH because the facility no longer serves children and adolescents. At the time of the last tour during which MSH served children and adolescents (March 2008), the facility was judged to be in substantial
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding	

	six months; and	compliance with the requirements of E.5 and sub-cells.
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. MSH has decreased the unjustified long-term use of high-risk medications (benzodiazepines and anticholinergic agents). 2. MSH has increased reporting of adverse drug reactions (ADRs). 3. MSH has completed appropriate intensive case analysis for ADRs that met severity thresholds. 4. MSH has completed drug utilization evaluations regarding the use of new generation antipsychotic medications, benzodiazepines and anticholinergic medications. 5. MSH has developed a policy and procedure to address the needs of individuals suffering from metabolic disorders. 6. MSH has initiated medication guidelines regarding the use of benzodiazepines and anticholinergic medications. **Summary of Progress on Psychological Services:** MSH has made significant improvement in the BY CHOICE Incentive System documentation in the Present Status section of the individuals' WRPs. The documentation is more comprehensive, in most cases included quantitative data, and in many cases included comparison from the previous documentation. **Summary of Progress on Nursing Services:** 1. MSH has made improvements regarding the documentation of circumstances of and responses to PRN and Stat medications. 2. MSH has implemented the new change of shift process and has made significant improvements in the clinical content of the report. **Summary of Progress on Rehabilitation Therapy Services:** 1. A plan outlining a process for F.4.a.ii has been developed and implemented. 2. An F.4 monitoring tool has been developed and implemented, though

	data for population (N) sizes appeared to be unclear in some areas of the audit tool, including F.4.a and F.4.c. 3. Data analysis based on requisite audit samples for each area of F.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Services:** 1. Review of data from the Meal Accuracy report shows substantial compliance with tray accuracy. 2. Nutrition PSR Mall group lesson plan appears to meet generally accepted standards of practice, though interventions and quality objectives are not being consistently listed in WRPs with progress in the group documented in the present status section of the WRP. **Summary of Progress on Pharmacy Services:** MSH has achieved substantial compliance with the EP requirements regarding pharmacy services. **Summary of Progress on General Medical Services:** 1. MSH has recruited a permanent Chief of Medical Services. 2. DMH has continued efforts to finalize a variety of nursing and medical protocols and templates for nursing documentation, with implementation planned during the next review period. **Summary of Progress on Infection Control:** 1. Infection Control continues to maintain substantial compliance in a number of areas. 2. The Infection Control Department has revised the Hospital Annual Update training, increasing the focus on the development of WRPs

	that address Infection Control issues. **Summary of Progress on Dental Services** 1. Dental Services has continued to maintained substantial compliance in a number of areas. 2. Increased collaboration between the Dental Department and the WRPTs has resulted in improved addressing of dental refusals. 3. MSH's Dental Department has implemented the new dental software.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Bala Gulasekaram, MD, Chief of Psychiatry 2. Behnam Behnam, MD, Chief of Professional Education 3. Michael Barsom, MD, Medical Director Reviewed: 1. The charts of the following 36 individuals: AB, AD, AJH, ARD, CB, DE, EGW, EW, EWC, FDA, FPR, GWB, JC, JGH, JM, JMC, JR, KDR, MD, MLC, NSM, PS, RAM, RG, RJA, RLH, RS, RU, SO, SS, TM, TM(2), TMC, TP, WH and YH 2. PSH Pharmacy and Therapeutics Manual: Disorders of Water Homeostasis, effective September 1, 2008 3. MSH DUE: Metabolic Syndrome at MSH and Plan of Action (October 1, 2008) 4. Draft of MSH lecture (planned): Hyponatremia 5. MSH list of individuals with psychotropic medications, diagnoses and attending physicians 6. MSH database regarding intra-class and inter-class polypharmacy 7. DMH Admission Psychiatric Assessment Auditing Form 8. DMH Admission Psychiatric Assessment Auditing Form Instructions 9. MSH Admission Psychiatric Assessment Auditing summary data (August 2008 to January 2009) 10. DMH Integrated Assessment: Psychiatry Section Auditing Form 11. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 12. MSH Integrated Assessment: Psychiatry Section Auditing summary data (August 2008 to January 2009) 13. DMH Monthly Psychiatric Progress Notes Auditing Form 14. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 15. MSH Monthly Psychiatric Progress Notes summary data (August

		2008 to January 2009) 16. MSH PRN and Stat monitoring summary data (August 2008 to January 2009) 17. MSH Benzodiazepine Monitoring summary data (August 2008 to January 2009) 18. MSH Anticholinergics Monitoring summary (August 2008 to January 2009) 19. MSH Polypharmacy Monitoring summary data (August 2008 to January 2009) 20. DMH New Generation Antipsychotic Medications Monitoring Form 21. DMH New Generation Antipsychotic Medications Monitoring Form Instructions 22. MSH New Generation Antipsychotic Medications Monitoring summary data 23. DMH Tardive Dyskinesia (TD) Monitoring Form 24. DMH TD Monitoring Form Instructions 25. MSH TD Monitoring summary data (August 2008 to January 2009). 26. MSH data regarding ADRs from August 2008 to January 2009 27. Last ten completed ADR reporting forms 28. MSH Intensive Case Analysis: ADR Report for Hyponatremia (September 2008) 29. MSH Intensive Case Analysis: ADR Report for Hyponatremia (October 2008) 30. MSH Intensive Case Analysis: ADR Report for Medication-Induced Pancreatitis (November 2008) 31. Last ten completed medication variance reporting forms 32. MSH data regarding medication variances (August 2008 to January 2009) 33. Meeting minutes of the Pharmacy and Therapeutics (P&T) Committee (August 14, August 28, September 25, October 9, October 23, December 9 and December 17, 2008 and January 8, 2009) 34. MSH data regarding continuing education status of psychiatry staff 35. MSH Policy and Procedure, Metabolic Syndrome, effective October 1,

		2008 36. MSH Medical Risk Factors and Metabolic Syndrome Group Curriculum Lesson Plan 37. MSH DUE reports completed during this period (New Generation Antipsychotics, Intra-Class Polypharmacy, Benzodiazepines and Anticholinergics) 38. MSH Psychopharmacology Guidelines: Benzodiazepines and Anticholinergics
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Specifically, ensure that the current guidelines are aligned with current standards regarding monitoring for pancreatic dysfunction in individuals receiving high-risk new generation antipsychotic medications. **Findings:** MSH reported that it developed guidelines for benzodiazepine medications, anticholinergic medications and management of metabolic syndrome during this review period. Additionally, the facility reported that it adopted the Water Homeostasis Guidelines developed at Patton State Hospital. The DMH New Generation Antipsychotic Medications Auditing form contains current standards in regard to monitoring for pancreatic dysfunction in individuals receiving high-risk new generation antipsychotic medications. **Recommendations 2 and 3, September 2008:** • Monitor these requirements using standardized indicators across state facilities. • Provide data analysis that evaluates areas of low compliance and

		delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the previously mentioned DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms. The average samples were 90%, 77% and 21%, respectively. In some instances the facility failed to provide the compliance information outlined in the introduction of this report. Available compliance data are summarized in each cell below. **Other findings:** See this monitor's findings in D.1.c.ii, D.1.c.iii, D.1.d.i and D.1.f. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. 2. Revise the current MSH guideline regarding the use of benzodiazepines to address parameters for the appropriate use of these medications in individuals diagnosed with substance use disorders. 3. Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing form based on at least 20% samples. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 5. Provide a summary outline of improvements in practice made as a

		result of the facility's review of internal monitoring data.
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	

Admission Psychiatric Assessment		
8.	*Plan of care includes:*	91%
8.a	*Regular psychotropic medications, with rationale.*	93%
8.b	*PRN and/or Stat medication as applicable, with specific behavioral indications*	75%
8.c	*Special precautions to address risk factors, as indicated.*	92%

The mean compliance rate for this indicator increased to 91% from 84% reported during the previous review.

Integrated Psychiatric Assessment		
7.	*Diagnostic formulation is documented*	84%
10.	*Psychopharmacology treatment plan includes:*	57%
10.a	*Current target symptoms*	82%
10.b	*Specific medication to be used*	96%
10.c	*Dosage titration schedules, if indicated.*	80%
10.d	*Adverse reactions to monitor for*	63%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation*	64%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications.*	92%
10.g	*Medication consent issues were addressed*	96%

The facility did not present comparative data from the last month of the previous review period to the last month of the current review period for the main items or the sub-items. However, comparative data that was presented did show improvements in mean compliance in the main indicators since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	77%	84%
10.	16%	57%

Monthly PPN		
2.b	*The current target symptoms which are the focus of treatment are identified in the progress note.*	98%
6.a.1	*The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	90%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.*	95%

Comparative data showed maintenance or improvements in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.b	98%	98%
6.1.a	84%	90%
6.1.b	90%	95%

To address the deficiencies identified through review of the facility's auditing data, MSH developed and implemented the MSH Corrective Action Form (CAF) during this review period. This form provides feedback that is specific to each physician's compliance with EP

<table>
<tr><td></td><td></td><td>requirements. In the facility's status report, MSH indicated that improvements in compliance rates have been noted following implementation of the CAF in November 2008.</td></tr>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.h.2</td><td>Current psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</td><td>97%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as F1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>98%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>98%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan (is documented).</td><td>98%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all indicators.
</td></tr>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented.)</td><td>86%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>93%</td></tr>
</table>
Comparative data showed modest changes in compliance since the
</td></tr>
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<tr>
<td></td>
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<td>previous review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.b</td><td>89%</td><td>86%</td></tr>
<tr><td>6.c</td><td>94%</td><td>93%</td></tr>
</table>
The facility did not present comparative data for the last month of the previous and current review periods for 6.b.</td>
</tr>
<tr>
<td>F.1.a.vi</td>
<td>modified based on clinical rationales;</td>
<td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.1</td><td>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>90%</td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>95%</td></tr>
</table>
Comparative data showed improvements in compliance since the previous review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a.1</td><td>84%</td><td>90%</td></tr>
<tr><td>6.a.2</td><td>90%</td><td>95%</td></tr>
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<tr>
<td>F.1.a.vii</td>
<td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td>
<td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>98%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented.)</td><td>86%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>93%</td></tr>
</table>

Comparative data showed mixed changes in compliance since the previous review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.c</td><td>93%</td><td>98%</td></tr>
<tr><td>6.b</td><td>89%</td><td>86%</td></tr>
<tr><td>6.c</td><td>94%</td><td>93%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.b</td><td>94%</td><td>94%</td></tr>
</table>
</td>
</tr>
<tr>
<td>F.1.a.viii</td>
<td>Properly documented.</td>
<td>
<table>
<tr><td>Admission Psychiatric Assessment</td><td>8.a, 8.b and 8.c</td><td>87%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>7 and 10</td><td>71%</td></tr>
<tr><td>Monthly PPN</td><td>2.b, 2.c, 2.d, 2.h.2, 6.a.1, 6.a.2, 6.b and 6.c</td><td>94%</td></tr>
</table>

Comparative data showed maintenance of compliance with regard to the Admission Psychiatric Assessments and Monthly PPNs and a significant increase in compliance for Integrated Assessments since the previous review as follows:
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<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>Admission Psychiatric Assessment</td><td>88%</td><td>87%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>46%</td><td>71%</td></tr>
<tr><td>Monthly PPN</td><td>93%</td><td>94%</td></tr>
</table>
</td></tr>
<tr><td>F.1.b</td><td>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.</td><td>
Current findings on previous recommendations:

Recommendations 1 and 2, September 2008:
• Monitor this requirement using the DMH Monthly PPN, DMH Nursing Services PRN and DMH Nursing Services Stat Auditing Forms, based on at least a 20% sample.
• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:

<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>7.</td><td>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:</td><td>84%</td></tr>
<tr><td>7.a</td><td>Describes the rationale/specific indications for all PRN orders.</td><td>89%</td></tr>
<tr><td>7.b</td><td>Reviews the PRNs and Stats during the interval period.</td><td>91%</td></tr>
<tr><td>7.c</td><td>Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.</td><td>73%</td></tr>
<tr><td>7.d</td><td>Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat</td><td>80%</td></tr>
</table>
</td></tr>
</table>

	medications.	

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
7.	74%	84%
Compliance rate in last month of period		
7.	60%	94%
7.a	87%	96%
7.b	73%	95%
7.c	47%	90%
7.d	38%	92%

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	97%
2.	*Documentation of the circumstances requiring PRN medication.*	89%
3.	*Documentation of the individual's response to PRN medication.*	90%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	97%	97%
2.	67%	89%
3.	68%	90%

	Previous period	Current period
Compliance rate in last month of period		
1.	95%	96%
2.	80%	92%
3.	83%	91%

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	98%
2.	*Documentation of the circumstances requiring Stat medication.*	88%
3.	*Documentation of the individual's response to Stat medication.*	89%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	96%	98%
2.	67%	88%
3.	66%	89%
Compliance rate in last month of period		
1.	91%	97%
2.	82%	89%
3.	80%	92%

Compliance:
Partial.

		Current recommendations: 1. Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least 20% samples. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Continue to monitor this requirement using the DMH instruments based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the DMH Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms (August 2008 to January 2009) to assess compliance with this requirement. The following summarizes the data:

Benzodiazepines (average sample has varied depending on the indicator, ranging from 80% to 100% of all individuals receiving regularly scheduled benzodiazepines)		
1.	*Indication for regularly scheduled use of benzodiazepine clearly documented in medical record*	80%
2.	*Benzodiazepine used for individuals with alcohol / drug use problems justified in PPN*	58%
3.	*Benzodiazepine used for individuals with cognitive disorders justified in PPN*	63%

	Routine Benzodiazepine use for more than two months, PPN clearly documents the risks of:	
4.	*Drug dependence*	75%
5.	*Cognitive impairment*	74%
6.	*Sedation*	75%
7.	*Gait unsteadiness / falls if indicated*	66%
8.	*Respiratory depression (for those with underlying respiratory problems e.g. COPD)*	52%
9.	*Toxicity if used in individuals with liver impairment (if using long acting agents)*	0%
10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.*	74%

Comparative data indicated improvement in compliance since the previous review, with the exception of item 9, as follows:

	Previous period	Current period
Mean compliance rate		
1.	67%	80%
2.	30%	58%
3.	14%	63%
4.	41%	75%
5.	43%	74%
6.	45%	75%
7.	29%	66%
8.	29%	52%
9.	11%	0%
10.	32%	74%

	Previous period	Current period
Compliance rate in last month of period		
1.	69%	93%
2.	18%	89%
3.	14%	100%
4.	45%	87%
5.	45%	87%
6.	45%	93%
7.	17%	73%
8.	25%	50%
9.	20%	0%
10.	24%	87%

MSH reported a decrease in the use of benzodiazepine medications from the previous review period:

	Average Number Prescribed During Previous Period	Average Number Prescribed During Current Period
Benzodiazepines, regardless of duration	61	50
Benzodiazepines for greater than 60 days	27	14

MSH indicated that it utilized the CAF to identify practitioners who were not meeting compliance in this area and provided additional training on the facility's Guidelines for Benzodiazepine Use.

Anticholinergics (Average sample has varied depending on the indicator, ranging from 17% to 100% of all individuals receiving regularly scheduled anticholinergic medications)			
1.	Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)	77%	
	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for 2-6.)		
2.	Cognitive impairment	37%	
3.	Sedation	44%	
4.	Gait unsteadiness/falls	27%	
5	Blurred vision, constipation, urinary retention	30%	
6.	Worsening narrow angle glaucoma	22%	
	Regularly scheduled anticholinergics use for more than 2 months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 7-13.)		
7.	Cognitive impairment	65%	
8.	Sedation as indicated	71%	
9.	Gait unsteadiness / falls (as indicated)	54%	
10.a	Blurred vision , constipation, urinary retention	67%	
11.	Worsening narrow angle glaucoma, if present	11%	
12.	Substance abuse/dependence if listed on Axis I	52%	
13.	Worsening TD if present	60%	
14.	Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained. N= all individuals on the four anticholinergics for 14.	98%	
15.	Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk.	68%	

	N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for 15.	

The facility did not provide comparative data for indicators 2-6. Comparative data for the remaining indicators showed improvement in compliance (or maintenance of compliance greater than 90% in the case of item 14) since the previous review period as follows:

	Previous period	Current period
Mean compliance rate		
1.	72%	77%
7.	44%	65%
8.	42%	71%
9.	0%	54%
10	50%	67%
11.	0%	11%
12.	20%	52%
13.	NA	60%
14.	100%	98%
15.	40%	68%
Compliance rate in last month of period		
1.	75%	100%
7.	63%	93%
8.	60%	100%
9.	0%	91%
10.	67%	88%
11.	NA	NA
12.	27%	38%
13.	NA	NA
14.	100%	100%
15.	50%	47%

MSH reported an increase in short-term use of anticholinergic medications and a decrease in long-term use as compared to the previous review:

	Average Number Prescribed During Previous Period	Average Number Prescribed During Current Period
Anticholinergics, regardless of duration	67	78
Benzodiazepines for greater than 60 days	34	23

Polypharmacy (Average sample size was 23% of all individuals prescribed medication meeting the definition of intra-class polypharmacy		
1.	*Target symptoms were clearly identified.*	98%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy.*	76%
3.	*Documentation in PPN justifies the need for intra-class for polypharmacy.*	77%
4	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions*	60%

Comparative data showed improvement in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	81%	98%

2.	58%	76%
3.	64%	77%
4.	41%	60%
Compliance rate in last month of period		
1.	79%	100%
2.	69%	83% (Nov)
3.	NA	98%
4.	48%	78%

MSH reported that it did not monitor interclass polypharmacy during December 2008 and January 2009. Rather, the facility focused on intra-class pharmacy due to concerns related to increased risk of metabolic syndrome secondary to antipsychotic medications. MSH indicated that it intends to monitor both inter- and intra-class polypharmacy during the next review period.

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

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

This monitor also reviewed the charts of individuals receiving the above types of medication uses.

The reviews found that the facility has decreased the overall number of individuals receiving long-term treatment with benzodiazepines and/or anticholinergic medications since the last review period. There was also a

significant decrease in the number of individuals who received these modalities and who were diagnosed with conditions that increase the risk of treatment.

However, the review also found that several individuals received long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented diagnostic justification and/or assessment of the individuals for the risks associated with this practice. These practices must be corrected in order to achieve substantial compliance with this requirement.

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

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AD	Clonazepam	Polysubstance Dependence and Dementia Due To Head Trauma
CB	Clonazepam	Polysubstance Dependence
FPR	Lorazepam	Polysubstance Dependence
JM	Clonazepam	Mild Mental Retardation
RAM	Clonazepam	Polysubstance Dependence
RU	Clonazepam	Alcohol Abuse
SO	Clonazepam	Dementia Due To General Medical Condition With Behavioral Disturbance
TM	Lorazepam	Polysubstance Dependence

Anticholinergic use (none had received medications for more than 60 days)

Individual	Medication(s)	Diagnosis
AJH	Benztropine	Vascular Dementia
ARD	Diphenhydramine	Borderline Intellectual Functioning
JMC	Benztropine	Borderline Intellectual Functioning
MLC	Hydroxyzine	
RG	Benztropine	

Polypharmacy use

Individual	Medication(s)	Diagnosis
FDA	Clozapine, risperidone, lorazepam, paroxetine, divalproex and lamotrigine	
JC	Clozapine, haloperidol, olanzapine and benztropine	
NSM	Clozapine, loxapine, citalopram, trazodone and clonazepam	Polysubstance Dependence
PS	Olanzapine, risperidone, quetiapine, divalproex and sertraline	
RS	Ziprasidone, haloperidol, sertraline, mirtazapine and olanzapine (PRN)	
TM(2)	Clozapine, risperidone, divalproex, duloxetine and lorazepam (PRN)	Polysubstance Dependence
WH	Clozapine, chlorpromazine, benztropine, lorazepam (PRN) and diphenhydramine (PRN)	

Compliance:
Partial.

		Current recommendations: 1. Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms based on at least a 20% sample 2. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
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.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Standardize the monitoring tool regarding the use of new generation antipsychotic medications. • Continue to monitor this requirement based on at least a 20% sample and provide data both for all medications (aggregate) and for each specific medication. • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). **Findings:** MSH reported that the DMH New Generation Antipsychotic Medications Audit Form was finalized and implemented during this review period (November 2008). The facility also reported that it revised the methodology utilized to review the use and monitoring of NGAs. Previously, the facility completed review of one specific medication each month. Presently, a sample of individuals prescribed any NGA is utilized. The facility's data is not reported here due to two factors. A review of comparative data is limited by the methodology change. Additionally, the data presented by the facility are inconsistent (i.e., November 2008 was

reported as the implementation date of the new DMH auditing tool, but auditing data is presented for the entire span of the review period [August 2008 to January 2009].)

Other findings:
This monitor reviewed the charts of 12 individuals who have received NGA medications and are diagnosed with a variety of metabolic disorders during this review period. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis/Diagnoses
AB	Clozapine	Diabetes Mellitus
CB	Quetiapine	Hyperlipidemia and Overweight
DE	Olanzapine	Obesity and Unspecified Hyperlipidemia
EWC	Risperidone	Diabetes Mellitus
GWB	Risperidone	Diabetes Mellitus and Obesity
JGH	Olanzapine	Dyslipidemia
JR	Clozapine	Diabetes Mellitus and Obesity
MD	Olanzapine and ziprasidone	Diabetes Mellitus
RJA	Risperidone	Diabetes Mellitus
RLH	Risperidone (and chlorpromazine)	Diabetes Mellitus, Hyperlipidemia and Overweight
TMC	Risperidone	Obesity
YH	Risperidone and quetiapine	Obesity

The following were positive findings based on this review:

1. In general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk.

		2. The facility has made further improvement in the frequency of laboratory monitoring of serum lipids and pancreatic enzymes for individuals diagnosed with metabolic disorders. 3. The facility has improved its practice regarding the frequency of obtaining serum prolactin level for individuals receiving high-risk medication regimens. However, several deficiencies exist that require corrective actions in order to achieve substantial compliance. The following is an outline: 1. The psychiatric progress notes did not address the medical and behavioral significance of decreased serum sodium levels in an individual who was experiencing increased water ingestion and progressive disturbance of water homeostasis (DE). 2. Some charts included evidence of infrequent monitoring of weight status in individuals diagnosed with a variety of metabolic disorders and receiving high-risk treatment with olanzapine (DE and JGH). 3. There was documentation that the lipid profile had "normalized" in an individual receiving high-risk treatment with quetiapine and diagnosed with hyperlipidemia. However, review of the chart found that the serum lipids had significantly worsened during the interval (CB). There was evidence of unacceptable delay in the initialed review by a physician of laboratory findings. However, this review was completed prior to the psychiatric reassessment. 4. In general, there was inadequate documentation of attempts to utilize/optimize safer antipsychotic treatment alternatives for individuals diagnosed with a variety of metabolic disorders and who were receiving high-risk treatments. 5. The WRP included inadequate objectives and interventions to address an individual's repeated refusal of required laboratory testing. The individual was diagnosed with Diabetes Mellitus and Hyperlipidemia and receiving high-risk treatment with risperidone (RLH). 6. There was no documentation of attention to hyperprolactinemia in

		female individuals receiving high-risk treatment with risperidone, including required update in diagnosis and laboratory and clinical monitoring (TMC and YH). 7. Some psychiatric progress notes included risk/benefit assessments that included a theoretical outline of potential side effects, but did not address the actual occurrences of adverse effects of treatment (TMC and YH). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH New Generation Antipsychotic Medications Audit Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Monitor this requirement based on a 100% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the DMH Tardive Dyskinesia (TD) Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The facility's data is not presented here due to inconsistencies in the data.

		The following are example of the inconsistencies: 1. N for Item 1 is stated to be "All new admissions by month;" however, the value reported for N is not consistent with the number of admissions reported in other areas (e.g. D.1.a). 2. N for Item 3 is stated to be "All individuals who have a positive AIMS, have a diagnosis of TD, or a history of TD;" however, a previous statement noted that the number of individuals with a history of TD had yet to be compiled. This inconsistency also applies to Item 7. MSH's improvements in the process related to identification, treatment and monitoring of TD are summarized: 1. A TD specialty clinic was developed and initiated during this review period. 2. Continuing education related to movement disorders was provided in October and November 2008. 3. MSH reported an increase in frequency of monitoring from quarterly to monthly for individuals with TD. 4. The facility plans to have the Senior Psychiatrists complete the annual AIMS assessment for all individuals. **Other findings:** This monitor reviewed the charts of six individuals (EGW, EW, JGH, KDR, SS and TP) who were currently diagnosed with TD as per the WRPs and/or the psychiatric assessments. This review found that MSH has maintained the progress noted during the last review as evidenced by the following examples: 1. The admission AIMS tests were completed in all the charts reviewed. 2. AIMS testing was completed or attempted at the required frequency in some charts (JGH, SS and TP).

		3. Most WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia (EGW, EW, JGH, SS and TP). 4. The objectives and interventions related to TD utilized appropriate leaning outcomes in a few charts (e.g. TP). 5. Some charts (EW and TP) documented the use of current medication regimens that were relatively less harmful for individuals with this condition compared to other available treatments. 6. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications. However, the review also showed a number of deficiencies that must be corrected to achieve substantial compliance with this requirement. The following are examples: 1. The facility's database identified only six individuals as having a current diagnosis of TD. This number appeared to indicate underreporting of this condition given the prevalence of TD in comparable populations. 2. The WRP did not include diagnosis, focus or interventions to address a diagnosis of TD as identified in the psychiatric progress notes and the facility's database (KDR). 3. The WRPs did not list a diagnosis of TD for some individuals. However, the WRPs documented focus, objectives and interventions to address the condition (EGW). 4. One WRP included an objective that was not attainable for the individual (JGH). 5. The AIMS tests were not documented quarterly as required (EGW, EW and KDR). **Compliance:** Partial.

		Current recommendations: 1. Improve identification of individuals with current diagnosis of TD, a history of TD and/or history of abnormal AIMS and ensure that the database lists these individuals. 2. Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on at least a 100% sample and identify the target population for all indicators. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendations 1,2 and 3 September 2008:** • Increase reporting of ADRs. • Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as severe and for any other reaction. e. Outline of intensive case analysis including description of ADR, recommendations and actions taken. • Provide analysis of patterns and trends, with corrective/ educational actions related to ADRs. **Findings:** The facility data is not presented here as it contained errors in

		calculation. The sums of the tallies reported for classifications of both probability and severity did not equal the total number of ADRs reported for either the previous or the current review period. Of the three severe ADRs, none resulted in permanent sequelae to the individual involved. The intensive case analyses involved the following: 1. Risperidone-induced hyponatremia resulting in discontinuation of risperidone and decision to adopt PSH Water Homeostasis Guidelines. 2. Oxcarbazepine-induced hyponatremia resulting in discontinuation of oxcarbazepine and decision to adopt PSH Water Homeostasis Guidelines. 3. Valproate-induced elevated amylase and lipase resulting in medical workup to rule out other potential causes of elevated amylase and lipase and discontinuation of valproate. **Other findings:** This monitor reviewed the facility's ICA reports for ADRs during this review period and found that the reports met generally accepted standards. **Compliance:** Substantial. **Current recommendations**: 1. Continue to increase reporting of ADRs. 2. Present summary data to address the following: a. Number of ADRs reported during the review period compared with the number during the previous period; b. Classification of ADRs by outcome category compared with the number during the previous period, c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved;

		d. Information regarding any intensive case analysis done for each reaction that was classified as severe, e. Outline of each intensive case analysis including description of ADR, recommendations and actions taken. 3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Conduct DUEs and provide summary data, including topic, findings, recommendations and actions taken. **Findings:** During this review period, MSH conducted three DUEs. These DUEs involved a review of MSH's utilization of benzodiazepines, anticholinergics, and intra-class polypharmacy. The DUEs were consistent with generally accepted standards. **Recommendation 2, September 2008:** Same as in F.1.a. **Findings:** Same as in F.1.a. **Compliance:** Partial. **Current recommendation:** Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.

F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1 and 2 September 2008:** • Increase reporting of potential variances. • Present data to address the following: a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above and for any other reaction; and e. Outline of ICAs, including description of variance, recommendations and actions taken. **Findings:** The following tables summarize the facility's data:

Frequency by Type	Previous period	Current period
Total MVRs	445	789
Potential	207	427
Actual	238	362

Frequency by Category	Current period as reported in facility's progress report	Current period as reported in Key Indicators
Prescribing	34	22
Transcribing	97	107
Order/Procurement	26	24

Dispensing	37	35
Administration	172	187
Drug Security	21	54
Documentation	402	419
Total	789	848

MSH's data on the frequency of specific outcomes of MVRs is not included here as the data is inconsistent with the total numbers of MVRs reported above, which are themselves inconsistent between the two sources of data (the facility's progress report and Key Indicator report).

No variance reached Category E or above; thus, no ICAs were completed during this review period.

Recommendation 3, September 2008:
Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.

Findings:
MSH reported that missing initials on the MAR accounted for more than 50% of MVRs during this reporting period. NOC nurses began implementing checks of the MAR during this review period, which MSH reported as the main contributing factor to the increase in MVRs during this period. The facility reported that analysis of MVRs discovered a case in which the transcription of an order was delayed by 16 days. As a corrective action, MSH developed a new procedure to ensure timely transcription of orders.

Compliance:
Partial.

Current recommendations:
1. Present data to address to address the following:

		a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period, b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual, c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved, d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above, and e. Outline of ICAs, including description of variance, recommendations and actions taken. 2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial. **Current recommendation:** Same as in F.1.a through F.1.h.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above.

		Findings: Same as above. **Compliance:** Partial. **Current recommendation**: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendation**: Same as above.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial.

		Current recommendation: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, September 2008:** Ensure that this practice is triggered for review by the facility's psychopharmacology consultant, with corrective follow-up actions by the Psychiatry Department. **Findings:** See F.1.c. **Current recommendations**: Same as in F.1.c.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above.

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

		Findings: Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in C.2.o, F.1.c and F.1.m.iii. **Findings:** Same as in C.2.n, C.2.o and F.1.c. **Compliance:** Partial. **Current recommendations**: Same as in C.2.n, C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction,	**Current findings on previous recommendation:**

	through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	**Recommendation, September 2008:** Continue current practice and present supporting documentation. **Findings:** MSH reported that 100% (45 of 45) of psychiatrists who provide direct care have received 16 hours of psychopharmacology CME during the previous year. **Compliance:** Substantial. **Current recommendation**: Continue current practice and present supporting documentation.

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** <u>Interviewed</u>: 1. The following two individuals: JC and PS 2. Alex Guerrero, PsyD, PBS Team Leader 3. Angela Appaiah, RN, Acting Nurse Coordinator 4. Aaron Baker, PsyD, Acting Senior Psychologist 5. Ashvind Singh, PhD, Psychologist 6. Christopher Cooper, PhD, PSSC Coordinator 7. Cindy Lusch, Clinical Administrator 8. Constance Nunley, WRP Auditor 9. Darren Sush, PsyD, PBS Team Leader 10. Edwin Poon, PhD., Senior Psychologist 11. Efi Rubinstein, PhD, Senior Psychologist 12. Gretchen Hunt, BY CHOICE Coordinator 13. John Lusch, Program Director 14. Jon Fogel, PhD, DCAT Leader 15. Kathleen Fitzpatrick, PhD, Acting Senior Psychologist 16. Ken Layman, Treatment Enhancement Coordinator 17. Kevin Buckheim, Mall Coordinator for Programs 1 and 2 18. Michael Barsom, MD, Psychiatrist 19. Michael Nunley, Standards Compliance Director 20. Mina Guirguis, PsyD, Acting Senior Psychologist 21. Ruth Flores, WRP Auditor 22. Sharon Smith Nevins, Executive Director 23. Sheri Greve, PsyD, Consulting Psychologist, PSR Mall Services 24. Siobhan Donovan, PsyD, Psychologist 25. Steven Jones, Mall Assistant 26. Swati Roy, PhD, Chief Department of Psychology <u>Reviewed</u>: 1. Charts of the following 45 individuals: AB, AEE, BE, BG, BMY, BTM, BY,

		CG, CH, CJ, CN, CW, DCE, DD, DG, DJB, DY, EF, FR, GG, GRS, GS, JaS, JeS, JH, JiS, JM, JT, LAD, LEL, LJ, LL, LS, MCL, NB, PAW, POG, PW, RR, SJW, SRC, SW, TM, TVM, and WH 2. AD 3415: Screening Individuals for Substance Abuse 3. AD 3465: Assessment of English Language Learners 4. Behavior Guidelines 5. BY CHOICE Program Training Course Curriculum 6. BY CHOICE Program Training Log 7. Focused Psychology Assessments 8. List of individuals meeting Trigger Threshold (August 2008 to January 2009) 9. Neuropsychology Assessment Reports 10. PBS Plan Fidelity Checks 11. PBS Plan Outcome Data and Graphs 12. PBS Staff Training Logs 13. Positive Behavioral Support Plans (PBS) 14. PSR Mall Data Variables from Disciplines' Integrated Assessments 15. PSR Services Add-Drop Request Form 16. PSR Services Add-Drop Request Procedures 17. PSR Services Course Catalog 18. Psychology Specialist Services Committee Meeting Minutes 19. Structural and Functional Assessments 20. Substance Abuse Provider Training Curriculum 21. Substance Abuse Treatment Program Plan of Improvement 22. Summary of Behavioral Interventions and Outcome <u>Observed</u>: 1. Demonstration of MSH MAPP2 Reporting Portal 2. MSH Psychology Specialty Service Committee Meeting 3. PSR Mall group: Acceptance and Commitment 4. PSR Mall group: Coping Skills 5. PSR Mall group: Medical Health and Wellness 6. PSR Mall group: Substance Recovery

		7. BY CHOICE Incentive Store 8. Psychology Specialty Services Committee Meeting 9. WRPC (Program III, unit 415) Monthly Review for AMP 10. WRPC (Program V, unit 405) Fourteen-Day Review for EM 11. WRPC (Program V, unit 411) Monthly Review for LS
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH currently has the three teams necessary to fulfill this requirement. MSH has two PBS teams (one fully staffed and one lacking a data analyst) and one DCAT team, which also lacks a data analyst. The facility is actively recruiting to fill these positions. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** With the establishment of the Psychology Specialty Services Committee (PSSC), MSH has improved its process and procedures for tracking and monitoring individuals in need of behavioral interventions and for the development, implementation and monitoring of PBS plans. The PSSC

		reviews high-risk individuals through the trigger data, reviews PBS plans developed and implemented, and tracks and monitors the plans' effectiveness to make appropriate changes to the plans as warranted by the data. This monitor's discussion with the PSSC coordinator and the Medical Director found that this process will further improve when the joint ETRC-PSSC meetings are implemented. The PSSC coordinator has developed and implemented a database summarizing PBS plan information for review and appropriate action (the documentation includes dates of plan implementation, outcome of target behaviors, plan revision dates, and barriers to effectiveness). Review of training logs found that MSH had conducted 15 training sessions during this review period. The training conducted included topics in assessment, role of the environment, role of choice, interactions, prompting, error correction, chaining and shaping, structural and functional assessments, designing behavior guidelines, PBS and WRP linkage, evaluation of applied research, integrated assessments/interventions in individuals with dual diagnoses, and research methodology. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Continue with competency-based training of all staff in correctly implementing the BY CHOICE program. • Continue to train WRPTs and individuals on the individuals' final choices in allocating points per cycle, ranging from 0 to 100 per cycle.

Findings:
Document review and interview of the BY CHOICE Coordinator found that MSH has been conducting training of Mall group facilitators and general staff on the BY CHOICE incentive system during New Employee Orientation (NEO) and on a monthly basis to the WRPTs, Nursing, and Program Management staff at the Hospital Annual Update (HAU) trainings. Training for individuals is conducted on a quarterly basis during Mall breaks.

The tables below showing the number of staff and individuals trained on the BY CHOICE system during this review period are a summary of the facility's data:

Staff Training						
	NEO	HAU	Clinical	Data Entry	Mgmt	Total
Number of staff	40	304	39	0	20	403

Quarterly Training for Individuals			
	Third quarter 2008	Fourth quarter 2008	Total
Number of individuals	254	210	464

This monitor's review of the BY CHOICE training curriculum found that both the WRPTs and the individuals are trained to know and understand that the individuals have the final choice in allocating points per cycle.

Recommendation 3, September 2008:
Report BY CHOICE point allocation in the Present Status section of the individual's case formulation and update at every scheduled WRPC.

Findings:
According to the BY CHOICE Coordinator, MSH continues to audit 20% of the WRPs to ensure that point allocation is documented under the BY CHOICE topic in the Present Status section of the case formulation of the individuals' WRPs. Data was not presented for review.

MSH's BY CHOICE documentation in the Present Status of the individuals' WPR has improved significantly. This monitor reviewed 16 charts (AEE, BG, BTM, CG, DCE, DD, DJB, JH, LAD, LEL, PAW, POG, SJW, SRC, TM and TVM) and found that the individual's BY CHOICE incentive system participation was documented in all WRPs in the charts. Most of the documentation in the Present Status section included comparative data from the previous WRP; fourteen of the 16 WRPs indicated that point re-allocation was considered; and 13 of the 16 WRPs contained documentation that the individual was a participant in the point allocation.

Using the Fidelity of Implementation by Individuals Form, MSH surveyed a sample of 4% of the individuals in the facility for each month of this review period:

1.	*The individual is holding his/her own point card.*	71%
2.	*The individual states, to the best of his/her ability how points are earned.*	80%
3.	*The individual states, to the best of his/her ability how points are spent.*	75%
4.	*The individual states, to the best of their ability, the expectations for earning FP, MP, or NP for the current cycle.*	78%
5.	*The individual states, to the best of their ability, the possible number of points that may be earned each day.*	57%
6.	*The individual states, to the best of their ability, how the points are reallocated for their point card.*	49%

7.	*The individual states, to the best of their ability, the hours the incentive store is open.*	75%
8.	*The individual states, to the best of their ability, the cycles of "high priority" on their point card.*	54%

As shown in item 5 in the table above, only about half the individuals surveyed were able to state the number of points they can earn daily and how the points are reallocated. It is essential that WRPTs are aware of this survey result and when necessary emphasize/repeat the process and procedures to the individuals during their WRPCs. This monitor interviewed two individuals (JC and PS). One of them stated that the team allocated the points for him, and stated that he was not aware he could make/request the changes himself. Both acknowledged that the Mall group facilitators informed them about their participation and points delivered.

MSH assessed individuals' satisfaction with the BY CHOICE incentive system (Q3 and Q4, of this review period) based on a 4% sample of individuals in the facility:

1.	*Is the point system helpful to you?*	60%
2.	*Do staff explain how you earn an 'FP', 'MP', or 'NP' for all your activities?*	34%
3.	*Do staff tell you if you earned an "FP,'MP', or 'NP' for all your activities?*	51%
4.	*Are you satisfied with the numbers of points you can earn for each cycle or group?*	48%
5.	*Do you like what is offered in the incentive store?*	53%
6.	*Do you hold on to your point card during the day?*	68%
7.	*Do you discuss how you want your points allocated when you meet with your team during your conferences?*	31%

The above results draw attention to two important indicators—items 2 and

7. For item 2, it is important that facilitators explain clearly to the individuals what participation level the facilitator expects for each level of points. It is also worth repeating the point portioning because individuals may have been absent or inattentive when it was first announced, or may have joined the groups at a later date, and more importantly, the level of participation will change according to the type activity conducted at each Mall session (for example, watching television, role-playing, worksheet, etc.) and should be confirmed proactively to the individuals at the beginning of the Mall session. For item 7, WRPTs should make it clear to individuals, using language that they can understand, how and why the points are re-allocated and that the individual has the right to re-allocate the points as they wish with support from the team to make the point allocation meaningful.

Using the Fidelity of Implementation by the BY CHOICE Staff Form, MSH monitored a sample of 58% of the BY CHOICE staff:

1.	*The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.*	100%
2.	*The incentive store includes a delivery system that assures that all individuals have access to incentive items.*	100%
3.	*The incentive store is well stocked with approved items from the incentive list*	95%
4.	*The incentive store has an inventory control system*	95%
5.	*The incentive store has a system to track and remove outdated food items*	95%
6.	*There is a BY CHOICE Manual located in the incentive store.*	100%

7.	*The incentive store staff have completed "Incentive Store training".*	95%
8.	*The individuals bring their point cards to the store to make a purchase.*	100%
9.	*There is a BY CHOICE Calorie Activity Guide located in the incentive store.*	95%
10.	*There is an Alert list in the incentive store, for staff reference.*	100%

The data in the table above show that the BY CHOICE staff know their duties and perform those duties (manage the incentive store, keep the inventory, run the database, etc.) to a high degree of integrity.

Using the Fidelity of Implementation BY CHOICE Direct Care Staff Competency and Fidelity Monitoring Form, MSH monitored 19% of the Level of Care staff:

1.	*Staff correctly states the current point cycle.*	64%
2.	*Staff correctly states the procedures for assigning participation levels on point cards.*	83%
3.	*Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.*	82%
4.	*Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.*	18%
5.	*Staff locates the By Choice Manual.*	84%
6.	*Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.*	88%
7.	*Staff correctly states where the point reallocation documentation is located.*	73%
8.	*Staff can locate a current By Choice Manual in their work site.*	18%
9.	*There is a system to orient new individuals to the By*	71%

	Choice Incentive System.	
10.	*Staff is able to state their unit's incentive store hours of operation.*	65%

The results indicate that the direct care staff needs to improve in a number of areas, especially items 4 and 8.

The facility's assessment of barriers to compliance is that some WRPTs still fail to involve, include, and/or assist the individual in determining his/her point allocation. The BY CHOICE Incentive System is in need of a new computer/software to set up levels and modify the point cards.

To improve compliance, MSH plans to provide further mentoring and training to WRPTs to ensure that the teams address the individuals' BY CHOICE point allocation according to the DMH WRP Manual and the BY CHOICE Incentive System Manual; to collect data monthly on a consistent basis; and to revise the data reporting methodology.

Compliance:
Partial.

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

F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

		Findings: A discussion with the Chief of Psychology confirmed that the Chief of Psychology 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. The duties and responsibilities for the BY CHOICE incentive program and the PBS teams under the Chief of Psychology or the Coordinator of the Psychology Specialty Services Committee include: • Hire and fire staff; • Determine the duties and responsibilities of the staff; • Supervise the PBS and BY CHOICE staff; • Conduct performance evaluations of the PBS and BY CHOICE staff; • Develop and implement policies and procedures, and • Evaluate program outcomes. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

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Findings:
Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans due during the review months (August 2008 to January 2009):

<table>
<tr><td>5.</td><td>PBS assessments include structural and functional assessments, and as necessary, functional analysis</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor reviewed eight PBS plans (AB, BMY, CG, CH, DY, LS, MCL and WH). All eight plans had been developed and implemented based on data derived from structural and functional assessments.

Current recommendation:
Continue current practice.

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<tr>
<td>F.2.c.ii</td>
<td>hypotheses of the maladaptive behavior are based on structural and functional assessments;</td>
<td>

Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans due during the review months (August 2008 to January 2009):

<table>
<tr><td>6.</td><td>Hypotheses of the maladaptive behavior are based on structural and functional assessments</td><td>100%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

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		The hypotheses documented in the eight PBS plans reviewed (AB, BMY, CG, CH, DY, LS, MCL and WH) were based on structural and functional assessments and aligned with findings from the assessments. MSH may want to consider writing the hypothesis statements completely and specifically, for example "non-social reasons" (ML) should specify the aspect of non-social reason (for example, sensory stimulation, pain attenuation, etc.), and escape from what (demands, noise, crowd, etc). The assessments considered "broader goals of interventions"; however, in all cases the statements are too general and not individualized. It is important to specify what the broader goals for the particular individual are (for example improved social skills, increased participation in leisure activities, etc.). Here is an opportunity for the PBS team members to collaborate with the SW discharge planning staff to discuss the skills and supports the individual needs in the next placement, and if appropriate include the skills/alternate behavior/replacement skills as one of the "broader goal" areas to be taught and/or reinforced. **Other findings:** Findings from review of PBS plans (AB, BMY, CG, CH, DY, LS, MCL and WH): The quality of the PBS plans generally has improved but a number of the plans still evidence deficits, including: 1. Many of the prevention and reactive strategies fail to include precursors that can be used to interrupt and/or redirect the individual at the earliest point in the behavior. 2. The "function" statement for CH (plan dated 01/09) is not a function statement. 3. It is not enough to say "Staff response should be brief and neutral . . . " (FR); specific staff responses should be stated (for example, verbal interruption, blocking, redirection, etc.). 4. When data point to biological/personality disorder (for example, AB) determination should be made if a PBS plan is warranted as opposed to

		other interventions (such as medication and/or individual therapies like NRT). 5. It can be confusing to individuals when they perceive inconsistencies in what they are asked to do/not do, for example, drawing a behavioral contract for "No emergency 911 calls or non-substantiated allegations . . . " and yet have the staff state to the individual, "This contract does not prevent you from 'alleging' staff abuse," (CG). Findings from review of the PBS-assisted Behavior Guidelines (BY, CJ, DG, JS, JT, LJ and PW) include the following: 1. Many of the guidelines use weak interventions to deal with the complexity/intensity of the behavior(s) under consideration; 2. Strategies are not aligned with the identified function; for example, if escape from task/activity is the function of the verbal aggression, then waiting for five minutes upon verbal expression before continuing participation in the activity is not good alignment (LJ); 3. No or poor reactive strategies to address target behavior (for example, when CH exhibits pica behavior); and 4. Incorrect application of one or more parts of an intervention strategy (for example, DRI for PW). Findings from review of Unit Psychologist Behavior Guidelines (NB, GG, GRS, SW, BE, JaS, JiS, JeS, JG, and FR) include the following: 1. Target behaviors not well operationalized; 2. Most guidelines except for JeS fail to use replacement/alternate behaviors that could reduce the individual's need for the target behavior; 3. Prevention strategies do not deal with antecedents/triggers, except for JaS; 4. Weak interventions to deal with complex behaviors; 5. Most active interventions are limited to verbal interruptions, and even

		then stop after a second prompt without any guide to what strategies to use if the maladaptive target behavior(s) continue; 6. Plans do not offer a function of the target behavior, the function is vague, or the function statement is incomplete (for example JG); 7. Many plans do not include active interventions for the target behaviors (for example KS); 8. Failure to train to competency staff responsible for implementing the behavior guideline; 9. Failure to adequately monitor implementation of the guideline; and 10. Lack of understanding by staff on the differences among educative, preventive, reactive/active intervention, and consequential strategies. Many of the unit behavior guidelines reviewed did not stage the phases of interventions appropriately (prevention strategies, active/reactive interventions). Instead they were all lumped under the heading "Interventions." **Current recommendations**: 1. Ensure that hypothesis statements and identified goals of interventions are complete and specific. 2. Address the deficiencies identified above pertaining to behavior guidelines and PBS plans.
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans due during the review period (August 2008 to January 2009):

7.	*There is documentation of previous behavioral interventions and their effects*	100%

Comparative data indicated improvement in compliance from 50% in the previous review period.

All eight PBS plans reviewed (AB, BMY, CG, CH, DY, LS, MCL and WH) had documented the previous interventions and their effects as part of the structural/functional assessments.

Other findings:
This monitor reviewed the outcome data of a number of PBS plans and Behavior Guidelines. Most of the PBS plans were developed and implemented recently and did not have meaningful quantitative data to analyze. Outcome data on 52 behavior guidelines for 48 individuals (AB, AE, BE, BY, CG, CH, CJ, DM, DT, FR, GG, GS, JeS, JG, JiS, JM, JS, KG, KO, KS, LC, MAC, MB, MC, MF, MK, ML, MM, NB, NM, PC, PD, PZ, RbL, RC, RJ, RL, RoL, RP, RR, SB, SW, TC, TP, TR, VF, VM and WH) were reviewed. The following table showing the categories, the number of cases under each category, and the percentage of cases in each category is a summary of the review:

	Number	Percentage
Durable positive change (continuous improvement for 3 months or more)	18	36%
Some improvement (near or below baseline, but variable across time)	17	32%
No change/worsening (trend in the wrong direction)	17	32%

To obtain better outcomes, MSH should ensure that plans are written for individuals with learned maladaptive behaviors, integrate treatment

<table>
<tr><td></td><td></td><td>modalities, ensure interventions are aligned with the hypothesis and function of the targeted behavior, target appropriate replacement behaviors and skills and supports, utilize appropriate positive preventive and intervention strategies, use potent reinforcers with a rich schedule, ensure staff is trained to competency and provide ongoing support and debriefing, conduct frequent fidelity checks, monitor data regularly, and be watchful for changing environments and physical and mental health of the individual. While the plan itself addresses the individual's maladaptive behaviors and related skills and supports, the individual's quality of life across the day (schedule, routine, staff attitude and response, medication) largely determines the plan's ultimate success.

Current recommendation:
Ensure that behavioral interventions are adjusted and refined as indicated by outcome data.</td></tr>
<tr><td>F.2.c.iv</td><td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans due during the review months (August 2008 to January 2009):

<table>
<tr><td>8.</td><td>Behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies</td><td>100%</td></tr>
</table>

MSH's progress report and this monitor's review of PBS plans and Behavior Guidelines found that all PBS plans, and PBS-supported Behavior Guidelines</td></tr>
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		were based on a positive behavior supports model. **Current recommendation**: Continue current practice.
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training. • Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings. **Findings:** Documentation review and interview of the Chief of Psychology found that staff across settings had been trained to implement PBS plans and PBS-supported Behavior Guidelines. However, the unit psychologist-developed behavior guidelines did not follow the same procedures, and staff was not trained to competency prior to implementation. MSH has collected fidelity data for PBS plans and PBS team member-assisted Behavior Guidelines, but not for the unit psychologist-developed Behavior Guidelines. Using the DMH Psychology Service Monitoring Form, MSH evaluated its compliance based on 100% of the behavior interventions implemented during this review period (August 2008 to January 2009). The table below (modified by this monitor for presentation) showing the percentage of behavior implementation plans consistently implemented across settings and their mean compliance is a summary of the facility's data: 9. *Behavioral interventions are consistently implemented across all settings, including school settings* 9.a *PBS Plans are consistently implemented across all* 100%

	settings, including school settings	
9.b	*PBS Behavioral Guidelines are consistently implemented across all settings, including school settings*	36%
9.c	*WRPT Behavioral Guidelines are consistently implemented across all settings, including school settings*	0%

Comparative data showed maintenance of compliance greater than 90% for PBS plans (item 9.a). There are no previous data for comparison for either type of Behavior Guideline.

As seen in the tables above, PBS teams train staff across settings and conduct fidelity checks across settings for PBS plans and for PBS team-assisted Behavior Guidelines. The same is not true for the unit psychologist-developed Behavior Guidelines. It is possible that a number of unit psychologist-developed Behavior Guidelines were implemented consistently and with fidelity; however, no training and or fidelity data were collected for analysis. During the last review, MSH had considered recruiting the support of the Clinical Administrator and the Program Directors and Assistant Program Directors to assist with the task of ensuring plan implementation and data collection. This gathering of support had not occurred at the time of this review. The hard work by unit psychologists in developing and implementing Behavior Guidelines cannot be of benefit to the individual unless staff training and fidelity data collection is considered as part of the behavior guideline process.

The primary barrier preventing PBS team-assisted and unit psychologist-developed behavior guidelines from being implemented consistently across setting is shortage of staff for training on implementation and collecting fidelity data.

To improve compliance MSH plans to recruit support of the Clinical

		Administrator and Progress Directors and Assistant Directors to assist with these issues and to train WRPT psychologists on DMH requirements for developing, implementing, training, and documenting Behavior Guidelines across settings. **Current recommendations**: 1. Ensure that staff across settings is aware of the individual's behavioral plan and that staff receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PSB plans by evaluating and implementing appropriate behavioral interventions. • Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately evaluated for behavioral interventions. **Findings:** MSH has implemented Special Order 262. The Special Order defines trigger thresholds and establishes a Risk Management System that includes performance improvement processes to identify and reduce risk. Documentation review and interview of the Chief of Psychology and the PSSC Coordinator found that MSH uses multiple pathways to track and monitor assessment/services of individuals with high triggers. The WRPTs make referrals of individuals with triggers either to the ETRC or the PSSC, and the PSSC also conducts its own review using the trigger list from the Standards Compliance Department. Upon review of cases referred to it, the ETRC may, if appropriate, refer the cases to the PSSC. The PSSC in

turns reviews all cases referred to it (both direct referrals and that coming from the ETRC) and takes appropriate action according to the findings from the reviews.

Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of individuals meeting trigger thresholds during this review period (August 2008 to January 2009):

10.	*Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control*	
10.a	*A referral has been made to the Coordinator of Psychology Specialist Services, and*	48%
10.b	*Appropriate assessment and/or interventions have been initiated*	100%

Comparative data showed progress in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.a	0%	48%
10.b	32%	48%
Compliance rate in last month of period		
10.a	0%	48%
10.b	14%	48%

This monitor's findings from a review of MSH's trigger list (Standards Compliance trigger list, August 2008 to January 2009) are in agreement with the facility's data. The trigger list reviewed included 91 individuals who had met trigger thresholds. The PSSC had reviewed a total of 202

		cases during this review period, including the referrals from the trigger list. All individuals referred were reviewed by the PSSC. This monitor reviewed six cases (BE, CH, CN, GG, RR and SW) referred to the PSSC from the trigger list. The documentation review (PSSC meeting minutes, chart, assessments, and behavioral interventions) found that the PSSC had discussed all six of the referrals. All six referrals were recommended for assessment and/or development and implementation of behavior interventions. All six cases are at varying states in the process (ranging from preliminary stages of assessment, completion of assessments, and development of intervention plans). However, in many cases, the process was slow in moving from behavior guidelines to PBS plans especially when the target triggers/target behaviors involve dangerousness to self and/or others. A number of cases discussed below highlight the point. CH met the trigger threshold for PRN/Stat/restraint on numerous occasions between August 1, 2008 and January 1, 2009. One of her triggers was four or more episodes of restraint in 30 days. This should have resulted in a WRP review and revision within three days. This was not done in a timely fashion. The behavior guideline (June 6, 2008) should have been revised sooner when the data trend was not in the right direction within two months of implementation or even sooner depending upon the nature and severity of the behaviors. The plan of correction on both these deficiencies has been completed. The revised behavior guideline (1/12/09) also did not show much improvement in the target behavior. CH now has a PBS plan (1/22/09). However, it is important to remember the function of the behavior and where the focus of the intervention should be. The now revised WRP (2/23/09) also has numerous deficiencies. Among others, the objectives are poorly written (for example, will have no incidents resulting in seclusion or restraint for the next 30 days) and the milieu intervention is not an intervention (collecting data on assaultive behavior). It is important to take notice that CH has a history of challenging behaviors including dangerousness to self and others and ingestion of non-nutritive objects,

		which is well documented in the initial seven-day WRP. Both the facility and CH would have benefitted if preventive steps had been taken at that time instead of waiting for the behaviors to strengthen. The WRPC also failed to address all the red flags that it had documented in the WRP (Present Status: recent history of self-abuse behavior, history of suicide attempts, other self-abusive behaviors, poor impulse control, and low frustration tolerance). The objectives and interventions and Mall groups were ineffective and insufficient to address CH's needs. KS engages in aggressive behaviors harmful to himself and others. KS's behavior guideline had been put on hold because KS had displayed no DTO for more than 60 days. It is a mistake to discharge an effective behavior plan before the positive change is durable. Fading, maintenance, and generalization phases should always be considered as part of the overall plan, especially for low-frequency, high-intensity behaviors such as KS's. Secondly, with better data pattern analysis the team would have realized that a 60-day absence of KS's target behavior was not that unusual, but rather appears to be a cyclical pattern (data show the following trend: aggression in June and July, no aggression in August and September, and aggression in October and November). The correction plans have been implemented (revised behavior plan and WRP and training of relevant staff). However, the latest WRP has conflicting entries (Present Status, under Risk Factors: "Since he began his hospitalization at MSH he has not had any known DTS threats, intentions, plans, or behaviors", and "Since K's admission to MSH on 4/14/08, he has not expressed any known DTS thoughts, behaviors, intentions, or plans"; under Symptoms: "Dr. …currently has behavioral guidelines in place to prevent recurrence of assaultive behavior", but later in the section, under BG/PBS plans it is stated that "These BGs will be kept on hold unless K begins the target behavior again," the Present Status give the picture of K having no DTO, but under the Discharge Criteria section, a statement reads, "At this time, DTO behavior is K's main barrier to discharge." A number of objectives are not measurable and they do not indicate how the progress is to be measured.

		Nevertheless, available data show that KS has had no aggressive acts in the last two months. **Current recommendations**: 1. Resolve the discrepancy between the number of individuals with high triggers and the number of individuals with Behavior Guidelines/PBS plans by evaluating and implementing appropriate behavioral interventions. 2. Evaluate trigger thresholds and amend as necessary so that serious/severe behavior management issues are appropriately evaluated for behavioral interventions.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Integrate all behavioral interventions with other treatment modalities, including drug therapy. **Findings:** MSH has established a system to ensure that interdisciplinary collaboration on interventions/therapies including drug therapies are jointly reviewed prior to the development and implementation of behavioral intervention plans. PBS team members attend WRPT meetings to discuss related matters with other disciplines in the WRPTs, and the referrals are also discussed during the ETRC/PSSC meetings on an ongoing as-needed basis. Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans implemented during this review period (August 2008 to January 2009): 11. *Positive Behavior Support teams and team psychologists integrate their therapies with other* — 100%

		treatment modalities, including drug therapy.

Comparative data indicated improvement in compliance from 19% in the previous review period.

This monitor's findings from documentation review (Psychology and Psychiatry progress notes) of eight PBS plans (AB, BMY, CG, CH, DY, LS, MCL and WH) were in agreement with the facility's data. The facility's data showed 75% compliance with this requirement for PBS team-assisted behavior guidelines and 0% compliance for unit psychologist-developed behavioral guidelines. MSH should ensure that all behavioral intervention plans developed and implemented in the facility are integrated through collaboration with other disciplines so that all aspects of the individual's medical, psychiatric, dietary, and physical status are considered, in order to obtain maximum results.

Current recommendation:
Integrate all behavioral interventions with other treatment modalities, including drug therapy.

F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual. **Findings:** Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans implemented during this review period (August 2008 to January 2009): 12. *All positive behavior support plans are specified in the objectives and interventions sections of the* 92%

		individual's Wellness and Recovery Plan Comparative data indicated improvement in compliance from 0% in the previous review period. Review of eight charts (AB, BMY, CG, CH, DY, LS, MCL and WH) of individuals with PBS plans found that all eight WRPs in the charts had documentation of the PBS plans in the Present Status section of the WRPs. MSHs documentation of the PBS plan status in the Present Status section of the individual's WRP has improved. Most of the documentation, other than plans newly developed and/or implemented, was comprehensive including staff training, baseline data, and outcome data. Five (AB, CG, DY, LS and WH) of the eight plans also had objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual. This monitor's findings from documentation review are in agreement with the facility's data showing that only 13% of the PBS team-assisted behavior guidelines and 20% of the unit psychologist-developed behavior guidelines had any documentation or proper documentation in the Present Status sections and intervention sections of the individual's WRP. **Current recommendation**: Specify PBS plans in the objectives and interventions sections of the individual's WRP as outlined in the DMH WRP Manual.
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendation, September 2008:** Update all PBS plans as indicated by outcome data and document at every scheduled WRPC in the Present Status section of the individual's case formulation.

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Findings:
Using the DMH Psychology Services Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans implemented during this review period (August 2008 to January 2009):

<table>
<tr>
<td>13.</td>
<td>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</td>
<td>93%</td>
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Comparative data indicated improvement in compliance from 0% in the previous review period.

MSH has improved its documentation of the PBS plans in the Present Status sections of the individuals' WRPs. All eight PBS plans reviewed (AB, BMY, CG, CH, DY, LS, MCL and WH) were documented in the Present Status sections of the individuals' WRPs and were updated with varying levels of descriptive and quantitative information. Many of the plans reviewed (for example AB, CG, CH, LS, MCL and WH) were recently implemented, and did not have outcome data to report.

Documentation review found that only 23% of the PBS team-assisted behavior guidelines and 22% of the unit psychologist-developed behavior guidelines met criteria for this recommendation.

Current recommendation:
Update all PBS plans as indicated by outcome data and document at every scheduled WRPC in the Present Status section of the individual's case formulation.

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<tr>
<td>F.2.c.x</td>
<td>all staff has received competency-based training on implementing the specific</td>
<td>**Current findings on previous recommendations:**</td>
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<td>behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</td>
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Recommendation 1, September 2008:
Continue current practice.

Findings:
Using the DMH Psychology Service Monitoring Form, MSH analyzed its compliance based on a 100% sample of the PBS plans in effect during this review period (August 2008 to January 2009):

<table>
<tr><td>14.</td><td>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.</td><td>95%</td></tr>
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Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

This monitor's findings from documentation review (PBS staff training) were in agreement with the facility's data. No staff training data was available for review of Unit Psychologist-developed behavior guidelines.

According to the PSSC coordinator, training for unit and program staff responsible for implementing behavioral guidelines is not provided consistently. To improve compliance, MSH plans to emphasize staff training on implementing behavioral intervention plans and to provide support through the PSSC to ensure staff training.

Current recommendation:
Continue current practice.
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<tr>
<td>F.2.c.
xi</td>
<td>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</td>
<td>Current findings on previous recommendation:</td>
</tr>
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		Recommendation, September 2008: Continue current practice. **Findings:** Interviews of the PSSC coordinator, the Chief of Psychology, and PBS team members found that PBS team members continue to have as their primary responsibilities the provision of behavioral interventions. According to the staff interviewed, PBS nursing staff is assigned to work holidays. The PSSC is working on a protocol in collaboration with Nursing and Executive Management as guideline for PBS staff duties during mandatory overtime work on state holidays. **Current recommendation**: Continue current practice.
F.2.c. xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. • Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan. **Findings:** MSH did not present data for this recommendation. According to the BY CHOICE coordinator, MSH continues with monthly auditing of 20% of the WRPs to ensure that BY CHOICE incentive system data is regularly reported in the Present Status section of the individual's WRP. MSH uses a modified curriculum for individuals who are bed-bound and for those with cognitive impairments. MSH continues to use point cards in the individual's primary language for those whose primary/preferred language is Chinese, Vietnamese, Korean or Spanish.

		This monitor reviewed 13 charts (BTM, CG, DD, DJB, JH, LAD, LEL, PAW, POG, SJW, SRC, TM and TVM). The individual's BY CHOICE incentive system participation was documented in all 13 WRPs in the charts. MSH's BY CHOICE documentation in the Present Status of the WRP has improved significantly. Most of the documentation in the Present Status section had comparative data from previous to current WRPs; 11 of the 13 WRPs showed that point re-allocation was considered; and 10 of the 13 WRPs contained documentation showing that the individual was a participant in the point allocation. **Current recommendations**: 1. Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. 2. Ensure that individuals who are bed-bound and individuals whose primary language is not English are fully included in the plan.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of 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	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Hire all members of the DCAT. • Ensure that all DCAT team members receive appropriate training. **Findings:** MSH has the clinical members of the DCAT. The missing team member is a Data Analyst. MSH is actively recruiting to fill the vacant position. The DCAT members have received training in PBS and DCAT services for individuals with cognitive disabilities. A review of the cases dealt with by the DCAT, the DCAT database, and the team's activities in cognitive assessments, PSR services, and collaboration with WRPTs regarding the individual's discharge issues found that the DCAT has increased its participation and activities during this review period.

	behavior support teams if the individuals they serve also need positive behavioral supports.	**Compliance:** Substantial. **Current recommendations**: 1. Hire all members of the DCAT. 2. Ensure that all DCAT team members receive appropriate training.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that all standing members and those involved in the cases/plans to be reviewed for the week attend the weekly PSSC meetings. **Findings:** According to the PSSC Coordinator, the committee's standing membership includes the Chief of Psychology, Chief of Psychiatry, Clinical Administrator, and the Risk Manager. In addition, PBS team members and WRPT members also attend the meetings on the basis of individuals discussed at each meeting. This monitor reviewed the minutes of 22 PSSC meetings conducted during this review period (August 2008 to January 2009). These meetings were poorly attended by the standing members of the committee (below a mean of 50%). Many individuals discussed/ reviewed at the meetings between August and October 2008 were not represented by members of their WRPTs (AE, CO, DY, FG, JF, JM, KS, KS, LB, MC, MG, PS, PW, RL, SA and VM). All individuals reviewed at the meetings since October 2008 to January 2009 were fully represented by members of their WRPTs. **Compliance:** Partial. **Current recommendation**: Ensure that all standing members and those involved in the cases/plans to

		be reviewed for the week attend the weekly PSSC meetings.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that neuropsychology referrals are addressed in a timely manner. **Findings:** According to the Chief of Psychology, a neuropsychologist resigned in October 2008. MSH promoted a neuropsychologist to Acting Senior Psychologist in December 2008 and hired a bilingual (Spanish/English) neuropsychologist in January 2009. The table below showing the number of neuropsychological assessments due for the review month, the number of assessments completed in the review month, and the mean time taken to complete assessments form the referral date is a summary of the facility's data:

		Aug	Sep	Oct	Nov	Dec	Jan	Mean
18.a.i	*Number of neuro-psychological assessments due for completion in the review month*	10	9	5	5	12	11	9
18.a.ii	*Of those in 18.a.i, number completed*	10	9	5	4	10	9	8
18.a.iii	*Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period*						24 Days	

		As the table above shows, MSH takes an average of 24 days to complete the referral for a Neuropsychological assessment (the acceptable maximum time to complete assessments is a calendar month). MSH should continue to educate WRPTs and other personnel to make appropriate referral for neuropsychological assessment of individuals with dementia, substance abuse, neurological diseases and associated conditions. Findings from a review of five Neuropsychological Assessments (CW, EF, GS, JM, and LL) are in agreement with the facility's data regarding the timeliness of the assessments and reports. **Compliance:** Substantial. **Current recommendation**: Ensure that neuropsychology referrals are addressed in a timely manner.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH has approved and implemented the directive (AD 0151) that all clinical psychologists with privileges at the facility 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. According to the Chief of Psychology, only PBS psychologists write orders for PBS plans and updates, and orders completed by unlicensed psychologists are co-signed by licensed psychologists with privileges.

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

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Alfred Johnson, RN, Program I 2. Ania Sobolewska, RN, Health Service Specialist, NP, C 3. Aubri Griffis, Acting Nursing Coordinator 4. Aurora Hendricks, Nurse Administrator 5. Estela D. Millan, RN, Program I 6. Fiora S. Yballe, RN, Program I 7. Kasia Kolansinski, RN, Health Service Specialist 8. Paul Bernoulli, RN, Program I 9. Shu Wang, WRP Mentor 10. Vicenta Gonzalez, RN, Program V Reviewed: 1. Medical records for the following 84 individuals: AB, AEE, AER, APQ, BB, BJW, BLM, BMY, BP, BTM, CB, CBS, CBT, CDJ, CH, CJ, CLP, CLW, CN, CPP, DC, DD, DE, DL, DLN, DS, EAB, FA, FG, FM, IR, JAM, JDA, JDF, JEF, JHT, JKS, JLA, JLG, JLW, JP, JRF, KDL, KDS, KS, LAD, LB, LEL, LES, LEY, LJS, LLW, LS, MG, MKC, MLD, MMS, NB, PA, PAL, PD, PS, RDA, RLH, RO, RR, RRA, RRR, RS, RTB, RWL, SJP, SJW, SL, SNM, SRC, SW, TC, TG, TLF, TME, TP, VLG and VTM 2. MSH's progress report and data 3. Medication Treatment Records and Controlled Drug Logs for Units 403, 405, 418, and 420 4. MSH's training rosters 5. Curriculum for WRP training 6. AD 3141, Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment 7. AD 3142, Provision of Medical Care to Individuals 8. AD 3144, Registered Nurse and Physician Communication About Physical Status Change

		9. AD 3147, CA DMH Change of Shift Report 10. AD 3148, CA DMH Kardex 11. AD 3149, CA DMH Nursing Staff Assignments for Individual Care Policy 12. MSH Nursing Education curriculum for Provision of Medical Care to Individuals <u>Observed</u>: 1. WRPC for KS Program I, Unit 410 2. WRPC for VWS Program V, Unit 405 3. WRPC for MD Program VI, Unit 418 4. WRPC for AB Program VI, Unit 419 5. Medication administration (8 a.m.) on Unit 410 6. Change of shift report on Unit 411
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that staff administering medications are familiar with individuals' medications. **Findings:** MSH did not address this recommendation.

Recommendation 2, September 2008:
Continue to monitor this requirement.

Findings:
MSH's progress report indicated a decrease in the use of psychotropic PRN and Stat medications during this review period.

In the previous review period (February – July 2008), 2,315 PRNs were administered. In the current review period (August 2008 – January 2009), 1,908 PRNs were administered, a decrease of 407 PRN administrations.

In addition, 1,520 psychotropic Stat medications were administered in the current review period, compared to 1,685 during the previous review period, for a decrease of 165 Stat administrations.

Data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 26% of PRNs administered each month during the review period (August 2008 - January 2009). indicated the following:

1.	*Safe administration of PRN medications*	97%
1.a	*PRN medication was administered based on a complete physician's order*	100%
1.c	*The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual*	97%

Comparative data showed maintenance of compliance greater than 90% from the previous review period.

Data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 29% of Stats administered each month during the review period (August 2008 - January 2009), indicated the following:

<table>
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<table>
<tr><td>1.</td><td>Safe administration of Stat medications</td><td>98%</td></tr>
<tr><td>1.a</td><td>Stat medication was administered based on a complete physician's order</td><td>100%</td></tr>
<tr><td>1.c</td><td>The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual</td><td>99%</td></tr>
</table>

Comparative data showed maintenance of compliance greater than 90% from the previous review period.

A review of 100 PRN and Stat medications orders for 34 individuals (AB, BLM, BMY, CB, CH, CJ, CLP, CN, DD, FA, FG, JDF, JHT, JKS, KDL, KDS, LB, LS, MG, NB, PD, PS, RR, RTB, RWL, SJW, SNM, SW, TC, TLF, TME, TP, VLG and VTM) found that 68 did not specify individual behaviors warranting the use of PRN or Stat medication. In addition, in 76 incidents the IDNs did not include all required documentation: the correct notation of Stat or PRN, the name of the medication administered, the dosage administered, the route by which the medication was administered and the exact time at which it was given, or no IDN was found documenting that the PRN or Stat medication was given. This continues to be an ongoing issue at MSH.

Current recommendations:
1. Ensure that the documentation of PRN and Stat medications in the interdisciplinary notes is in alignment with appropriate documentation requirements.
2. Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>F.3.a.ii</td>
<td>documentation of the circumstances requiring PRN and Stat administration of medications;</td>
<td>
Current findings on previous recommendation:

Recommendation, September 2008:
Continue to monitor this requirement.
</td>
</tr>
</table>

Findings:
Data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 26% of PRNs administered each month during the review period (August 2008 - January 2009), indicated the following:

3.	*There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.*	92%

Comparative data indicated an increase in compliance from 84% in the previous review period.

A review of 79 incidents of PRN medication for 27 individuals (AB, BLM, BMY, CB, CH, CJ, CLP, DD, FG, JDF, JHT, JKS, KDL, KDS, LB, LS, MG, PD, PS, RR, RWL, SJW, SNM, SW, TLF, TME and VTM) found that the IDNs in 71 incidents included adequate documentation of the circumstances requiring the PRN.

Data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 29% of Stats administered each month during the review period (August 2008 - January 2009). indicated the following:

4.	*There is documentation in the Interdisciplinary Note of the individual prior to the STAT medication administration, which includes the circumstances/behavior requiring the medication.*	95%

Comparative data indicated an increase in compliance from 77% in the previous review period.

A review of 21 incidents of Stat medication for 20 individuals (AG, AS,

<table>
<tr><td></td><td></td><td>BJB, CLP, CN, DP, DS, ELH, FA, JDK, JHT, LG, LMK, NB, RTB, TC, TP, VH, VLG and WRB) found that the IDNs in 17 incidents included adequate documentation of the circumstances requiring the Stat medication.

Overall, the documentation regarding circumstances and behaviors warranting PRN and Stat medications has improved since the last review.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.a.iii</td><td>documentation of the individual's response to PRN and Stat medication.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 26% of PRNs administered each month during the review period (August 2008 - January 2009), indicated the following:

<table>
<tr><td>5.</td><td>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</td><td>93%</td></tr>
</table>

Comparative data indicated an increase in compliance from 75% in the previous review period.

A review of 79 incidents of PRN medication for 27 individuals (AB, BLM, BMY, CB, CH, CJ, CLP, DD, FG, JDF, JHT, JKS, KDL, KDS, LB, LS, MG, PD, PS, RR, RWL, SJW, SNM, SW, TLF, TME and VTM) found that the IDNs in 73 incidents contained a comprehensive assessment of the individual's response to the PRN medication.</td></tr>
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<tr>
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<td>Data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 29% of Stats administered each month during the review period (August 2008 - January 2009), indicated the following:

<table>
<tr><td>6.</td><td>There is documentation in the Interdisciplinary Note of the individual's response to the STAT medication within one hour of administration.</td><td>95%</td></tr>
</table>

Comparative data indicated an increase in compliance from 75% in the previous review period.

A review of 21 incidents of Stat medication for 20 individuals (AG, AS, BJB, CLP, CN, DP, DS, ELH, FA, JDK, JHT, LG, LMK, NB, RTB, TC, TP, VH, VLG and WRB) found that the IDNs in 18 incidents contained a comprehensive assessment of the individual's response to the Stat medication.

MSH has put significant effort into increasing the compliance regarding the documentation of the individuals' response to PRN and Stat medications. The documentation has significantly improved since the last review.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.b</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue to monitor this requirement.

Findings:
MSH's data regarding medication variances indicated that the population (N) was the number of medication variances for missed signatures, titles</td>
</tr>
</table>

		and/or initials on the MTR or the controlled medication log reported and the sample (n) was the number followed up to prevent recurrence of signature variances. The compliance rate was reported at 100%. However, there was no explanation or supporting data demonstrating what the follow-up included. Also, the data does not indicate if any of the missing initials found on spot checks had Medication Variance Reports (MVRs) initiated by the unit staff/medication nurses to accurately reflect the reliability of the Medication Variance System. Consequently, there is no way to determine if the Medication Variance System is capturing all variances. A review of the current MTRs and Controlled Sheets for Units 403, 405, 418, and 420 found a number of missing initials on the MTRs and a number of noon medications that were pre-signed as given on unit 420. When a missing initial on the MTR for an 8 a.m. medication was pointed out to a medication nurse, the nurse immediately initialed the MTR without any type of verification that the medication had in fact been given. When asked about the need for making out a MVR, the nurse stated she did not think she needed to since she remembered giving the medication. Clearly, the nurse was not familiar with the policy regarding medication variances and without prompting would not have reported the variance. The facility did not produce Medication Variance Reports for the missing initials found during the review. These findings indicated that MSH does not have a reliable system for identifying medication variances. **Compliance:** Noncompliance. **Current recommendations**: 1. Ensure that the medication nurses are familiar with policies addressing medication variances. 2. Develop strategies to ensure reporting of medication variances is not

		punitive. 3. Identify and address barriers regarding medication administration that includes input from medication nurses. 4. Provide data addressing this requirement that includes appropriate supporting documentation. 5. Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue to implement strategies to increase compliance with this requirement. **Findings:** The Central Nursing Services Monitor/Mentor provided a two-hour WRP training session to 83 out of 137 RNs. Class size was limited to 15 and additional RN Mentors assisted in the training to provide 1:2 ratios. The remaining RNs are scheduled to receive the training during the week of March 30 – April 3, 2009. Also, beginning in October 2008, RNs that have been assigned to a non-patient area are assigned to work on modifying the WRPs on their caseload. In addition, in response to the facility's data analysis, MSH has implemented a three-day one–on-one training for the RNs assigned to the skilled nursing units. In December 2008, two HSSs were assigned to mentor the unit RNs that are responsible for writing plans of care for infection control problems. At the time of this review, 78 RNs out of 137 have received the initial mentoring and will be provided on-going assistance. MSH also implemented a 24-hour help desk through CNS to facilitate the use of the computers for staff assigned to evening, night, weekend and holiday shifts. **Recommendation 2, September 2008:** Continue to monitor this requirement.

		Findings: See C.2.l. **Other findings:** During the review, no nursing care plans other than the nursing interventions integrated in the WRPs and no nursing diagnoses other than as specified in the WRP in terms of the current DSM criteria were found. **Compliance:** Partial. **Current recommendation**: See C.2.l.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement. **Findings:** Data from the DMH Nursing Staff Familiarity Monitoring audit, based on an average sample of 20% of the total number of nursing staff audited, indicated the following: 9. *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.* — 91% Comparative data indicated a modest increase in compliance from 86% in the previous review period.

		See cell C.2.l for findings regarding the development and implementation of nursing objectives and interventions. **Compliance:** Substantial. **Current recommendation**: See C.2.l.
F.3.e	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.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue to implement strategies addressing shift report to meet the elements of this requirement. **Findings:** In November 2008, the statewide task force developed policies and new forms addressing Change of Shift, Nursing Documentation and Assignments for Individual Care. Training on the new procedure was conducted from November 2008 through January 2009. The new Shift Change procedure was implemented on January 15, 2009 on all units at MSH, adequately addressing this recommendation. **Recommendation 2, September 2008:** Implement training addressing the provision and administration of medical care. **Findings:** In September 2008, MSH implemented Special Order 136, Provision and Administration of Medical Care. In October 2008, training was provided on the new Provision of Medical Care policies and forms. The training is ongoing and is provided twice per month, adequately addressing this recommendation.

Recommendation 3, September 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Medicine Medical Transfer Audit form, based on a 100% sample of individuals transferred to community hospitals each month during the review period (August 2008 - January 2009), indicated the following:

1.	*There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	98%
1.a	*There is an appropriate identification of the change in the individual's condition including vital signs.*	100%
1.b	*There is documentation of when the change in the individual's status changed.*	100%
1.c	*There is documentation of when the physician was notified and the physician's name.*	98%
1.d	*There is timely (immediate for emergent conditions and no later than one hour for urgent conditions) notification by the nurse to the physician.*	98%
1.e	*There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time.*	100%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	65%
7.a	*The present status of the case formulation includes information about the medical transfer, and*	67%

7.b	*As appropriate, objectives and interventions are developed or revised to reflect the individual's current needs, or there is documentation in the physician's progress note substantiating that the WRP does not need to be updated.*	76%

Comparative data indicated an increase in mean compliance for items 1 and 7:

	Previous period	Current period
Mean compliance rate		
1.	64%	98%
7.	15%	65%
Compliance rate in last month of period		
1.	72%	100%
1.a	100%	100%
1.b	100%	100%
1.c	80%	100%
1.d	95%	100%
1.e	88%	100%
7.	8%	0%
7.a	20%	14%
7.b	76%	29%

MSH did not provide barriers to compliance and plan of correction for item 7.

A review of the records of nine individuals transferred to a community emergency room/hospital during the review period (AB, CBS, CBT, CDJ, JLA, KS, RLH, SJP and TP) found the following issues:

		1. AB a) No mental status assessment or neuro checks documented after individual found in bathroom. b) Notes state vital signs stable; vital signs within normal limits after an acute injury. c) Name of physician notified not included in progress note. d) No description or assessment of individual's complaints of pain to head. e) No assessment of mental status upon return from hospital. f) Interdisciplinary notes out of order. 2. CBS a) Good documentation of assessments prior to transfer to hospital. However, no assessment documented at the time of transfer. b) Note upon return difficult to read. Individual was in hospital for 10 days. There was no indication of why CBS was hospitalized, such as treatment received, diagnoses, and change in medications. c) No mention of hospitalization found in the WRP. 3. CBT a) Individual experiencing an increase in confusion. Nurse's note report vital signs within normal limits. Thus, no baseline vital signs for comparison. b) Good documentation of assessments upon transfer and on return from hospital. 4. CDJ a) No documentation or assessment addressing why individual was sent to hospital. b) A complete set of vital signs not documented upon return from hospital. c) No mental status assessment documented upon return from hospital. 5. JLA: No RN assessment upon return from hospital. 6. KS a) No status or assessment documented prior to transfer to

hospital.
b) Nursing Transfer Note illegible.
c) Good assessment documented upon return from hospital.
7. RLH: No assessment of mental status upon transfer to hospital.
8. SJP
a) Nursing Transfer Note upon return from hospital was blank.
b) Blood pressure upon return from hospital documented on RN Change in Physical Status Note as141/98. No indication that it was retaken or that physician was notified.
9. TP: Difficult to determine exactly what time individual was transferred to the emergency room.

Overall, there was improvement in the nursing documentation regarding change in medical conditions. However, as noted above, there continue to be problematic issues regarding Nursing assessments, which does not support MSH's data. Nursing needs to ensure that the quality of the documentation regarding change in status is reflected in the auditing.

Data from the DMH Nursing Services Audit form, based on a 10% sample of Change of Shift Reports in January 2009 (MSH implemented a new monitoring tool in January 2009), indicated the following:

10.	*Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.*	83%
10.c.	*The nursing staff reports to the oncoming shift the target variable that the individual exhibited.*	83%
10.d	*The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.*	83%

MSH did not provide barriers to compliance for this item. However, the

		facility has implemented a new Shift Change process beginning on January 15, 2009. Observations of shift change on unit 411 found significant improvements in the clinical information being reported. A copy of each individual's Kardex with pertinent medical/psychiatric clinical information was projected so all staff could see the Axis diagnoses and WRP objectives when hearing the report. The staff member presenting the report did an excellent job connecting the symptoms individuals were experiencing and the Axis I diagnoses. Thus far, this was the best change of shift report observed to date. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the quality of the documentation regarding change in status is reflected in the auditing. 2. Continue implementing the new process for change of shift. 3. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendation:** **Recommendation, September 2008:** See F.3.a.i. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 23% of level of care nursing staff who are licensed and medication certified, indicated the following:

8.	*Nursing staff are knowledgeable regarding each individual's prescribed medications.*	97%
8a.	*If a medication requires vital sign assessment prior to administration, the nursing staff is observed reviewing this reading.*	99%
8b.	*If a medication requires a blood glucose level prior to administration, the nursing staff is observed reviewing this reading.*	99%
8c.	*The nursing staff is able to answer questions about one medication that is administered to the individual. (The question may include purpose of medication, common side effects, etc.)*	98%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

Basically no medication education was provided in the 8 a.m. medication administration observed on Unit 410. In addition, the medication nurse was not consistently checking to ensure that individuals had swallowed their medication. Also, there were a number of individuals who needed to have their vital signs taken before receiving certain medications, but the medication nurse had to delay administering medications to some of these individuals because the treatment nurse had not obtained the required vital signs. When one individual refused a medication, the nurse did not explore the reasons for the refusal. Another individual was noted to cough when swallowing his medications and when swallowing water, but the nurse did not recognize this as a potential risk for choking or aspiration. Also when administering medications, the nurse just handed the cup of pills to individuals without telling them what medication they were receiving. In fact, the medication nurse made inappropriate comments to some individuals about the number of medications that they were receiving. This medication administration was an unfortunate

<table>
<tr><td></td><td></td><td>demonstration of an institutional process. The reviewer's findings did not support MSH's data.

Current recommendations:
1. Review auditing process and compliance scoring for this requirement to ensure accurate compliance data.
2. Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.ii</td><td>education is provided to individuals during medication administration;</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
See F.3.a.i.

Findings:
Data from the DMH Medication Administration Monitoring audit, based on an average sample of 23% of level of care nursing staff who are licensed and medication certified, indicated the following:

<table>
<tr><td>9.</td><td>Education is provided to individuals during medication administration.</td><td>91%</td></tr>
<tr><td>9.a</td><td>If an individual asks a question, the nursing staff is able to competently answer the question.</td><td>98%</td></tr>
<tr><td>9.b</td><td>When an individual has been prescribed a new medication, the nursing staff provides education about the medication.</td><td>95%</td></tr>
<tr><td>9.c</td><td>Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.</td><td>94%</td></tr>
</table>

Comparative data indicated a modest increase in compliance from 88% in the previous review period.

See F.3.f.i for reviewer's findings.</td></tr>
</table>

		Current recommendation: See F.3.f.i.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 23% of level of care nursing staff who are licensed and medication certified, indicated the following: 10. *Nursing Staff are following the appropriate medication administration protocol.* 100% 10.a *The correct medications are administered.* 100% 10.b *The medications are administered to the correct individual.* 100% 10.c *The medications are administered in the ordered form.* 100% 10.d *The medications are administered by the correct route.* 100% 10.e *The medications are administered at the correct time.* 100% 10.f *The medications are administered on the correct date.* 100% 10.g *The medications are administered for the right indication.* 100% Comparative data indicated that the facility has maintained compliance of greater than 90% from the previous review period.

		See F.3.f.i for reviewer's findings. **Other findings:** Observations of medication administration (F.3.f.i) and review of the MARs (F.3.b) do not support MSH's compliance data. Discussions with the Nursing Administrator, Acting Nursing Coordinator and a number of medication nurses indicated that staff still view the medication variance system as punitive and that issues such as delays in receiving vital signs (which subsequently delays medication administration), interruptions, the number of individuals for whom one medication nurse is responsible for administering medications, reviewing and noting physician orders and meeting the appropriate time frame for medication administration (one hour before and one hour after the scheduled medication time) are not formally reported and consequently not addressed. For each review thus far, the reviewer's findings have not supported MSH's data regarding medication administration. Nursing needs to review how this requirement is being audited and scored to ensure that accurate compliance data is being generated. **Current recommendation:** See F.3.f.i.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Data from the DMH Medication Administration Monitoring audit, based on an average sample of 23% of level of care nursing staff who are licensed and medication certified, indicated the following: 14. *Medication administration is documented in* 97%

	accordance with the appropriate medication administration protocol.	
14.a	*Medications are documented upon administration, prior to the administering medications to the next individuals*	97%
14.b	*Nursing staff correctly documents the MTR to reflect what actually occurred.*	97%

Comparative data indicated that the facility has maintained a compliance rate greater than 90% from the previous review period.

See F.3.b and F.3.f.i.

Current recommendation:
See F.3.f.i.

F.3.g

Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.

Current findings on previous recommendations:

Recommendation 1, September 2008:
Ensure that data regarding this requirement is accurate.

Findings:
MSH did not address this recommendation.

Recommendation 1, September 2008:
Continue to monitor this requirement.

Findings:
The DMH Nursing Bed-Bound Monitoring audit, based on a 100% sample (nine individuals) of bed-bound individuals during the review period (August 2008 - January 2009), indicated the following:

12.	*There is a physician's order justifying the clinical*	0%

		reason for the bed-bound status

MSH's progress report for the previous review period (February-July 2008) indicated that there were no bed-bound individuals. However, documentation from the Skilled Nursing Unit indicated that two individuals were bed-bound. Consequently, no data was generated for the last review.

MSH did not provide any barriers to compliance regarding this requirement. The plan of correction includes the development of a draft policy in March 2009 that outlines specific criteria for bed rest vs bed-bound to be finalized and implemented on March 20, 2009. The draft policy was not provided in the supporting documentation section of the progress report and thus could not be reviewed.

A review of the medical records of five bed-bound individuals (BP, DC, DE, DL and JP) found that none had a physician's order justifying the bed-bound status.

Other findings:
MSH's data indicated that the compliance score was zero for each month of the review period (August 2008 - January 2009). However, if the facility was conducting monthly audits on this requirement, it is alarming that there is no indication that the units were notified they were not in compliance after each monthly audit.

Compliance:
Noncompliance.

Current recommendations:
1. Implement and provide training regarding the policy addressing bed-bound individuals.
2. Ensure monthly audit data is shared with the appropriate units and

		staff. 3. Continue to monitor this requirement.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Substantial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH's training rosters verified that all 23 (100%) nursing and psychiatric technicians hired during this review period (August 2008 - January 2009) received and passed the required training. **Current recommendation**: Continue current practice.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.3.h.i. **Current recommendation**: Continue current practice.

F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.3.h.i. **Current recommendation**: Continue current practice.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH's data regarding training for existing staff does not accurately reflect compliance. The data does not clearly identify the number of staff that was due for annual training each month and of those, the number that completed and passed the training. The data as presented reflect 11% compliance that existing staff received the required training. See F.3.h.i for new employee training. **Compliance:** Partial. **Current recommendations**: 1. Present data regarding existing staff training to accurately reflect compliance with this requirement. 2. Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Andrea Cirota, Supervising Rehabilitation Therapist 2. Asha Vij, Occupational Therapist 3. Donna Gilland, Assistant Clinical Administrator 4. Jack McClary, Supervisor of Vocational Services 5. Jamie Critie, Supervising Rehabilitation Therapist 6. Lisa Adams, Supervising Rehabilitation Therapist 7. Mari Cobb, Rehabilitation Therapy Chief 8. Marion Paclibar, Physical Therapist 9. Rebecca McClary, Rehabilitation Therapy Program Assistant 10. Terez Henson, Supervising Rehabilitation Therapist 11. Troy Zelones, Physical Therapist Reviewed: 1. DMH Rehabilitation Therapy F.4 Audit Tool and instructions 2. DMH MH-C 9090 POST Monthly Progress Note 3. F.4 audit data for August 2008 - January 2009 4. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 5. Records of the following 16 individuals participating in observed Mall groups: AS, CG, DM, EAB, EV, JJS, JLH, KF, KM, LD, MAB, MBM, RD, RM, SB and SC 6. List of individuals who received direct Physical Therapy services from August 2008 - January 2009 7. Records of the following six individuals who received direct Physical Therapy services between August 2008 - January 2009: FR, IR, KS, MAB, RLH and TDR 8. List of individuals who received direct Occupational Therapy services from August 2008 - January 2009 9. Records of the following six individuals who received direct

		Occupational Therapy services from August 2008 - January 2009: BJW, DEM, GSZ, JS, PA and PMH 10. List of individuals with a 24-Hour Rehabilitation Support Plan 11. Records of the following individuals with 24-Hour Rehabilitation Support Plans: GSZ and PA 12. DMH MH-C 9091 24-Hour Rehabilitation Support Plan guidelines and instructions 13. List of individuals with Physical or Occupational Therapy Plans implemented by Nursing 14. Records of the following five individuals with PT/OT plans implemented by nursing staff in January 2009: CR, JL, JP, LB and RLS 15. Leisure Education PSR Mall group lesson plan 16. Introduction to Vocational Rehabilitation Services PSR Mall group lesson plan 17. Health Management and Exercise PSR Mall group lesson plan 18. Coping Skills through Art PSR Mall group lesson plan 19. Community Integration PSR Mall group lesson plan 20. School of Rock PSR Mall group lesson plan 21. Rehabilitation Therapy training binder <u>Observed</u>: (all groups were observed on site by Rob Schaufenbil with findings regarding group lesson content reported via teleconference) 1. Leisure Education PSR Mall Group 2. Introduction to Vocational Rehabilitation Services PSR Mall Group 3. Health Management and Exercise PSR Mall Group 4. Coping Skills through Art PSR Mall Group 5. Community Integration PSR Mall Group 6. School of Rock PSR Mall Group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally	**Compliance:** Partial.

	accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that data for F.4 audit tool is reliable and valid. **Findings:** It was reported that audits for F.4.a.i were not done consistently in vivo, and were done retrospectively as the POST supervisor was hired at the end of the review period. In addition, the populations (Ns) for F.4.a.i data related to direct services and the F.4.c. data related to PSR Mall groups were initially inaccurately reported. **Recommendation 2, September 2008:** Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services is documented in the present status section of the WRP. **Findings:** The data below presents the number of scheduled and completed appointments for direct OT and PT services for the week of 1/12/09: [table below] Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based

	Scheduled	Provided
OT	9	8
PT	14	13

on an average sample of 100% of individuals participating in Occupational and Physical Therapy direct treatment each month during the review period of August 2008 - January 2009 who also had an annual or quarterly WRP scheduled (total of 7). The following table outlines the indicators with corresponding mean compliance rates:

1.	*The provision of direct services by rehabilitation therapy services staff*	57%
1.a	*There is an appropriate Focus of Hospitalization (typically Focus 6).*	71%
1.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.*	57%
1.c	*The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.*	57%
1.d	*There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.*	60%

Comparable data were not available from the last evaluation period.

The facility plans to improve compliance with items 1.a-1.d by implementing a process by which POST team therapists directly input recommendations, foci, objectives and interventions into the WRP document.

Other findings:
A review of records of six individuals (FR, IR, KS, MAB, RLH and TDR) receiving direct Physical Therapy treatment to assess for compliance with provision of direct services found all records in partial compliance

		with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Foci, objectives and interventions are not consistently included in the WRP. 2. Progress in Physical Therapy treatment is not consistently documented in the present status section of the WRP. A review of records of six individuals (BJW, DEM, GSZ, JS, PA and PMH) receiving direct Occupational Therapy treatment to assess for compliance with provision of direct services found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Progress in Occupational Therapy treatment is not consistently documented in the present status section of the WRP. 4. Progress notes are not consistently comprehensive and complete. It was noted upon record review that many individuals (four out of 12) were discharged from direct treatment due to three consecutive refusals. The facility reported that it is policy to discharge following three refusals and to report the problem to the WRP for discussion. However, none of the WRPs for individuals discharged contained evidence that refusals were discussed by the team, and some individuals did not have the direct treatment service listed in the WRP. The Occupational

		and Physical Therapist reported that there is currently no system by which they can determine the reason for refusal (e.g. due to schedule conflict or unwillingness to attend). **Current recommendations**: 1. Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities, changes to programs are made as needed, adequate foci, objectives and interventions are aligned and incorporated into the WRP, and progress with direct services are documented in the present status section of the WRP. 2. Ensure that data for F.4 audit tool is reliable and valid. 3. Develop a process to determine reasons for refusals to attend direct OT and PT treatment, and to ensure appropriate trigger to the WRPT if three consecutive refusals and subsequent discharge occur.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs, with Physical and Occupational Therapy oversight that is available to all individuals who require it facility-wide. **Findings:** The INPOP program was developed and implemented at MSH on January 1, 2009. **Recommendation 2, September 2008:** Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or Occupational

Therapist to determine the continued appropriateness of the program.

Findings:
A facility-wide INPOP database was implemented on January 1, 2009 to track individuals receiving these services hospital-wide.

Other findings:
Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals with OT and PT programs implemented by nursing staff during the month of January (total of 5). The following table outlines the indicators with corresponding mean compliance rates:

2.	*The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.*	60%
2.a	*The POST team IDN documents reassessment by the PT and/or OT, as clinically indicated.*	100%
2.b	*There is documentation in the Present Status Section of the individual's WRP of the current status of the PT and/or OT interventions implemented by the nurses.*	60%

A review of records of five individuals (CR, JL, JP, LB and RLS) who received oversight of OT or PT programs implemented by Nursing staff in January 2009 to assess compliance with F.4.a.ii criteria found all records in partial compliance. Identified areas of deficiency that the facility should focus on in order to achieve compliance include the following:

1. Re-assessment was limited to review of RNA documentation rather than OT or PT assessment of individual progress and response to intervention.

		2. Progress or response to intervention is not consistently documented in the present status section of the WRP. **Compliance:** Partial. **Current recommendation**: Ensure that the oversight by rehabilitation therapists of individualized Occupational or Physical Therapy programs implemented by nursing staff occurs as needed, and that results are documented in the present status section of the WRP.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed. **Findings:** Currently, there does not seem to be a system to determine on a facility-wide basis which nurses require training related to physical rehabilitation. The facility reported that in August 2008, 35% of nurses requiring training (7 out of 20) were trained to competency; in November 2008, 100% of nurses requiring training (28 out of 28) were trained to competency, and in January 2009, 98% of nurses requiring training (66 out of 67) were trained to competency. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to identify which nurses require

		training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence on a facility-wide basis. 2. Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned. **Findings:** Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample (stratified by discipline) of 18% of individuals participating in Rehabilitation Therapy and Vocational Rehabilitation PSR Mall groups for each month for the review period of August 2008 - January 2009. The following table outlines the indicators with corresponding mean compliance rates:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	5%
4.a	*There is an appropriate Focus of Hospitalization.*	87%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.*	14%
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall*	22%

	facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.	
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	27%

Comparative data for mean compliance rates from the previous period were not available. Comparative data for compliance rates in the last month of each period showed mixed changes as follows:

	Previous period	Current period
Compliance rate in last month of period		
4.	3%	15%
4.a	91%	84%
4.b	8%	37%
4.c	10%	31%
4.d	31%	24%

Facility analysis of barriers to compliance and/or proposed plan(s) of correction were not provided.

Recommendation 2, September 2008:
Implement proposed plan of correction based on data analysis to improve compliance with Recommendation 1.

Findings:
No facility data was provided regarding this recommendation.

Recommendation 3, September 2008:
Provide training to Rehabilitation Therapy staff on writing quality foci,

		objectives and interventions based on content of the revised PSR Mall Manual. **Findings:** The facility reported that 16/42 Rehabilitation Therapy staff received WRP update and alignment training. **Recommendation 4, September 2008:** Convert all Rehabilitation Therapy PSR Mall group lesson plans, course outlines and curricula to the new format as this process is implemented. **Findings:** This recommendation has been partially met. The facility reported that three lesson plans have been converted to the new format and submitted for approval. **Recommendation 5, September 2008:** Ensure that all individuals with Dining Plans and Physical Support Plans are reviewed to ensure that they meet the criteria for the new 24-hour Rehabilitation Support Plans, with conversion to the new format. **Findings:** No data was provided by the facility regarding this recommendation. However, upon review of two records of individuals with 24-hour plans (GSZ and PA), it was noted that both individual plans met the criteria according to the statewide procedure. **Other findings:** Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample 100% of individuals with 24-Hour Rehabilitation Therapy Support Plans (total of 2)to assess compliance with timely and adequate provision of Rehabilitation Therapy Services for each month of the review period (August 2008 - January 2009). The following table

outlines the indicators with corresponding mean compliance rates:

4b.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	0%
a.	*The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.*	100%
b.	*The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP*	0%

Comparative data from the previous review period were not available.

The facility plans to improve compliance with item 4.b by instructing the Physical Therapist to address the 24-hour support plan in the present status section of the WRP.

A review of records of two individuals with 24-hour Rehabilitation Support plans (GSZ and PA) to assess for compliance with provision of timely and adequate Rehabilitation Therapy services found both records in partial compliance.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Vocational Rehab during the week of1/26/09:

	Scheduled	Provided
RT	380	311
Voc Rehab	6	3

Analysis regarding barriers to compliance or possible plan of correction to improve compliance regarding the number of scheduled and provided treatment hours was not provided.

		A review of the records of 16 individuals participating in PSR Mall groups led by Rehabilitation Therapists (AS, CG, DM, EAB, EV, JJS, JLH, KF, KM, LD, MAB, MBM, RD, RM, SB and SC) to assess for compliance with provision of timely and adequate Rehabilitation Therapy services found all records in partial compliance. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Progress is not consistently documented in the present status section of the WRP. Observation of six PSR Mall groups found that five out of six had a lesson plan in use and that all six groups provided activities that were in line with the individual's assessed needs. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned. 2. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual.

		3. Ensure that all individuals with 24-Hour Rehabilitation Support Plans meet criteria for 24-hour plans and receive provision of timely and adequate Rehabilitation Therapy services.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment. • Implement F.4 audit process to present data and data analysis regarding provision and re-assessment of adaptive equipment. **Findings:** Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database for each month (total of four) for the review period of August 2008 - January 2009 for indicators e. through h. Using the same tool, MSH also assessed its compliance based on an average sample of 100% of individuals within the adaptive equipment database who required re-assessment for each month (total of three) for the review period of August 2008 - January 2009 for indicator i. The following table outlines the indicators with corresponding mean compliance rates: e. *The individual was assessed for the appropriateness of adaptive equipment by an RT professional* — 100% f. *The individual was provided with the equipment as per the doctor's order* — 100% g. *The individual's level of functioning related to independence versus supports needed was assessed.* — 100% h. *Training for the individual on the use of adaptive equipment was provided.* — 100%

		i.	*Reassessment of adaptive equipment, if clinically indicated*	100%

Other findings:
While the data above relates to individuals with adaptive equipment issued during the review period, it was noted that the facility does not have a process in place to assess or re-assess individuals with adaptive equipment issued prior to the review period to ensure that equipment meets assessed needs and promotes independence.

Compliance:
Partial.

Current recommendations:
1. Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.
2. Develop and implement a system to ensure that individuals with adaptive equipment issued by RT prior to the August 2008 - January 2009 review period have access to equipment that meets assessed needs and promotes independence.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Chris Marshall, Director of Nutrition Services 2. Geovanne Dimas, Assistant Director of Nutrition Services 3. Portia Salvacion, Assistant Director of Nutrition Services 4. Virginia Tovar, Assistant Director of Nutrition Services Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from August 2008 - January 2009 for each assessment type 2. Records of the following 53 individuals with type a-j.ii. assessments from June–November 2008: ADF, AMB, AMP, BA, BMT, BTM, BU, CB, CC, CJ, CL, CPB, CRT, CSR, DCE, DD, DLH, FMR, FTR, IPF, ITJ, JA, JB, JC, JCY, JKW, JLG, JM, JMA, JS, KAR, LAC, LB, LD, LL, MCL, MJA, MMA, MWM, NB, OH, PA, PAF, PW, RLF, RR, RU, SC, SMR, TBM, TR, VPN and WOS 3. Meal Accuracy Report audit data from August 2008 - January 2009 4. Nutrition Care Monitoring Tool audit data from August 2008 - January 2009 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 5. Audit data for August 2008 - January 2009 regarding WRP integration of Nutrition Services recommendations 6. Facility training data and competency scores for RNs and Dietitians, as well as raw data binders 7. WRPC Post-Test 8. Nutrition and Wellness PSR Mall Group 10-week lesson plan 9. Records of the following three individuals participating in Nutrition and Wellness PSR Mall Group: LB, MLC and VLA Observed: (observed on site by Rob Schaufenbil with findings regarding group lesson content reported via teleconference)

<table>
<tr><td></td><td></td><td>1. Nutrition and Wellness PSR Mall group</td></tr>
<tr><td>F.5.a</td><td>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.</td><td>
Current findings on previous recommendations:

Recommendation 1, September 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with these indicators based on an average sample of 33% of Nutrition Assessments (all types) due each month for the review period of August 2008 - January 2009 (total of 461 out of 1379). The following table presents these indicators with corresponding mean compliance rates:
<table>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
</table>
Comparative data showed maintenance of compliance greater than 90% from the previous review period.

Other findings:
A review of records of 53 individuals with completed Nutrition Care assessments across sub-types (ADF, AMB, AMP, BA, BMT, BTM, BU, CB, CC, CJ, CL, CPB, CRT, CSR, DCE, DD, DLH, FMR, FTR, IPF, ITJ, JA, JB, JC, JCY, JKW, JLG, JM, JMA, JS, KAR, LAC, LB, LD, LL, MCL, MJA, MMA, MWM, NB, OH, PA, PAF, PW, RLF, RR, RU, SC, SMR, TBM, TR, VPN and WOS) to assess compliance with documentation of provision of Nutrition Education Training and documentation of response to Medical Nutrition Training found all records in substantial compliance.
</td></tr>
</table>

		Recommendation 2, September 2008: Convert all Nutrition Services PSR Mall group lesson plans, course outlines and curricula to the new format as this process is implemented. **Findings:** The 10-week lesson plan for the Nutrition and Wellness PSR Mall Group was reviewed and appeared to be thorough and comprehensive, and in line with accepted standards of practice. **Other findings:** According to review of Meal Accuracy Report data, 100% of trays (regular and modified diets) audited from August 2008 - January 2009 (total of 753 out of 3770, for a 20% sample) were 100% accurate. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 26% of Nutrition Assessments (all types) due each month for the review period of August 2008 - January 2009 (total of 355 out of 1379). The following table presents these indicators with corresponding mean compliance rates:

19.	*The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated*	91%
20.	*The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated*	71%

Comparative data indicated mixed changes in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
19.	88%	91%
20.	77%	71%
Compliance rate in last month of period		
19.	88%	100%
20.	76%	75%

The facility plans to improve compliance by having dietitians input recommendations, foci, objectives and interventions directly into the WRP; this process was initiated on 2/24/09.

Recommendation 2, September 2008:
Provide training to dietitians on writing quality foci, objectives and interventions that meet WRP criteria and are aligned.

Findings:
According to facility report, 7/7 Nutrition staff received training on writing Focus 6 objectives and interventions on 12/3/08 (WRP training for Nurses); however, training rosters and post-tests were not available for review.

A review of records of 13 individuals with completed Nutrition Care

		assessments across sub-types (ADF, AMP, BA, CC, CDJ, FTR, JCY, LB, LL, RLF, RR, SC and SMR) found that in all records, foci, objectives and interventions were aligned. **Recommendation 3, September 2008:** Ensure that for individuals participating in Nutrition PSR Mall groups, appropriate foci, objectives and interventions are present in the WRP. **Findings:** A review of records of 13 individuals with completed Nutrition Care assessments across sub-types (ADF, AMP, BA, CC, CDJ, FTR, JCY, LB, LL, RLF, RR, SC and SMR) to assess compliance with having an adequate focus, objective and intervention integrated into the WRP found five records in substantial compliance (CC, FTR, JCY, RR and SMR) and eight records in partial compliance (ADF, AMP, BA, CDJ, LB, LL, RLF and SC). An identified pattern of deficiency that the facility should focus on in order to improve compliance is that WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable. A review of records of three individuals participating in the Nutrition and Wellness PSR Mall Group (LB, MLC and VLA) to assess for compliance with provision of timely and adequate Nutrition services found all records in partial compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP and are not consistently aligned. 3. Progress is not consistently documented in the present status section of the WRP.

		Observation of the Nutrition and Wellness PSR Mall group found that the lesson plan was in use and that the group provided activities that were in line with the individual's assessed needs. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

		Findings: No new Registered Dietitians who would require competency-based training were hired during the review period. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Glen Itow, PharmD, Director, Pharmacy Department 2. Harold Plon, PharmD, Assistant Director, Pharmacy Department Reviewed: 1. MSH monitoring data regarding recommendations made by the pharmacists and physicians' responses to these recommendations 2. MSH document regarding all pharmacy recommendations that were not followed with no rationale documented, including event, recommendation and outcome
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue to monitor this requirement. **Findings:** The following table outlines the types and number of recommendations made by the Pharmacy Department during this review period:

1.	Drug-to-drug interactions	29
2.	Side-effects	41
3.	Need for lab work and testing	40
4.	Dose ranges	26
5.	Indications	4
6.	Contraindications	0
7.	Need for continued treatment	5
8.	Food-drug interactions	4
9.	Drug levels (outside therapeutic range)	9
10.	Formulation changes	0

11.	Drug allergy	2
12.	Polypharmacy	5
Total number of recommendations		165

Comparative data showed that the facility has increased the number of recommendations in most categories since the last review. The total number reported for this review period was 165 compared to 103 during the last review period.

Recommendation 2, September 2008:
Provide data analysis to explain why the pharmacists were concerned about the need for further laboratory testing for new orders.

Findings:
A review of the facility's data regarding recommendations presented by the Pharmacy Department adequately explained concerns by the pharmacists.

Recommendation 3, September 2008:
Provide specific information regarding current vacancies.

Findings:
The Director of the Pharmacy Department indicated that current Pharmacy allocation is adequate to meet EP requirements.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period.

<table>
<tr>
<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
<td>

Current findings on previous recommendations:

Recommendation 1, September 2008:
Monitor this requirement based on a 100% sample.

Findings:
Based on a review of a 100% sample, MSH presented the following data:

<table>
<tr><td>Recommendations followed</td><td>99</td></tr>
<tr><td>Recommendations not followed, but rationale documented</td><td>5</td></tr>
<tr><td>Recommendations not followed and rationale/response not documented</td><td>61</td></tr>
</table>

Recommendation 2, September 2008:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
The facility has instituted the following mechanisms (since February 2009) to address this recommendation:

1. The Pharmacy Department has reported all recommendations not followed without rationale documented by the prescribing physician to the Medical Director on a monthly basis.
2. The facility has identified the prescribing physicians who do not follow the recommendations without documented rationale.
3. A letter from the Medical Director has been generated to accompany the monthly summary of pharmacists' recommendations, instructing the prescribing physician to either follow the recommendation or justify why not.

</td>
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</table>

		Other findings: This monitor reviewed the facility's data regarding eight recommendations that were made by the pharmacist without action by the physicians in response to the recommendations. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement and provide comparative data for the review period compared to the last period.

7. General Medical Services		
		Methodology: Interviewed: 1. Adella Davis-Sterling, Supervising RN 2. Chi Vu, M., Physician and Surgeon 3. Daisy Kutty, MD, Physician and Surgeon 4. Leonard Liu, MD, Physician and Surgeon 5. Michael Barsom, MD, Medical Director 6. Nae Kim, MD, Physician and Surgeon 7. Nghi Pham, MD, Physician and Surgeon 8. Quynh Pham, DO, Physician and Surgeon 9. Raymond Flores, MD, Physician and Surgeon 10. Thai Vu, MD, Physician and Surgeon 11. Tuyen Le, MD, Physician and Surgeon 12. Zakaria Bushra, MD, Chief Physician and Surgeon Reviewed: 1. The charts of the following 10 individuals: CJ, CS, CT, GR, JA, KS, RH, SP, TN and TP 2. DMH Medical Surgical Progress Notes Auditing Form 3. DMH Medical Surgical Progress Notes Auditing Form Instructions 4. DMH Integration of Medical Conditions into the WRP Auditing Form 5. DMH Integration of Medical Conditions into the WRP Auditing Form Instructions 6. MSH Integration of Medical Conditions into the WRP Auditing summary data (August 2008 to January 2009) 7. DMH Medical Transfer Auditing Form 8. DMH Medical Transfer Auditing Form Instructions 9. MSH Medical Transfer Auditing summary data (August 2008 to January 2009) 10. MSH medical and psychiatric night/weekend and holiday coverage schedule (August 2008 to January 2009)

		11. DMH Diabetes Mellitus Auditing Form 12. DMH Diabetes Mellitus Auditing Form Instructions 13. MSH Diabetes Mellitus Auditing summary data (August 2008 to January 2009) 14. DMH Hypertension Auditing Form 15. DMH Hypertension Auditing Form Instructions 16. MSH Hypertension Auditing summary data (August 2008 to January 2009) 17. DMH Dyslipidemia Auditing Form 18. DMH Dyslipidemia Auditing Form Instructions 19. MSH Dyslipidemia Auditing summary data (August 2008 to January 2009) 20. DMH Asthma/COPD Auditing Form 21. DMH Asthma/COPD Auditing Form Instructions 22. MSH Asthma/COPD Auditing summary data (August 2008 to January 2009) 23. DMH Physician Order Form (Transfer to Outside Facility), finalized October and implemented at MSH November 2008 24. DMH Physician Note: Transfer to Outside Facility for Emergency or Other Services, finalized October and implemented at MSH November 2008 25. DMH RN Change in Physical Status Note, finalized October and implemented at MSH November 2008 26. DMH Nursing Transfer Note, finalized October and implemented at MSH November 2008 27. Metropolitan State Hospital Medical Physician Performance Profile, effective January 2009 28. Special Order 205.05, Mortality Review, effective 3/17/08 29. Mortality Interdisciplinary Review Committee Meeting Minutes (August 7 2008, September26, 2008 and January 12, 2009) 30. Mortality Review for KR

F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Ensure proper oversight of medical services to correct this monitor's findings of clinical deficiencies (listed in other findings above). **Findings:** MSH reported several corrective actions that occurred at the DMH level to address the clinical deficiencies discovered during the previous review. These actions are summarized below: 1. DMH developed standardized policies and documentation policies related to: a. Provision of Medical Care to Individuals; b. Transfer to and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment; c. Psychiatric and Medical Coverage; and d. Registered Nurse and Physician Communication about Change in Physical Status. 2. DMH developed documentation templates that align with the newly developed policies: a. Sick Call Referral Log b. Physician Note: Transfer to Outside Facility for Emergency or other Services c. Physician Order Form (Transfer to Outside Facility) d. Nursing Transfer Note e. RN Change in Physical Status Note 3. DMH developed a series of reference materials (Reference for Assessment and Notification.) These documents are designed to assist RNs in assessing high-risk changes in status and communicating relevant information to the physician. References were developed for the high-risk areas of cardiovascular, altered mental status, infection, abdominal pain, gastrointestinal bleeding and respiratory.

		4. The policies, templates and references were implemented during November 2008. 5. DMH developed joint medical and nursing policies for the high-risk areas of constipation, dehydration, dysphagia, diabetes, hypertension, asthma, COPD, seizures, weight management and pressure ulcers and wounds to standardize practice. These policies were implemented in January 2009. 6. In addition, the Medical Task Force was in the process of reviewing a new policy on medical emergency management at the time of the current review. MSH also reported corrective actions that occurred at the facility level. These are summarized below: 1. MSH hired a new Chief of Medical Services (Dr. Zakaria Boshra) in September 2008. 2. The newly hired Chief of Medical Services began communicating with unit physicians each day to discuss new admissions, individuals with unstable medical conditions, medical transfers to outside facilities and individuals who return from outside facilities. 3. A physician double-boarded in internal medicine and geriatric medicine was assigned to the Skilled Nursing Facility area of MSH, and a female board-certified physician has been assigned to the female units to address issues related to women's healthcare. 4. A Liaison Team consisting of a physician and utilization nurse was developed. This team was designed to increase communication (including receipt of timely reports) between MSH and outside medical facilities. 5. Annual CME credits in geriatrics and pain management were added to the requirements for privileging. 6. The Medical Risk Management Committee was established in alignment with Special Order 262. During this review period, the committee reviewed the care of individuals with falls, osteoporosis

and metabolic syndrome.

7. The facility intends to initiate weekly clinical rounds with all physicians on individuals identified as at high risk related to medical factors in March 2009.

Recommendation 2, September 2008:
Finalize DMH SO #136.

Findings:
DMH Special Order136, Provision of Medical Care to Individuals was finalized and implemented in November 2008.

Other findings:
This monitor reviewed the charts of 10 individuals who were transferred to an outside medical facility during the reporting period (CJ, CS, CT, GR, JA, KS, RH, SP, TN and TP) and interviewed the physicians and surgeons who were involved in their care. The following table outlines on an anonymized basis the date/time of physician evaluation at the time of transfer and the reason for the transfer:

Individual	Date/time of MD evaluation	Reason for transfer
1.	01/26/08 13:27	Syncopy vs. Seizure
2.	11/03/09 22:30	Recurrent Pancreatitis and Hypertension
3.	08/11/08 12:45	Confusion and Hypertension
3.	08/28/08 16:30	Confusion and Hyponatremia
4.	11/20/08 (no time)	R/O Pneumonia
5.	01/14/09 21:15	R/O Upper Gastrointestinal Bleeding
6.	09/16/08 00:25	Status Epilepticus
7.	12/17/08 10:15	Pneumonia

8.	11/24/08 08:25	Altered Level of Consciousness
9.	10/13/08 14:1	Abdominal Pain
10.	12/30/08 14:45	Recurrent Foreign Body Ingestion

The review found evidence of timely and appropriate care in most charts. However, a persistent pattern of deficiencies was found as follows:

1. The chart did not include a timely assessment by nursing of an individual who was later transferred to an outside facility because of increasing confusion and hypertension.
2. The physician order for vital signs checks of an individual who was being monitored for hypertension did not include parameters for nursing notification of the physician regarding significant change.
3. There was evidence of delayed notification of a physician of a significant change in the blood pressure of an individual who was being monitored for hypertension.
4. The admission orders for an individual included an inappropriate entry (not signed or dated) regarding precautions for dangerousness to self.
5. The WRP of an individual who was diagnosed with questionable status epilepticus and repeatedly refused anticonvulsant medications did not include appropriate objectives or interventions to address the individual's needs.
6. The physician acceptance note for an individual who returned to the facility following hospitalization for seizure activity did not include required information.
7. The WRP included inappropriate objectives and interventions for an individual who refused medical interventions for a colonic mass.
8. The on-call physician evaluation of an individual who had altered consciousness and sustained a fall was incomplete and inadequate.
9. An individual who was transferred to an outside facility for recurrent ingestion of foreign bodies received a behavioral support plan that

		did not meet generally accepted standards of care. In addition, this monitor reviewed the mortality review data regarding KR. The review found that the facility has implemented the DMH SO 205.05, including an adequate external mortality review process. However, the review found that the facility's Mortality Interdisciplinary Review Committee (MIRC) did not adequately address all the performance improvement recommendations in the external reviewer's report. **Compliance:** Partial. **Current recommendations**: 1. Implement corrective actions to address the monitor's findings of deficiencies in this report. 2. Ensure consistent implementation of DMH SO#205.5, Mortality Review, including appropriate attention by the facility's MIRC to all conclusions and recommendations regarding contributing and non-contributing factors in the external reviewer's report.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. **Findings:** Although the DMH Initial Medical Assessment was finalized and implemented in August 2008, the DMH Initial Medical Assessment

standardized monitoring tool has yet to be developed.

Recommendations 2 and 3, September 2008:

- Implement the quarterly medical reassessments and monitor implementation, using the DMH Medical Surgical Progress Notes Auditing Form based on a 20% sample.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:

MSH used the DMH Medical-Surgical Progress Notes Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 16% of the individuals with at least one diagnosis on Axis III. The following summarizes the data:

1.	*There is a quarterly note that documents reassessment of the individual medical status.*	85%
2.	*Significant conditions for which the individual is at risk for complications are identified.*	90%
3.	*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.*	98%

Comparative data is not available given that this audit was implemented during this review period (September 2008).

Compliance:

Partial.

		Current recommendations: 1. Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i. 2. Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period) 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities. **Findings:** See F.7.a above. **Recommendations 2 and 3, September 2008:** • Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the DMH Medical Transfer Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 100% of the records of individuals transferred to an external facility. The following summarizes the data:

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	99%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	79%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	65%
4.	*Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.*	90%
5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	96%
6.	*Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	90%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	63%

Comparative data showed improvements in compliance since the previous review as follows:

	Previous period	Current period
Mean compliance rate		
1.	65%	99%

2.	28%	79%
3.	11%	65%
4.	74%	90%
5.	83%	96%
6.	80%	90%
7.	14%	63%
Compliance rate in last month of period (for indicators < 90%C)		
2.	72%	75%
3.	36%	88%
7.	8%	50%

MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form (August 2008 to January 2009) to assess compliance with this requirement. The average sample was 21% of the monthly WRPs. The following summarizes the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	73%
2.	*The WRP includes each medical condition listed on the Medical Conditions form*	49%
3.	*There is an appropriate focus statement for each medical condition or diagnosis*	50%
4.	*There is an appropriate objective for each medical condition or diagnosis*	15%
5.	*There are appropriate intervention(s) for each objective*	8%

Comparative data showed mixed results in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	55%	73%
2.	39%	49%
3.	43%	50%
4.	17%	15%
5.	6%	8%
Compliance rate in last month of period		
1.	55%	84%
2.	38%	44%
3.	42%	53%
4.	18%	6%
5.	6%	75

The facility's training/mentoring plan designed to address these deficiencies is described in C.1.a.

MSH did not provide audit data regarding timeliness of off-site consultations.

Compliance:
Partial.

Current recommendations:
1. Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.
2. Monitor this requirement using the DMH Medical Transfer Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

		compared to the last period. 4. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH reported that it continues to adhere to policies and procedures aligned with Special Order 136 that defines these duties and responsibilities. **Compliance:** Partial. **Current recommendation:** Continue current practice.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH reported that both a psychiatrist and medical physician are available on campus at all times after hours. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as in F.7.b.ii. **Findings:** Same as in F.7.b.ii, and see F.7.a for a description of the Liaison Team implemented during this review period. **Compliance:** Partial. **Current recommendation**: Same as in F.7.b.ii.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendations 1 and 3, September 2008:** • Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** MSH used the DMH standardized tools regarding the management of Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD (August 2008 to January 2009) to assess compliance with this requirement. The average samples were 19%, 18%, 31% and 21% respectively of the records

of individuals diagnosed with these disorders. The following summarizes the data:

Diabetes Mellitus

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	100%
2.	*HgbA1C was ordered quarterly.*	99%
3.	*The HgbA1C is equal to or less than 7%.*	98%
4.	*Blood sugar is monitored regularly.*	98%
5.	*Urinary micro albumin is monitored annually.*	99%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	100%
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	100%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	100%
9.	*Blood pressure is monitored weekly.*	100%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	100%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	100%
12.	*Podiatry care was provided by a podiatrist at least annually.*	100%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	100%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	93%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	93%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for indicators 1 through 7 and 9 through 15, and improvement from 86% for item 8.

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	99%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	97%
3.	*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.*	100%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	99%
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	92%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	92%
7.	*The individual has been assessed for a flu vaccination.*	100%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1, 6, 7 and 8, and improvement for items 2, 3 and 5 from 88%, 88%, and 87% respectively. Compliance for item 4 declined from 98% in the previous review period.

Hypertension

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%

2.	*Blood pressure is monitored weekly.*	100%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	99%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	88%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	92%
6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	91%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	100%
8.	*The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.*	100%
9.	*An exercise program has been initiated.*	100%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	99%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1-3, 5, 7, 9 and 10, and improvement for items 4, 6 and 8 from 77%, 87% and 45% respectively.

MSH indicated that some physicians had not carried information regarding the appropriateness of intervention with aspirin (item 4) from previous notes into the most recent quarterly notes (the audited document), resulting in the current compliance audit data.

<u>Dyslipidemia</u>

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	100%
2.	*A lipid panel was ordered at least quarterly.*	100%

3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	100%
4.	*The LDL level is ≤ 130 or a plan of care is in place.*	99%
5.	*The Triglyceride level is ≤ 200 of a plan of care is in place.*	96%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	85%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	85%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	99%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	99%
10.	*An exercise program has been initiated.*	100%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.*	100%

Comparative data indicated maintenance of compliance at or above 90% from the previous review period for items 1, 2, 4, 5, 8, 10 and 11. Compliance for items 3, 6, 7 and 9 improved from 61%, 84%, 83% and 45% respectively.

Recommendation 2, September 2008:
Monitor preventive care and care of cardiac disease using NSH indicators.

Findings:
MSH reported that it implemented the Cardiac Disease and Preventative Care Audit forms during January 2009 to assess compliance with this requirement. The average sample for the preventative care audit was 14% of individuals. The percentage sample size for cardiac disease was

not reported (26 records were reviewed.) The following presents the January data:

Cardiac Disease

1.	*Did the individual receive CAD symptom and activity assessment?*	100%
2.	*Did the individual receive at least one lipid profile in last year?*	100%
3.a	*Did the individual receive lipid-lowering therapy for LDL > 100?*	100%
3.b	*Did the individual receive lipid-lowering therapy for LDL-C > 100?*	90%
4.	*Does the individual have a LDL-C level <130mg/dl?*	92%
5.	*Does the individual have a LDL-C <100mg/dl?*	85%
6.	*Was antiplatelet therapy prescribed?*	87%
7.	*Was beta blocker prescribed after MI or contraindication documented?*	100%
8.	*Was ACE inhibitor (or ARB) prescribed?*	70%

Preventive Care

1.	*If the individual indicated that he/she is a smoker on the Admission Medical H&P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?*	20%
2.	*If the patient has a BMI >27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6*	88%

			months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?	
		3.	*If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?*	88%
		4.	*If the individual is 65 or older, has a pneumococcal vaccine been ordered in the previous two years as documented on the Preventive Care Tracking Form?*	87%
		5.	*If the individual is 50 or older, was the individual offered an influenza immunization during the previous September through February as documented on the Preventive Care Tracking Form?*	84%
		6.	*If the individual is a women age 50 or older or has a family history of breast cancer as indicated on the Admission H&P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?*	58%
		7.	*If the individual is age 51 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered:* *(1) fecal occult blood test during the past year,* *(2) flexible sigmoidoscopy during the past four years,* *(3) double contrast barium enema during the past four years or* *(4) colonoscopy during the past nine years?*	59%
		8.	*If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as*	50%

	documented on the Preventive Care Tracking Form?	
9.	*If the individual is a woman age 16 or older, has one chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?*	48%
10.	*If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?*	63%

Compliance:
Partial.

Current recommendations:
1. Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia, Asthma/COPD, Cardiac Disease and Preventative Care using the standardized tools, based on at least 20% samples.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
3. Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Implement a Physician Performance Profile for physicians and surgeons and utilize the data in the processes of reappointment and reprivileging. **Findings:** The Medical Physician Performance Profile tool was developed by the Chief of Medicine and implemented on January 1, 2009. The instrument

		includes performance evaluation on the following criteria: patient care, medical knowledge, interpersonal and communication skills, professionalism and system-based practice. Data are collected and analyzed in order to give feedback to individual physicians. The facility reported that it intends to utilize the data for reappointment and granting hospital privileges. **Recommendation 2, September 2008:** Continue to update practice guidelines guided by current literature and relevant clinical experience. **Findings:** MSH did not report any additional updates to practice guidelines related to this recommendation. **Recommendation 3, September 2008:** Provide peer review data analysis regarding practitioner and group trends, with systemic corrective actions as indicated. **Findings:** MSH reported that a new peer review system was implemented during this review period. The facility did not present the outcome of data review or corrective actions based on this review in its status report. **Recommendation 4, September 2008:** Develop and implement process and clinical outcomes to assess medical care. **Findings:** The facility reported that number of seizure episodes, incidence of chest pain, incidence of pneumonia, numbers and seriousness of falls, incidence of resistant infections including MRSA and incidence of transfers to outside facilities have been selected to measure clinical outcomes and to

		assess medical care. **Recommendation 5, September 2008:** Finalize efforts to automate data systems to facilitate data collection and analysis. **Findings:** MSH reported three automated data systems: 1. PLATO data collection and analysis system is in place and is used to generate performance reports. 2. One program has piloted the Medical Scheduler system. This system is designed to track completed appointments, refusals and missed appointments. 3. The eRad system, which allows physicians to review imaging studies from remote sites, was implemented. **Compliance:** Partial. **Current recommendations**: 1. Utilize data from the Medical Physician Performance Profile in the processes of reappointment and reprivileging. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. 3. Provide peer review data analysis regarding practitioner and group trends, with systemic corrective actions as indicated. 4. Develop and implement process and clinical outcomes to assess medical care. 5. Finalize efforts to automate data systems to facilitate data collection and analysis.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Adella Davis-Sterling, SRN 2. Aurora Hendricks, Nurse Administrator 3. Charlene Hooper, PHN 4. Loraine Clinton, PHN 5. Lorda R. Moufy, RN, HSS Reviewed: 1. MSH's progress report and data 2. MSH Interdepartmental Performance Improvement Committee minutes dated 3/25/08, 4/22/08, 5/27/08, 7/22/08 and 12/23/08 3. Infection Control Committee Meeting minutes dated 6/25/08, 7/30/08, 8/23/08, 10/29/08, 11/24/08 and 1/28/09 4. Hepatitis C Bundle for physicians 5. MSH Public Health Lesson Plan 6. Joint Commission Requirements for Improvements dated 9/21/08 7. Joint Commission Plan of Correction 8. MSH Infection Control Plan, July 1, 2008-June 30, 2009 9. MSH Hepatitis C Teaching Protocol 10. Algorithm for Focus 6 documentation for refusals 11. Revised AD 401.3, Blood-Borne Pathogen Education 12. Revised AD 3120, AIDS Prevention and Management 13. Revised AD 3120.2, Condoms: AIDS Prevention and Management 14. Revised AD 3120.3, HIV Education for Individuals 15. Draft of Job Description of Public Health Liaison Nurse 16. Infection Control Key Indicator data 17. Medical records for the following 94 individuals: AB, ABH, AE, AEE, AER, APQ, AR, AS, BB, BJW, BMA, BMT, BTM, BTS, CF, CFS, CG, CH, CPP, DKB, DLG, DLN, DS, EAB, EAR, EGW, EM, EW, FM, GCR, GM, GT, IIG, IR, JA, JAM, JCM, JDA, JEY, JJB, JK, JLA, JLG, JLS, JLW,

		JOM, JRF, JS, JSB, JSL, KLD, KS, KTR, LAD, LEL, LES, LJ, LL, LLW, LO, MAO, MHA, MJB, MKC, MKD, MLC, MLD, MMR, MMS, MSR, NM, OH, PA, PAL, PC, PD, PGD, PMH, PMZ, RB, RDA, RO, RRA, RRR, RS, RU, SL, SRC, SW, SWA, TBC, TC, TG and TP
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Evaluate the need to secure an additional RN to facilitate IC activities between the IC Department and the units. **Findings:** In December 2008, MSH assigned an RN from Central Nursing Services to assist with IC issues on the units. However, after interviewing the IC staff and the RN, it was apparent that there has been absolutely no collaboration between the two. No training has been provided to the RN by IC regarding appropriate criteria for WRPs or sharing of any audit findings. In addition, there had been no sharing of information regarding lists of individuals who have IC issues, which became evident when IC and the RN had different names on their respective lists regarding refusals. There was no formal description of duties for the Public Health Liaison Nurse. However, a draft was developed at the time of the review. The unfortunate result of this situation was the significant lack of improvement in the addressing of IC issues in WRPs. The significant clinical indications are of major concern since they ultimately affect the individuals at MSH. During the review, a discussion was held with the Medical Director and Executive Director regarding this reviewer's concerns about how the lack of cooperation has hampered progress and clinical practice on the units.

Recommendation 2, September 2008:
Continue to monitor this requirement.

Findings (by test/disease):

Admission PPD
The DMH IC Admission PPD Auditing Form, based on an average sample of 30% of individuals admitted to the hospital with a negative PPD in the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the admission procedure.*	98%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	93%
4.	*1st step PPDs were read by the nurse within 7 days of administration.*	99%
5.	*2nd step PPDs were read by the nurse within 48-72 hours of administration.*	91%

Comparative data indicated maintenance of compliance greater than 90% for all items from the previous review period.

F.8.a.ii: Assesses these data for trends
Compliance remains at or near 100% for all items.

F.8.a.iii: Initiates inquiries regarding problematic trends
No problematic trends were identified.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of 29 individuals admitted during the review period (AER, APQ, BB, BJW, CPP, DLN, DS, EAB, FM, IR, JAM, JDA, JLA, JLG, JRF, KS, LAD, LEL, LES, LLW, MKC, MLD, MMS, PA, PAL, RRR, SL, SRC and TG) found that all had a physician's order for PPD upon admission and 27 were administered within 24 hours. Also, 27 of the first-step PPDs and 24 of the second-step PPDs were timely read.

Annual PPD
The DMH IC Annual PPD Auditing Form, based on an average sample of 27% of individuals needing an annual PPD during the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the annual review procedure.*	100%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	97%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	98%

Comparative data indicated maintenance of compliance greater than 90% for all items from the previous review period.

F.8.a.ii: Assesses these data for trends
Compliance remains at or near 100% for all items.

F.8.a.iii: Initiates inquiries regarding problematic trends
No problematic trends were identified.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of 25 individuals receiving an annual PPD (ABH, AE, AR, BTS, CFS, DKB, EAR, JCM, JEY, JK, JLS, JS, JSB, KTR, LL, MAO, MHA, MJB, MKD, MSR, PGD, PMZ, RB, RO and SWA) found that all had a physician's order for PPD and 24 were timely given and read.

Hepatitis C
The DMH IC Hepatitis C Auditing Form, based on an average sample of 100% of individuals admitted to the hospital who are positive for Hepatitis C in the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	33%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	93%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	21%
5.	*A Focus 6 is opened for Hepatitis C.*	47%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	20%

7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual*	0%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	96%	33%
3.	93%	93%
4.	92%	21%
5.	74%	47%
6.	8%	20%
7.	11%	0%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	50%
3.	100%	100%
4.	80%	0%
5.	83%	50%
6.	20%	0%
7.	17%	0%

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 2: Nursing has not been consistently documenting receipt of the lab work in the IDNs. Due to a change in auditing methodology, there was a

		disruption in communicating the findings to nursing staff. Item 4: The unit physicians have been inconsistent in their documentation due to confusion regarding which physician was responsible for conducting the evaluation (clinic physician, unit physician, or program medical consultant). Items 5-7: The decrease in compliance for item 5 represents an inappropriate Focus Statement incorporated into the WRP. Sustained low compliance for items 6 and 7 represents inadequate formulation of objectives and interventions in the WRPs. A liaison nurse was appointed in December 2008 to address these issues. <u>F.8.a.iv: Identifies necessary corrective action</u> Item 2: In February 2009, the Public Health Nurse (PHN) began to conduct audits during a specified week and to provide the findings to nursing within the review months. Item 4: In January 2009, the PHNs developed Hepatitis cards to assist the physicians in completing items 4 and 5. Items 5- 7: The Hospital Annual Update training was modified to included writing appropriate IC care plans with interventions. Also, in December 2008, the Nursing Administrator assigned a Registered Nurse to work in assisting the unit nurses regarding writing appropriate IC objectives and interventions. <u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> The Infection Control Department will continue to monitor these items for compliance. A review of the charts of 10 individuals who were admitted Hepatitis C positive (GCR, GT, LES, OH, PAL, PC, PMH, RDA, TBC and TP) found that

five contained documentation that the medication plan and immunizations were evaluated and five WRPs contained appropriate objectives and interventions.

HIV Positive

The DMH IC HIV Positive Auditing Form, based on a 100% sample (two individuals) of individuals who were positive for HIV antibody in the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	N/A
5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.*	100%
6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	50%
7.	*Appropriate objective is written to address the progression of the disease.*	0%
8.	*Appropriate interventions are written.*	0%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	N/A
5.	80%	100%
6.	100%	50%
7.	60%	0%
8.	60%	0%
Compliance rate in last month of period		
1.	N/A	N/A
2.	N/A	N/A
3.	N/A	N/A
4.	N/A	N/A
5.	N/A	N/A
6.	N/A	N/A
7.	N/A	N/A
8.	N/A	N/A

There were no new cases of HIV during the last month of either review period.

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Compliance for items 7 and 8 declined due to inappropriate Focus Statements and inadequate formulation of objectives and interventions incorporated into the WRP. See Hepatitis C, F.8.a.iii.

F.8.a.iv: Identifies necessary corrective action
See Hepatitis C, F.8.a.iv.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the record for one individual admitted during the review period with HIV (PC) found that it was in compliance regarding clinic referrals and follow-up and that the WPR contained appropriate objectives and interventions. (The second individual with HIV had been discharged and the chart was transferred to receiving facility.)

Immunizations
The DMH IC Immunization Auditing Form, based on an average sample of 28% of individuals admitted to the hospital during the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	97%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	89%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	76%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	96%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	83%	97%
2.	93%	89%
3.	90%	76%
4.	93%	96%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	82%	65%
4.	100%	100%

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 2: Removal of admission labs from the clinical record prevents evaluation of immune status. Also, the staff is not consistently reporting refusals to public health.

Item 3: One physician has not been consistently ordering immunizations.

F.8.a.iv: Identifies necessary corrective action
Item 2: Memos sent to physician to order immunizations and to have admission labs kept in the record

Item 3: Email sent to Dr. Boshra regarding the physicians' ordering of immunizations.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items

for compliance.

A review of the charts of 16 individuals (AEE, DLN, DS, EAB, FM, IR, JAM, JDA, JLW, LAD, MKC, MLD, RDA, RO, RRA and TG) found that 13 contained documentation that the immunizations were ordered by the physician within 30 days of receiving notification by the lab and 15 were timely administered.

Immunization Refusals

As noted above, the data for refusals of immunization is unreliable. The PHNs and the liaison nurse will need to collaborate to ensure that the data is reliable to accurately and adequately address F.8.a.ii-F.8.a.v.

MRSA

The DMH IC MRSA Auditing Form, based on a 50% sample (23 individuals) of individuals in the hospital who tested positive for MRSA during the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained*	88%
3.	*The individual is placed on contact precaution per MRSA policy.*	57%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	100%
6.	*A Focus 6 is opened for MRSA.*	67%

7.	*Appropriate objective is written to include prevention of spread of infection*	22%
8.	*Appropriate interventions are written to include contact precautions.*	11%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	83%	88%
3.	75%	57%
4.	100%	100%
5.	83%	100%
6.	43%	67%
7.	33%	22%
8.	33%	11%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	50%	100%
4.	100%	100%
5.	50%	100%
6.	50%	50%
7.	50%	50%
8.	0%	50%

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 2: See Hepatitis C, F.8.a.iii regarding documentation issue.

Item 3: Not all individuals warrant contact precautions and individuals colonized with MRSA have a MRSA Alert in their medical record.

F.8.a.iv: Identifies necessary corrective action
See Hepatitis C, F.8.a.iv regarding objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of 15 individuals with MRSA (BTM, CG, CH, DLG, EW, JJB, JS, JSL, LO, MLC, NM, PD, RS, SW and TC) found that 14 were placed on contact precautions; 14 were placed on the appropriate antibiotic and four had MRSA appropriately addressed in their WRPs.

Positive PPD
The DMH IC Positive PPD Auditing Form, based on an average sample of 33% of individuals in the hospital who have a positive PPD test during the review months (August 2008 - January 2009), indicated the following:

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	86%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	77%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	N/A
5.	*If LTBI is present, there is a Focus 6 opened.*	41%
6.	*If LTBI is present, there are appropriate objectives*	14%

	written to provide treatment and to prevent spread of the disease.	
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	5%

Comparative data indicated that compliance for most items declined from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	92%	86%
3.	92%	77%
4.	N/A	N/A
5.	50%	41%
6.	25%	14%
7.	36%	5%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	50%
4.	N/A	N/A
5.	60%	25%
6.	20%	0%
7.	20%	0%

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Items 2 and 3: Refusals of chest x-rays and clinic evaluation.

Items 5-7: See Hepatitis C, F.8.a.iii.

F.8.a.iv: Identifies necessary corrective action
Items 2-3 and 5-7: See Hepatitis C, F.8.a.iv.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

Review of records for 16 individuals who had a positive PPD (AB, AS, BMA, CF, EGW, EM, FM, GM, IIG, JA, JOM, MMR, PMH, RRA, RRR and RU) found that 13 had the required chest x-rays and three refused; 15 had documentation of an evaluation from the physician and one refused; and nine had appropriate objectives and interventions in the WRP.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
The DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (August 2008 - January 2009), indicated the following:

1.	*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.*	17%
2.	*There is a Focus opened for the lab work or PPD refusal*	0%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	0%

4.	*There are appropriate interventions written for the lab work or PPD refusal.*	0%

Comparative data indicated declines in compliance for all items from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	60%	17%
2.	6%	0%
3.	7%	0%
4.	7%	0%
Compliance rate in last month of period		
1.	100%	0%
2.	20%	0%
3.	20%	0%
4.	20%	0%

F.8.a.ii: Assesses these data for trends
See comparative data table above.

F.8.a.iii: Initiates inquiries regarding problematic trends
Item 1: Most refusals are identified during the audit process.

Items 2-4: See Hepatitis C, F.8.a.iii.

F.8.a.iv: Identifies necessary corrective action
Item 1: A memo is sent to the physician of any individual who refused admission lab to include test for Hepatitis B & C, varicella and rubella when reordering the admission labs. Also, a memo is sent when admission labs are purged from the records to have them replaced.

		Items 2-4: See Hepatitis C, F.8.a.iv. F.8.a.v: Monitors to ensure that appropriate remedies are achieved The Infection Control Department will continue to monitor these items for compliance. A review of four records of individuals that have refused admitting or annual labs/diagnostics (BMT, KLD, LJ and MKC) found that none of the refusals were addressed in the WRPs. **Sexually Transmitted Diseases** MSH's data could not be interpreted. The data presented indicated that there was one individual (N=1) meeting the criteria for a sexually transmitted disease. However, during the review, the IC staff indicated that there not been any cases of active disease, thus no one meeting the audit criteria. In addition, there were noted to be no individuals who met these criteria during the previous review. However, MSH's current data included comparison data that did not match the data from the last review. **Current recommendations**: 1. Ensure collaboration between the Infection Control Department and Liaison nurse. 2. Ensure reliable data regarding immunizations refusals. 3. Clarify data regarding Sexually Transmitted Diseases. 4. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

		Findings: See F.8.a.i. **Other findings:** The key indicator data for Hepatitis C was noted to fall from 90 to 7 in one month. From discussion with the IC staff, the issue may be related to the difference between the total numbers of individuals with Hepatitis C in the facility versus the number of individuals admitted with Hepatitis C during the month. By the end of the review, the issue had not been clarified. The Infection Control Department needs to review data related to their area to ensure that it accurately reflects the facility's trends. **Compliance:** Partial. **Current recommendations**: 1. Review and analyze Infection Control key indicator data to ensure it accurately reflects the trends regarding Infection Control issues. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial.

		Current recommendations: Continue to monitor this requirement.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.8.a.i. **Other findings:** The significantly low compliance scores regarding appropriate objectives and interventions in the WRPs underscores the importance of addressing the lack of collaboration between Infection Control and RN liaison. An Infection Control program cannot be considered effective if policy and practices do not translate to the unit level. This is especially pertinent since the Infection Control Committee Meeting minutes indicated that the committee had selected MRSA for Health Risk Factor as an area of concentration. The committee noted the goal was to reduce the risk of health care-associated MRSA. The impact of inadequate WRPs for individuals who have MRSA has to be reviewed as an essential factor in clinical outcomes. **Compliance:** Partial. **Current recommendations**: 1. Develop a system to ensure collaboration between the Infection Control Department and RN liaison. 2. Continue to monitor this requirement

F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendations**: Continue to monitor this requirement
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** A review of the minutes of IC Committee meetings and the MSH Interdepartmental Performance Improvement Committee found that several IC issues have been discussed with plans of action integrated into the different departments and into the facility's Performance Improvement program, including: • Restructured/returned to Infection Control Surveillance Monitoring by Programs; • Construction of an algorithm for auditing clinical records; • Revision of AD 401.3, Blood-Borne Pathogen Education; • Revision of AD 3120, AIDS Prevention and Management; • Revision of AD 3120.2, Condoms: AIDS Prevention and Management; • Revision of AD 3120.3, HIV Education for Individuals;

		• Revision of Hospital Annual Update training for the Infection Control Section; • Conduct of hand hygiene classes; • Institution of a checklist for hand hygiene compliance; and • Development of the Hepatitis C Bundle that assists physicians with the requirements for documentation. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Adella Davis-Sterling, SRN 2. Rung Tan, DDS 3. Toni Nguyen, DDS Reviewed: 1. MSH's progress report and data 2. Dental treatment logs 3. List of individuals who had extractions 4. List of individuals refusing dental services 5. List of individuals needing preventative and restorative dental treatment 6. List of individuals admitted to MSH 7. Medical records of the following 77 individuals: AB, ABH, ACE, AE, AH, AHB, AMA, AMW, AR, BA, BBM, BDM, BTS, BU, BW, CFS, CP, CPP, DKB, DLE, DLH, DVY, EAR, EBW, EV, FC, GCR, GFM, GSZ, HQN, IR, JAC, JBC, JCM, JCW, JEC, JEY, JIP, JJM, JK, JKA, JLA, JLS, JS, JSB, JSJ, KDC, KDH, KS, KTG, KTR, LCL, LD, LL, MAO, MDW, MHA, MJB, MKD, MSR, PAL, PD, PGD, PMZ, POS, RA, RB, RLS, RO, RTW, SB, SHL, SJF, SWA, TC, TM and VSF
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** At the time of this review, MSH has two full-time dentists, one part-time annuitant dentist, two full-time Registered Dental Assistants and one part-time annuitant dental assistant. MSH does not have a position for a

		Dental Hygienist or for a Chief Dentist. There have been some significant decreases in compliance due to the Dental Department being temporarily short of staff during August, September and October 2008. The annuitants provided some relief during this time. Dr. Nguyen indicated that if a similar staff shortage would reoccur, the clinical schedule will be modified temporarily to accommodate the workload to complete the dental exams in a timely manner. **Other findings:** MSH's Dental Department has implemented the new dental software program during the review period. Both Dr. Nguyen and Dr. Tan reported that the system can track a number of issues and that the Dental Treatment Plans are easy to read and can be printed out at the appointments and placed in the chart without the need to duplicate any documentation. However, from review of the medical records, dental records at MSH have been kept in the Consultation section of the chart, making it difficult to find and follow the dental services provided to individuals. Adding a separate tab in the medical record for Dental should be considered. **Compliance:** Partial. **Current recommendations**: 1. Include a separate tab in the medical records for Dental documentation. 2. Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendation:**

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals scheduled for a comprehensive dental exam during the review months (August 2008 - January 2009), indicated the following:

1.a	*Comprehensive dental exam was completed*	77%

Comparative data indicated a decrease in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.a	96%	77%
Compliance rate in last month of period		
1.a	93%	92%

The barrier to compliance was the Dental Department being temporarily short of staff during August, September and October 2008. The annuitant provided some relief during this time. The plan of correction included that in the event of a similar staff shortage, the clinical schedule will be modified temporarily to accommodate the workload to complete the dental exams in a timely manner.

A review of the records of 20 individuals (AB, ACE, BA, BW, CP, CPP, FC, GSZ, HQN, IR, JCW, JEC, JLA, KDH, KS, LD, PAL, RTW, SHL and TM) found that 17 had a comprehensive dental exam.

Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals who have been in the hospital for 90 days or less during the

review period (August 2008 - January 2009), indicated the following:

1.b	*If admission examination date was 90 days or less*	78%

Comparative data indicated a decrease in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.b	96%	78%
Compliance rate in last month of period		
1.b	96%	91%

The barrier to compliance and plan of correction are noted above.

A review of the records of 20 individuals (AB, ACE, BA, BW, CP, CPP, FC, GSZ, HQN, IR, JCW, JEC, JLA, KDH, KS, LD, PAL, RTW, SHL and TM) found that 17 were timely seen for their admission exam.

Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals due for annual routine dental examination during the review months (August 2008 - January 2009), indicated the following:

1.c	*Annual date of examination was within anniversary month of admission*	75%

Comparative data indicated a decrease in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.c	93%	75%
Compliance rate in last month of period		
1.c	91%	92%

The barrier to compliance and plan of correction are noted above.

A review of the records of 25 individuals due for an annual dental exam during the review period (ABH, AE, AR, BTS, CFS, DKB, EAR, JCM, JEY, JK, JLS, JS, JSB, KTR, LL, MAO, MHA, MJB, MKD, MSR, PGD, PMZ, RB, RO and SWA) found that 21 annual exams were timely completed.

MSH further assessed compliance using the DMH Dental Services Audit Form, based on a 23% sample of individuals with dental problems identified on admission or annual examination and on a 100% sample of individuals with problems identified during the hospital stay other than on admission or annual examination. The data for the review period (August 2008 – January 2009) are summarized in the tables below respectively:

1.d	*Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner*	94%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

1.e	*Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a*	91%

	timely manner	

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records of 45 individuals (AB, ABH, ACE, AE, AR, BA, BTS, BW, CFS, CP, CPP, DKB, EAR, FC, GSZ, HQN, IR, JCM, JCW, JEC, JEY, JK, JLA, JLS, JS, JSB, KDH, KS, KTR, LD, LL, MAO, MHA, MJB, MKD, MSR, PAL, PGD, PMZ, RB, RO, RTW, SHL, SWA and TM) found that 41 were timely seen for follow-up care.

Current recommendation:
Continue to monitor this requirement.

F.9.b.ii

documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:

Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Dental Services Audit Form, based on a 23% sample of individuals scheduled for follow-up dental care during the review months (August 2008 - January 2009), indicated the following:

2.a	*The current status*	94%
2.b	*Findings of the examination*	94%
2.c	*Plan of care*	94%
2.d	*The plans of care are consistent with examination findings*	94%

Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period.

<table>
<tr><td></td><td></td><td>A review of the records of 45 individuals (AB, ABH, ACE, AE, AR, BA, BTS, BW, CFS, CP, CPP, DKB, EAR, FC, GSZ, HQN, IR, JCM, JCW, JEC, JEY, JK, JLA, JLS, JS, JSB, KDH, KS, KTR, LD, LL, MAO, MHA, MJB, MKD, MSR, PAL, PGD, PMZ, RB, RO, RTW, SHL, SWA and TM) found that 42 were in compliance with the documentation requirements.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.b.iii</td><td>use of preventive and restorative care whenever possible; and</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals due for annual routine dental examinations during the review months (August 2008 - January 2009), indicated the following:

<table>
<tr><td>3.a</td><td>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</td><td>92%</td></tr>
<tr><td>3.b</td><td>Oral hygiene instruction</td><td>92%</td></tr>
</table>

Comparative data indicated maintenance of compliance at 90% or greater from the previous review period.

A review of the records of 25 individuals' annual dental exams (ABH, AE, AR, BTS, CFS, DKB, EAR, JCM, JEY, JK, JLS, JS, JSB, KTR, LL, MAO, MHA, MJB, MKD, MSR, PGD, PMZ, RB, RO and SWA) found that 23 were provided preventative care.

Data from the DMH Dental Services Audit Form, based on a 100% sample</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>of individuals scheduled for Level 1 restorative dental care during the review months (August 2008 - January 2009), indicated the following:
<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>93%</td></tr>
</table>
Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records of 45 individuals (AB, ABH, ACE, AE, AR, BA, BTS, BW, CFS, CP, CPP, DKB, EAR, FC, GSZ, HQN, IR, JCM, JCW, JEC, JEY, JK, JLA, JLS, JS, JSB, KDH, KS, KTR, LD, LL, MAO, MHA, MJB, MKD, MSR, PAL, PGD, PMZ, RB, RO, RTW, SHL, SWA and TM) found that 39 received restorative care.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals who had tooth extractions during the review months (August 2008 - January 2009), indicated the following:
<table>
<tr><td>4.a</td><td>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</td><td>100%</td></tr>
<tr><td>4.b</td><td>If none of the above reasons is included, other reason stated is clinically appropriate</td><td>N/A</td></tr>
</table></td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records of 16 individuals who had tooth extractions during the review period (AMA, BDM, DLH, EV, GCR, JAC, JBC, JSJ, KTG, LCL, LD, MAO, MDW, PD, RA and TC) found that all were in compliance.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.c</td><td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Dental Services Audit Form, based on a 23% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (August 2008 - January 2009), indicated the following:

<table>
<tr><td>5.a</td><td>Physical health impact on dental service</td><td>96%</td></tr>
<tr><td>5.b</td><td>Medications</td><td>100%</td></tr>
<tr><td>5.c</td><td>Allergies that impact on dental service</td><td>100%</td></tr>
<tr><td>5.d</td><td>General condition of current oral environment</td><td>97%</td></tr>
<tr><td>5.e</td><td>When individual compliant is noted within the findings, there is documentation related to exam results</td><td>96%</td></tr>
</table>

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of the records for 45 individuals (AB, ABH, ACE, AE, AR, BA,</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>BTS, BW, CFS, CP, CPP, DKB, EAR, FC, GSZ, HQN, IR, JCM, JCW, JEC, JEY, JK, JLA, JLS, JS, JSB, KDH, KS, KTR, LD, LL, MAO, MHA, MJB, MKD, MSR, PAL, PGD, PMZ, RB, RO, RTW, SHL, SWA and TM) found that 44 were in compliance with the documentation requirements.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>F.9.d</td>
<td>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Dental Services Audit Form, based on a 100% sample of individuals scheduled for a dental appointment during the review months (August 2008 - January 2009), indicated the following:

<table>
<tr><td>6.a</td><td>The individual attended the scheduled appointment</td><td>60%</td></tr>
</table>

Comparative data indicated an increase in compliance from the previous review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a</td><td>51%</td><td>60%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a</td><td>48%</td><td>65%</td></tr>
</table>
</td>
</tr>
</table>

		MSH's data analysis showed that nearly 40% of all dental appointments are missed and refusals are the major reason for missed appointments. MSH's data for this item indicated an increase in compliance. Barriers to compliance included behavior issues and individuals' fears and dislike of dentistry. The plan of correction includes continuing to work with WRPTs to educate and encourage individuals to attend dental appointments as well as accept recommended dental treatments. A review of the missed dental appointment logs for August 2008 - January 2009 verified that the majority of missed appointments were due to refusals; not transportation or staffing issues. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Provide data regarding this requirement. **Findings:** MSH provided data addressing this recommendation. **Recommendation 2, September 2008:** Formalize process addressing refusals. **Findings:** The Dental Department is now sending a list of individuals with at least two refusals along with their Dental Treatment Plans to the Units at the end of each month so the WRPTs can address this issue.

Recommendation 3, September 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Integration of Medical Conditions in WRP Audit Form, based on a 30% sample of individuals who refused to attend dental appointment twice in the review months (August 2008 - January 2009), indicated the following:

7.a	*Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP, and*	83%
7.b	*When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.*	64%

MSH reported that comparison data for the last review period was not available. The barrier to compliance included lack of communication between the Dental Team and the WRPTs. The plan of correction included the Dental Department sending a list of individuals with at least two refusals along with their Dental Treatment Plans to the Units at the end of each month so the WRPTs can address this issue.

A review of the records of 18 individuals who refused dental appointments (AH, AHB, AMW, BBM, BU, DLE, DVY, EBW, GFM, JIP, JJM, JKA, KDC, POS, RLS, SB, SJF and VSF) found that the WRPs of 14 individuals included documentation regarding refusal in the Present Status section and WRPs of 11 individuals included an open focus with interventions addressing refusals.

		Compliance: Partial. **Current recommendation**: Continue to monitor this requirement.

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. MSH has made significant progress in reducing the use of seclusion and restraint. 2. Although compliance has not yet been achieved, considerable progress has been made regarding the documentation of seclusion and restraint.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Aurora Hendricks, Nurse Administrator 2. Carmen Fayloga, HSS, Standards Compliance 3. Cindy Lusch, Clinical Administrator 4. Donna Gilland, Assistant to the Clinical Administrator 5. Ed Serrate, RN, NC 6. Gloria Figueroa, Unit Supervisor 7. Joe Beccerra, Assistant Program Director 8. John Nallira, Unit Supervisor 9. Juanita Coleman, PT 10. Karen Chong, Program II Director 11. Linda Gross, RN, NC 12. Loida Marquez, HSS 13. Michael Nunley, RN, Standards Compliance Director 14. Noemi Ann Valledor, RN, HSS 15. Reneé Kelly, Program VI 16. Rose B. Mizae, SRN Program I 17. Susan Chen, RN, HSS <u>Reviewed</u>: 1. MSH's progress report and data 2. AD 3306, Behavioral Seclusion or Restraint

		3. Special Order 119.06, Seclusion and Behavioral Restraint 4. Training roster for Nursing Annual Update, Day 1 and Day 2; Therapeutic Strategies and Interventions; PMAB Update 5. Medical Records for the following 28 individuals: AB, AMM, BLM, BMY, CB, CG, CH, CJ, DY, FJG, FR, JDF, KDS, LAB, LB, LS, MG, ML, PS, RR, RWL, SW, TLF, TME, TP, VLG, VTM and WH
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH continues to implement SO 119.06 and AD 3306 regarding the Use of Behavioral Seclusion and Restraints. A review of episodes of restraint and seclusion found no use of prone restraints, prone containment or prone transportation. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Present data for next review in alignment with the Court Monitor's requirements.

Findings:
Data from MSH are in alignment with the CM's requirements.

Recommendation 2, September 2008:
Continue to monitor this requirement.

Findings:
Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of initial restraint orders for August 2008 - January 2009, indicated the following:

1.	*Restraints and seclusion are used in a documented manner.*	79%
1a.	*The IDN described specific behavior that was imminently dangerous to self or others, and*	95%
1b.	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	82%
2.	*Restraints and seclusion are used only when the individual posed an imminent danger*	96%
2a.	*The justification for seclusion was to prevent harm to self or to others*	96%
2b.	*Did not include prevention of harm from others.*	100%
3.	*The IDN described:*	82%
3a.	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	82%
3b.	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	82%

Comparative data showed variability in compliance rates from the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	96%	79%
2.	98%	96%
3	84%	82%
Compliance rate in last month of period		
1.	79%	75%
1.a	84%	100%
1.b	90%	75%
3.	79%	75%
3.a	90%	75%
3.b	79%	75%

Barriers to compliance included that physicians' orders do not consistently identify specific behaviors warranting the use of restraint or specific release criteria. Also, nursing staff are not consistently documenting the less restrictive interventions that were tried prior to use of seclusion or restraints and the individual's responses to those interventions. To address these barriers, the Psychiatry Department follows up with physicians who have written incomplete orders. The Unit Shift Lead reviews the seclusion/restraint documentation to ensure that the requirements are met. Standards Compliance, in collaboration with Nursing, is developing a guideline/checklist for the Shift Leads to use when reviewing the documentation. MSH has developed a hierarchy of checks and reviews of practices and documentation for consistent follow-up.

A review of 20 episodes of restraint for 18 individuals (AB, AMM, BLM, BMY, CH, CJ, FJG, JDF, KDS, LAB, LS, MG, PS, SW, TLF, TME, VLG and

VTM) found that the documentation for 16 episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in 14 episodes. Orders documenting specific behaviors were not found in any of the episodes reviewed.

Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of initial seclusion orders for August 2008 - January 2009, indicated the following:

1.	*Restraints and seclusion are used in a documented manner.*	75%
1a.	*The IDN described specific behavior that was imminently dangerous to self or others, and*	100%
1b.	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	75%
2.	*Restraints and seclusion are used only when the individual posed an imminent danger*	100%
2a.	*The justification for seclusion was to prevent harm to self or to others*	100%
2b.	*Did not include prevention of harm from others.*	100%
3.	*The IDN described:*	83%
3a.	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	83%
3b.	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	83%

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	78%	75%
2.	89%	100%
3	33%	83%
Compliance rate in last month of period		
1.	67%	0%
1a.	100%	100%
1b.	67%	0%
3.	0%	50%
3a.	0%	50%
3b.	0%	50%

Barriers to compliance and plan of correction are the same as described above for restraint.

A review of five episodes of seclusion for three individuals (CB, LB and RWL) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in three episodes. Orders documenting specific behaviors were not found in any of the episodes reviewed.

Other findings:
A review of physicians' orders for seclusion and restraint found that the Physician Order for Behavioral Seclusion and Restraint form only lists "To prevent harm to self" and "To prevent harm to others" as justifications. This does not meet the criteria for describing specific behaviors that indicate imminent danger to self or others. In addition, MSH uses a number of forms for seclusion and restraint that actually make it more difficult to chronologically identify the sequence of events. In many cases, the time noted in the IDNs when the individual was placed

		in seclusion or restraints is often different than the time on the observation log, which is often different than the time on the Behavioral Seclusion and Restraint Documentation form. MSH has invested much energy in decreasing its use of restrictive procedures. The mean number of restraint events per month declined from 32 in the previous review period to 9.3 in the current review period. The mean number of seclusion events per month remained low, at 1.8 per month in the previous review period and two per month in the current review period. Discussions with unit staff indicated that they are committed to decreasing the use of restraint and seclusion. **Current recommendations**: 1. Develop a streamlined system for documentation of seclusion and restraint. 2. Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendation:** **Recommendation, September 2008:** See H.2.a. **Findings:** Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of initial restraint orders for August 2008 - January 2009, indicated the following: 4. *Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.* 93% 4.a *There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion* 93% 4.b *There is a linked objective.* 93%

4.c	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion.*	93%
5.	*The individual has been in restraints and the staff did not:*	79%
5.a	*Use restraints or seclusion in an abusive manner.*	100%
5.b	*Keep the individual in restraints or seclusion even when the individual was calm.*	84%
5.c	*Use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	95%
5.d	*Use restraints or seclusion as coercion.*	100%
6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	70%

Comparative data indicated a decline in mean compliance for these items from the previous review period:

	Previous period	Current period
Mean compliance rate		
4.	98%	93%
5.	96%	79%
6.	95%	70%
Compliance rate in last month of period		
5.	84%	100%
5.a	100%	100%

5.b	84%	100%
5.c	100%	100%
5.d	100%	100%
6.	72%	75%

Barriers to compliance included that physicians' orders do not consistently identify specific behaviors warranting the use of restrictive interventions or specific release criteria. Also, Nursing does not consistently document when the individuals is released. In addition, information about the individual's preferences as documented in the Seclusion and Restraint Preference and Family Notification Form is not proactively utilized to prevent an episode. See H.2.a for plan of correction.

A review of 20 episodes of restraint for 18 individuals (AB, AMM, BLM, BMY, CH, CJ, FJG, JDF, KDS, LAB, LS, MG, PS, SW, TLF, TME, VLG and VTM) found that the WRPs of 16 individuals contained documentation addressing behaviors, objectives and interventions and documentation in 13 incidents indicated that the individual was released when calm.

Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of initial seclusion orders for August 2008 - January 2009, indicated the following:

4.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	83%
4.a	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in Seclusion*	83%
4.b	*There is a linked objective.*	83%
4.c	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to*	83%

	be placed in seclusion.	
5.	*The individual has been in restraints and the staff did not:*	83%
5.a	*Use restraints or seclusion in an abusive manner.*	100%
5.b	*Keep the individual in restraints or seclusion even when the individual was calm.*	83%
5.c	*Use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	100%
5.d	*Use restraints or seclusion as coercion.*	100%
6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	58%

Comparative data indicated a decline in compliance rates from the previous review period:

	Previous period	Current period
Mean compliance rate		
4.	89%	83%
5.	100%	83%
6.	100%	58%
Compliance rate in last month of period		
4.	67%	50%
4.a	67%	50%
4.b	67%	50%
4.c	67%	50%
5.	100%	100%

5.a	100%	100%
5.b	100%	100%
5.c	100%	100%
5.d	100%	100%
6.	100%	0%

Barriers to compliance included a misinterpretation of the instructions by two auditors. In addition, a number of physicians' orders do not contain criteria for release. Also, the information from the Seclusion and Restraint Preference and Family Notification Form regarding the individual's preferences are not utilized by staff. Standards Compliance has re-instructed the two auditors and will be monitoring their audits. Also see H.2.a.

Review of five episodes of seclusion for three individuals (CB, LB and RWL) found that the WPRs of two individuals contained documentation addressing behaviors, objectives and interventions, and documentation in two incidents indicated that the individual was released when calm.

Current recommendation:
Continue to monitor this requirement.

H.2.c

are not used as part of a behavioral intervention; and

Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
Data from the DMH Psychology Services Monitoring audit, based on a 100% sample of new Behavior Guidelines and Positive Support Plans during the review period (August 2008 - January 2009), indicated the following:

8.	*Behavioral interventions, which include Positive*	100%

		Behavior Support Plans, are based on a positive behavior support model, and do not include the use of aversive or punishment contingencies.

Comparative data indicated maintenance of compliance greater than 90% from the previous review period.

A review of PBS plans for 10 individuals (AB, BMY, CG, CH, DY, FR, LS, ML, TP and WH) found that all were in compliance with this requirement.

Current recommendation:
Continue current practice.

H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, September 2008:** See H.2.a. **Findings:** Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of all episodes of restraint for August 2008 - January 2009, indicated the following: 7. *Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.* 70% 7.a *The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.* 72% 7.b *The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.* 80%

7.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	83%
7.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	87%
7.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	87%
7.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	89%
7.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	91%

Comparative data indicated a decrease in mean compliance for this item from the previous review period:

	Previous period	Current period
Mean compliance rate		
7.	82%	70%
Compliance rate in last month of period		
7.	58%	100%
7.a	63%	100%
7.b	68%	100%
7.c	90%	100%
7.d	84%	100%
7.e	74%	100%
7.f	84%	100%

7.g	84%	100%

See H.2.a for barriers and plan of correction and H.2.b for reviewer's findings.

Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of all episodes of seclusion or August 2008 - January 2009, indicated the following:

7.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	67%
7.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	67%
7.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	75%
7.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	92%
7.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	92%
7.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	92%
7.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	92%
7.g	*The individual did not continue to be in restraints*	92%

	or seclusion because he/she was unable to say he/she is sorry for his/her actions.	

Comparative data indicated a significant decrease in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
7.	100%	67%
Compliance rate in last month of period		
7.	100%	0%
7.a	100%	0%
7.b	100%	50%
7.c	100%	50%
7.d	100%	50%
7.e	100%	50%
7.f	100%	50%
7.g	100%	50%

See H.2.a for barriers and plan of correction and H.2.b for reviewer's findings.

Current recommendation:
Continue to monitor this requirement.

H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is	**Current findings on previous recommendation:** **Recommendation, September 2008:** See H.2.a.

continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.

Findings:
Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of all episodes of restraint for August 2008 - January 2009, indicated the following:

8.	*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.*	66%
8.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	91%
8.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	73%
8.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	89%

Comparative data indicated significant decreases in compliance for some items from the previous review period:

	Previous period	Current period
Mean compliance rate		
8.	90%	66%
Compliance rate in last month of period		
8.	79%	50%
8.a	95%	100%
8.b	84%	50%
8.c	100%	100%

Barriers to compliance include that physicians do not consistently see individuals within one hour of the initiation of seclusion or restraint. In some cases, an RN writes the initial note describing the behavior that leads to the use of the restrictive intervention but there is no follow-up assessment by the RN within the initial 15 minutes. MSH's Medical Director has implemented a system whereby he is notified whenever an individual has not been evaluated by a Physician within 40 minutes of the initiation of seclusion or restraint. In addition, the HSSs are to ensure compliance with the RN Assessment requirements.

A review of 20 episodes of restraint for 18 individuals (AB, AMM, BLM, BMY, CH, CJ, FJG, JDF, KDS, LAB, LS, MG, PS, SW, TLF, TME, VLG and VTM) found that the RN conducted a timely assessment in 15 episodes; the individual was seen timely by the psychiatrist in 14 episodes.

Data from the DMH Seclusion/Restraint Audit, based on a 100% sample of all episodes of seclusion for August 2008 - January 2009, indicated the following:

8.	*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.*	42%
8.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	92%
8.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	50%
8.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	83%

Comparative data indicated significant decreases in compliance for most items from the previous review period:

	Previous period	Current period
Mean compliance rate		
8.	89%	42%
Compliance rate in last month of period		
8.	67%	0%
8.a	100%	100%
8.b	67%	0%
8.c	100%	50%

Barriers to compliance and plan of correction are the same as those noted for restraint above.

A review of five episodes of seclusion for three individuals (CB, LB and RWL) found that the RN conducted a timely assessment in two episodes and that the individual was seen timely by the psychiatrist in three episodes.

A review of training rosters verified compliance regarding competency-based training on seclusion and restraint.

Annual PMAB Training Competency Report							
	Aug	Sept	Oct	Nov	Dec	Jan	Mean
N	38	44	47	32	48	41	42
N	38	44	47	32	48	41	42
%C	100	100	100	100	100	100	100

N = total number of nursing staff who attended PMAB training
n = total number of nursing staff who completed and passed the training

		Compliance: Partial. **Current recommendation**: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendations 1-3, September 2008:** • Provide supporting data to verify compliance. • Provide data addressing accuracy of seclusion/restraint and PRN/Stat data. • Continue to monitor this requirement. **Findings:** Standards Compliance checks the Seclusion/Restraints database once a month and coordinates with Programs and the IT Department to reconcile identified discrepancies. The HSS Daily 24-Hour Report on Seclusion/Restraints and PRN/Stat Use is also utilized to reconcile Seclusion/Restraints data. In addition, the Plato Data Analyzer for data entry and reporting is also utilized to establish data accuracy. The accuracy of Seclusion/Restraint use entered in the Seclusion/Restraint database for this review period was 94%. In addition, Standards Compliance checks the PRN/Stat database to ensure that PRN/Stat medication is consistently and accurately entered in the database. The accuracy of PRN/Stat medication entered in the PRN/Stat database for this review period was 91%. A review of 25 seclusion/restraints episodes and 100 PRN/Stat medications from the medical records found that all were included in the appropriate database.

		Compliance: Substantial. **Current recommendation**: Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation, September 2008:** See H.2.a. **Findings:** Data from the DMH Restraint Audit, based on a 100% sample of individuals who have been in restraint more than three times in 30 days during the review period (August 2008 - January 2009), indicated the following:

9.	*Required to 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*	100%
9a.	*The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion or Restraints within the last 30 days*	100%
9b.	*The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done*	100%
9c.	*If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was*	100%

	documented in the Present Status in the Case Formulation Section of the WRP	

Comparative data indicated a significant increase in compliance from the previous review period:

	Previous period	Current period
Mean compliance rate		
9.	30%	100%

A review of the records of four individuals (BMY, LB, LS, RR and SW) who met the trigger criteria for restraint/seclusion during the review period found that all were in compliance with the documentation requirements.

Data from the DMH Seclusion Audit, based on a 100% sample of the number of individuals who have been in seclusion more than three times in 30 days for August 2008 - January 2009.

9.	*Required to 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*	100%
9a.	*The review was held within 3 business days for any individual who had 4 or more episodes of Seclusion or Restraints within the last 30 days*	100%
9b.	*The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done*	100%
9c.	*If the team decided to revise the WRP, a*	100%

		statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP There were no individuals who meet the trigger criteria for seclusion during the previous review; therefore comparative data is not available. A review of the record of one individual (RL) who met the trigger criteria for restraint/seclusion during the review period found compliance with the documentation requirements. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendations:** **Recommendations 1 and 2, September 2008:** • Same as F.1.b. • Continue to monitor this requirement. **Findings:** See F.1.b.

		Current recommendations: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendations**: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See F.1.b. **Current recommendations**: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to monitor this requirement.

<table>
<tr><td></td><td></td><td>Findings:
See F.3.a.iii for MSH's data and reviewer's findings.

Current recommendation:
See F.3.a.iii.</td></tr>
<tr><td>H.6.e</td><td>A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Same as in D.1.f, F.1.b and H.6.a.

Findings:
Same as in D.1.f, F.1.b and H.6.a

Current recommendations:
Same as in D.1.f, F.1.b and H.6.a.</td></tr>
<tr><td>H.7</td><td>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.</td><td>Current findings on previous recommendation:

Recommendation, September 2008:
Continue current practice.

Findings:
MSH reported the following data regarding competency-based training:

<u>Nursing Orientation Competency Report</u>

<table>
<tr><td></td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Mean</td></tr>
<tr><td>N</td><td>3</td><td>5</td><td>6</td><td>2</td><td>5</td><td>2</td><td>4</td></tr>
<tr><td>N</td><td>3</td><td>5</td><td>6</td><td>2</td><td>5</td><td>2</td><td>4</td></tr>
<tr><td>%C</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>
N = total number of new nursing staff</td></tr>
</table>

n = number of new nursing staff who completed and passed competency-based Nursing Orientation class (pertains to table at bottom of previous page)

Nursing Annual Update Competency Report – Day 1

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	36	51	47	48	34	63	47
n	36	51	47	48	34	63	47
%C	100	100	100	100	100	100	100

N = total number of nursing staff who attended Nursing Annual Update – Day 1
n = total number of nursing staff who completed and passed the competency-based training

Nursing Annual Update Competency Report – Day 2

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
N	43	48	51	45	41	56	47
n	43	48	51	45	41	56	47
%C	100	100	100	100	100	100	100

N = total number of nursing staff who attended Nursing Annual Update – Day 2
n = total number of nursing staff who completed and passed the competency-based training

The Nursing Annual Update classes integrates competency-based curriculum for PRN and Stat medications and is an annual mandatory class for all nursing staff.

See F.3.h.i, F.3.i and H.3 for MSH data and reviewer's findings.

Review of MSH's training rosters verified that competency-based training addressing this requirement was being provided.

		Compliance: Substantial. **Current recommendations**: 1. See F.3.i. 2. Continue to monitor this requirement.
H.8	Each State hospital shall:	**Compliance:** Substantial.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** MSH has implemented a number of strategies that have eliminated the use of side rails as a restraint. MSH no longer uses full side rails and any side rails that are currently being used are the half side rails. In addition, low beds are used on the SNF Units (418 and 419). **Current recommendation**: Continue current practice.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** See H.8.a.

		Current recommendation: See H.8.a.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. Many of the investigations reviewed met current practice standards with the exception of timeliness. 2. The problem with long delays in autopsies appears to have been dealt with effectively. 3. All deaths within the review period were reviewed by the MIRC as required by Special Order 205.05. The MIRC is tracking completion of recommendations. 4. MSH produced data on incident type, location and time of day. 5. The facility has begun implementation of the Risk Management Special Order. Specifically, all committees are functioning, the infrastructure is in place to track individuals who require review beyond the program level, and the ASH database is used to track individual's triggers and the corresponding response by the reviewing committee. It has provided teams with graphed trigger data on specific individuals to inform their treatment planning. 6. The facility has established criteria for identifying high-risk individuals for certain medical and behavioral triggers. It has produced several of these lists including ones for repeat aggressors and repeat victims. This information has been shared with the program for review by the Program Review Committee. 7. The facility has been tracking whether WRPTs have responded back with a proposed action to certain triggers. It has also done limited monitoring of the implementation of the proposed action. 8. The facility has successfully directed appropriate attention to the problem of incontinence in the WRPs of the relevant individuals. 9. The opening of the OT/PT module within the compound will allow individuals to participate in therapy without restrictions in their movements. 10. The common areas of the units visited were, for the most part, clean and odor-free. 11. The facility has continued to produce small studies on high-risk

		situations. Repeat aggressors, suicide threats and attempts have been the focus of several of these.
1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Fayloga, Acting Risk Manager 2. C. Loop, Supervising Special Investigator 3. C. Lusch, Clinical Administrator 4. C. Rivera, Standards Compliance 5. G. Hahn, Hospital Administrator 6. H. Mears, Chief of Hospital Police 7. L. Dieckmann, Standards Compliance Lead Psychologist 8. M. Nunley, Director, Standards Compliance 9. Z. Boshra, MD, Chief of Medical Services Reviewed: 1. 13 investigations completed by the Office of Special Investigations 2. 13 Headquarters Reportable Briefs 3. Incident Review Committee minutes (August 2008—January 2009) 4. Nine clinical records for signed Notification of Rights 5. Investigation Compliance Monitoring Data 6. Portions of the personnel and training records of 19 staff members 7. Aggregate incident and investigation data 8. AD 0205: Incident Review Committee 9. All materials related to the deaths of seven individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and	**Compliance:** Partial.

	practices shall require:	
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Develop a reliable system whereby an appropriate treatment response follows a serious incident. **Findings:** See findings in I.2.a.ii and throughout the Performance Improvement section of the report. **Other findings:** See also I.1.a.v for evidence of failure to take action when staff members failed to report A/N/E allegations in a timely manner. **Current recommendation**: Write guidelines for progressive discipline for failure to report staff misconduct.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Clarify with the other facilities the correct role designation for the individual in incidents involving suicide attempts and advise staff and reviewers accordingly. **Findings:** The facility reports that all facilities have agreed that the individual will be coded as aggressor in incidents concerning suicide attempts. Review of the Client Incidents by Type list finds that suicide attempts were correctly coded. Individuals who made suicide threats, however,

were sometimes coded "aggressor" and sometimes "involved."

Recommendation 2, September 2008:
Check SIRs, investigations and logs to ensure that sexual incidents are correctly coded.

Findings:
The facility reports that a Standards Compliance staff member checks all SIRs for coding correctness and changes the database to correct any errors.

Review of the Client Incidents by Type list (created from the SIR database) reveals that in some instances (not those cited below), entries appear to be coding errors because a series of events was considered a single incident, e.g. peer-to-peer aggression resulting in use of a restraint technique that results in an allegation of abuse. A single individual will be assigned several different roles in these cases.

Examples of coding errors not assignable to this issue include:

Incident number	Type	Problem
215835	Physical aggression to another individual	No individual listed as victim
215829	Verbal aggression to another individual	No individual listed as victim or aggressor
216264	Sexual contact between adults	Only one individual listed
316996	Alleged verbal abuse	Individual listed as aggressor
516869	Alleged psychological abuse	Individual is listed as aggressor

		Recommendation 3, September 2008: Ensure all facilities are using the same business rules for counting individuals who have made allegations of abuse, neglect or exploitation for Performance Indicator data. **Findings:** The facility reports that this is no longer a problem. The business rules have been clarified. **Other findings:** Some confusion remains around the use of the term "sexual abuse." This term should be used only when describing the actions of someone other than another individual. The 12/10/08 IRC minutes repeatedly refer to an allegation of unwanted sexual contact between two individuals as sexual abuse. **Current recommendations**: 1. Resolve the coding issue for individuals who make suicide threats. 2. Determine how the grouping of events on a single SIR is affecting the assignment of roles, particularly the identification of victims. Ensure that all allegations of abuse, neglect, and exploitation result in an SIR that identifies the alleged victim and perpetrator. 3. Use the SIR definitions in identifying incident types.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The facility reports that it removes a staff member when he/she has been named in an allegation of abuse/neglect until the investigation is complete. If there is no credible basis to the allegation, the OSI

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<td>Supervisor may make an exception to this practice.

Other findings:
The relevant investigations reviewed contained documentation that the named staff member in allegations of A/N was removed until completion of the investigation. For example, in the investigation of the 5/24/08 allegation of physical abuse, the named staff member was reassigned to Central Program Services. Similarly, the named staff member in the 2/25/08 allegation of sexual abuse had been removed and reassigned to non-individual contact duties as had three staff members named in the 8/19/08 allegation of physical abuse.

Current recommendation:
Continue current practice.</td>
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<tr>
<td>I.1.a.iv</td>
<td>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;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that training requirements are adhered to for all staffing positions.

Findings:
The training records of 19 staff members indicated that five had not received annual training in recognizing and preventing abuse and neglect. The remaining 14 staff members had received A/N annual training within the last 12 months.
<table>
<tr><td></td><td colspan="4">Date of:</td></tr>
<tr><td>Staff member*</td><td>Hire</td><td>Background clearance</td><td>Signing of Mandatory Reporter</td><td>Most recent A/N training</td></tr>
<tr><td>_A</td><td>6/4/1999</td><td>4/29/08</td><td>6/4/1999</td><td>Not yet taken</td></tr>
</table></td>
</tr>
</table>

_A	8/8/1997	Not found	8/8/1997	8/18/08
_C	4/21/08	3/7/08	4/21/08	6/30/08
_D	7/2/04	5/20/04	7/2/04	10/17/08
_E	4/28/06	3/21/06	4/21/06	Not yet taken
_E	10/3/08	8/25/08	10/3/08	10/15/08
_G	6/25/07	6/11/07	6/25/07	9/17/08
_G	7/21/1997	Not found	7/21/1997	10/16/08
_H	11/3/06	5/30/06	11/2/06	Left employ 7/29/08
_H	2/19/1991	Not found	2/19/91 6/27/07	9/15/08
_K	2/11/1991	Not found	2/11/91 2/8/07	5/14/08
_K	2/8/1979	Not found	9/15/86 9/5/06	8/21/08
_M	7/3/03	4/11/03	7/3/03	6/30/08
_M	8/14/08	7/15/98	8/14/08	1/14/09
_O	10/16/1998	8/19/98	10/16/98	1/14/04
_P	7/15/1991	7/8/91	7/15/91 3/9/07	10/15/08
_S	5/12/97	3/9/97	5/12/97	Not yet taken
_V	12/3/99	11/2/99	12/3/99	Not yet taken
_W	5/1/1990	Not found	5/1/90	Not yet taken

*Only last initials are provided to protect confidentiality.

Current recommendations:

1. Ensure that the five individuals cited above receive annual A/N training.

		2. Take the necessary measures to identify all other employees who have not attended annual A/N training and ensure their participation.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The personnel records of all 19 staff members reviewed indicated that each had signed the mandatory reporting acknowledgement form. The facility reports that during the review period, all newly hired employees signed the mandatory reporting acknowledgement form. **Other findings:** In the investigations reviewed, six staff members were found to have failed to report an allegation of abuse/neglect in a timely manner. Disciplinary action is pending for one staff member who, in addition to failure to report in a timely manner, was found to have violated the policy regarding individual/staff relationship. No disciplinary action was taken or is pending for the other five staff members. **Current recommendation**: Develop a policy addressing the consequences for failure to report an allegation of A/N as required by the facility's reporting policy. Take appropriate action in all cases.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

Findings:
A notification of rights form was signed within the last 12 months by all nine individuals sampled as indicated in the table below:

Individual	Date of most recent signing
CB	6/10/08
JC	8/24/08
JM	5/30/08
MB	7/27/08
NO	3/4/09
RR	3/5/09
SA	7/28/08
SB	8/26/08
TR	2/28/09

The facility reports that 95% of the sampled individuals admitted in the August 2008—January 2009 period had signed the Rights Notification and 58% of a sample of longer-term individuals had signed within the last year. This latter finding represents a substantial improvement over the previous review period, in which the facility's review found that 22% of individuals sampled had signed within the last year.

The facility has identified the need to improve communication between the auditing team and the programs, so that Program Directors can take action when compliance is low.

Current recommendation:
Continue improving compliance with the facility's expectation that each individual's WRPT will discuss rights annually (at the time of the annual review) and ask the individual to sign the notification form.

I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Each unit visited had a posting detailing rights and how to reach the Patient Rights Advocate. All units asked to produce forms for making a complaint to the advocate had an ample stock of blank forms. **Current recommendation**: Continue current practice.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Follow up with units when incident reports are not received within the time limits set by policy to remind them of the importance of timely reporting and completion of the incident report and the negative impact that late reporting has on the investigation. **Findings:** MSH reports that the Office of Special Investigations notifies a program when there has been a delay in reporting an allegation and documents this in the investigation report. This is consistent with review of 13 investigation reports, all of which clearly identified the date of the incident, the date received by OSI, and the date assigned to an investigator. See the table in I.1.b.iv.1. **Other findings:** In the investigation of the allegation of sexual contact between adults, the alleged aggressor was not interviewed because he was in jail on another matter. While none of the 13 investigations reviewed required

		referral of an individual to law enforcement outside the facility, this incident provides some evidence that the hospital police and OSI discharge their responsibility to refer individuals, as appropriate, to law enforcement agencies. The Incident Review Committee minutes also document instances in which cases of assault were referred to the Office of the District Attorney. **Current recommendation**: Continue current practice.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The annual update and new employee orientation training on Incident Management contains language addressing the protection against retaliation for reporting allegations of abuse or neglect. **Other findings:** There were no instances of in the investigations reviewed of persons who were threatened with retaliation for reporting staff misconduct. **Current recommendation**: Continue current practice.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of	**Compliance:** Partial.

<table>
<tr><td></td><td>care. Such policies and procedures shall:</td><td></td></tr>
<tr><td>I.1.b.i</td><td>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;</td><td>Current findings on previous recommendations:

Recommendation 1, September 2008:
Diagnose and then fix the system for completing Headquarters Reportable Briefs.

Findings:
This recommendation has not yet been implemented. Review of 13 Headquarters Reportable Briefs for the month of November revealed that none had been completed. The Standards Compliance Director attributed the tardiness, in large measure, to inadequate staffing.

Recommendation 2, September 2008:
Use the Incident Review Committee as a forum for identifying and discussing elements in the Headquarters Reportable Briefs.

Findings:
Factors contributing to the incident were not delineated in any of the 13 Headquarters Reportable Briefs reviewed.

Recommendation 3, September 2008:
Take appropriate action to get the autopsies for individuals who died many months ago. Implement procedures for ensuring Mortality Interdisciplinary Review Committee members receive copies of autopsies in a timely manner, as referenced in the Executive Risk Management Committee minutes of July 31.

Findings:

<table>
<tr><td>Individual</td><td>Date of death</td><td>Autopsy date or date received</td></tr>
<tr><td>KR</td><td>7/28/08</td><td>Autopsy noted as received by MSH.</td></tr>
</table></td></tr>
</table>

		No date or copy provided.
TR	8/16/08	8/22/08
BB	8/22/08	Question of autopsy not addressed; Coroner's Cause of Death provided.
RM	8/27/08	8/29/08
RM	10/3/08	10/5/08—results pending toxicology
DL	10/14/08	10/16/08
MS	11/27/08	12/01/08

Recommendation 4, September 2008:
Ensure that the letter referenced in those same minutes [referenced in Recommendation 3 above] is written and made available to all external facilities informing them that all deaths of MSH individuals are coroner's cases.

Findings:
The facility reported that the Medical Examiner is aware of MSH's need for autopsies and will determine on a case-by-case basis whether an autopsy is necessary.

Recommendation 5, September 2008:
Implement to the degree possible the procedures for the review of deaths described in SO 205.04: Mortality Review.

Findings:
The facility has implemented some procedures described in the Special Order governing Mortality Reviews. Review of the materials provided documenting the review of seven deaths (cited in the table above) found the following:

- All Medical Death Summaries did not address all of the issues as required by the Special Order. See particularly the medical summary for RM (date of death: 10/3/08).

		• No Medical Death Summaries made recommendations to improve the provision of care. • Although some Nursing Death Summaries identified gaps in the performance of specific staff members, corrective actions directed at the named staff were not identified. • An external review of the death was not provided in all instances where the death was unexpected. The deaths of DL, MS, RM-1, RM-2 and TR were unexpected and no external review was provided. • All deaths were reviewed by the Mortality Interdisciplinary Review Committee. **Other findings:** The MIRC minutes describe a multi-dimensional review of the death under consideration. A number of system issues were identified, sometimes in multiple cases. A tracking log identified the problem, recommended solution, staff member responsible, and date of completion. The systemic issues that repeatedly surfaced included the need to be more aggressive in requesting individuals to provide advance directives, the need for a liaison team to communicate with outside treating hospitals about the condition and discharge plans for MSH individuals under their care, and the need for suicide awareness and prevention training, revision of suicide assessment forms and ensuring their accessibility to all clinicians. In response, suicide prevention training was provided in January 2009, and psychologists received specialized training. Suicide assessments are now kept in the clinical record. The facility adopted AD 3355: Advance Health Care Directive in January 2009 that requires the facility to provide individuals with information about AHCDs at admission, annually and upon request. The facility established a Liaison Team composed of a physician and a nurse who communicate with the treating hospital when MSH individuals are in their care. The MIRC tracking form followed to completion other recommendations including, but not limited to, 1) shortening cords attached to hospital beds

		to reduce the likelihood that they could be used by an individual to hurt himself/herself, 2) the use of low-dose aspirin discussed with MSH physicians and 3) Medical Risk Management prioritizing osteoporosis as a high-risk condition. The facility continues to track other recommendations that have not yet been implemented/completed. The facility did not agree with a central finding of the external review of the suicide death of KR. This finding provided the basis for a number of recommendations that the facility has chosen not to accept. **Current recommendations**: 1. Continue tracking to completion all recommendations made by the MIRC. 2. Review critically the nursing death summaries and medical death summaries to ensure they meet the intent of the Special Order. 3. Reconsider the recommendations made in the external review of the death of KR. 4. Secure an external review for all unexpected deaths.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** All hospital police have completed investigation training. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:**

		Recommendation, September 2008: Continue current practice. **Findings:** In the investigations reviewed, there was no indication that evidence was not properly safeguarded. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** Nearly all of the 13 investigation reports reviewed reflected an investigation that met professional standards. The few exceptions are described in the appropriate cells in this section of the report. These include not interviewing all relevant parties and failure to address all parts of an allegation. **Current recommendation**: Ensure all investigations are complete prior to closing and approval.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice wherein the Office of Special Investigations scans the CNS daily report looking for incidents that would require an investigation by that office.

Findings:
This practice continues, according to the Chief of Police and the Senior Special Investigator.

Other findings:
The hospital police responded quickly to the scene in the investigations reviewed and began the investigation. Delays occurred for other reasons: In seven of the investigations reviewed, the OSI did not receive notice in a timely manner, and in eight investigations the first OSI interviews did not occur promptly.

Incident type	Incident date or reported	Assigned in OSI	First interview	Date closed
Inappropriate relationship between indiv. and staff	2/13/08	2/15/08	6/5/08	8/14/08
Allegation of sexual abuse	2/25/08	2/29/08	7/1/08	9/11/08
Allegation of psychological abuse	2/29/08	5/29/08	5/29/08	8/12/08
Allegation of physical abuse	5/13/08	6/10/08	6/16/08	10/15/08
Allegation of individual exploitation	5/13/08	7/28/08	8/11/08	1/27/09
Allegation of physical abuse	5/24/08	6/10/08	8/1/08	8/18/08
Allegation of sexual assault	6/17/08	6/23/08	7/9/08	10/20/08
Allegation of physical abuse	7/6/08	7/14/08 reassigned 10/1/08	9/24/08	11/17/08

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<tr><td></td><td></td><td>
<table>
<tr><td>Sexual contact between adults</td><td>7/8/08</td><td>9/24/08</td><td>No OSI interview. Aggressor was in jail on another matter.</td><td>1/21/09</td></tr>
<tr><td>Allegation of physical abuse</td><td>8/1/08</td><td>8/25/08</td><td>8/27/08</td><td>9/24/08</td></tr>
<tr><td>Allegation of physical abuse and neglect</td><td>8/19/08</td><td>8/29/08</td><td>9/29/08</td><td>10/30/08</td></tr>
<tr><td>Battery with serious injury</td><td>10/6/08</td><td>11/24/08</td><td>12/10/08</td><td>2/27/09</td></tr>
<tr><td>Allegation of physical abuse</td><td>12/30/08</td><td>1/7/09</td><td>1/14/09</td><td>1/20/09</td></tr>
</table>

Current recommendations:
1. Take measures to ensure that OSI is promptly notified of incidents that require its investigation.
2. Promptly begin OSI interviews so as not to jeopardize the investigation.
</td></tr>
<tr><td>I.1.b.iv.2</td><td>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;</td><td>
Current findings on previous recommendation:

Recommendation, September 2008:
The Supervising Special Investigator should monitor investigations as they are progressing to offer assistance and guidance as necessary and to ensure they are completed in a timely manner.

Findings:
The table in the cell above indicates that two of the 13 sample investigations were completed within 30 working days. The remaining investigations were closed between three and eight months after the incident was reported. One-half of the sample investigations were
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		completed five or more months after the incident was reported. This is consistent with the facility's monitoring, which found that 38% of the investigations completed during the review period met the 30-business-day time frame. **Other findings:** The IRC minutes reviewed (August 2008—January 2009) include no documentation of members questioning the tardiness of the cases reaching them. **Current recommendations**: 1. Identify the factors that are causing the timeliness problem and take measures to correct them. 2. IRC should be noting in the minutes its review of any aspect of the investigation that does not meet EP requirements.
I.1.b.iv.3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The investigators at MSH sometimes make recommendations for corrective actions. For example, in the investigation of the allegation of exploitation of individuals in which a staff member was found to have been selling bags of coffee to individuals at an extremely high price, the investigation report recommended that Program V pay closer attention to policies and procedures related to "allowables" and that the facility contraband policy and the Program V allowable list be reconciled. **Other findings:** Notwithstanding the above example, the identification of corrective actions is generally left to the Incident Review Committee. Review of the

		Investigation Compliance Monitoring forms for the 13 investigation reports reviewed supports this finding. Three Investigation Compliance Monitoring Forms ,in answer to question 25 [*If disciplinary or programmatic action was necessary to correct a situation or recurrence, was such action implemented promptly and thoroughly tracked and documented, with corresponding outcomes?*], cited the IRC as the answer. Seven of the 13 monitoring forms indicated NA in answer to the question, "Did the investigation provide recommendations for corrective actions?" This question was left blank on one form. No forms answered "No." The IRC minutes note discussion of specific incidents and of system issues. Most often, the action step related to specific incidents is for HR to notify the program that the named staff member can return to his/her duties. Other recommendations are hidden in the discussion section of the minutes, but the minutes do not track the completion of the recommendations discussed. For example, the 10/22/08 minutes state that two staff members must complete PMAB (now TSI—Therapeutic Strategies and Interventions) training before returning to work after an incident. Review of the training records of both staff members found that one had completed the training on 11/24 and 12/3, but the other had not taken the training as recommended. The Committee discussed the need for tracking its recommendations on several occasions. The October minutes cite the need for a tracking log to identify the recommendation, the staff member responsible, and the date for reporting back on implementation. This log was never initiated. In the 12/10/08 minutes, the issue surfaced again with the question being raised of how programs are notified of IRC recommendations and how the Committee receives feedback. Direct communication by the IRC to the program was identified as the resolution. AD 0205: Incident Review Committee (effective 7/31/08) places the responsibility for monitoring implementation of corrective actions with the Standards Compliance Department. In order for the Department to

		comply, recommendations and follow-up dates must be clearly documented. **Current recommendations**: 1. Develop and use a tracking form to document recommendations, the staff member responsible and the date for feedback to the Committee and the resolution. 2. Standards Compliance will monitor implementation of recommendations on at least a sample basis and report its findings to the IRC.
I.1.b.iv.3 (i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Investigate all aspects of a compound allegation. **Findings:** Compound allegations were made in two of the investigations reviewed. One investigation addressed all aspects of the allegation and the other did not. In the investigation of the allegation of sexual assault made by SS on 2/25/09, allegation #1 concerned groping and the threat of retaliation should SS not comply. Allegation #2 concerned pornographic images that the named staff member showed SS on his phone. Allegation #3 concerned a second staff member's misconduct in showing sexually explicit pictures and using sexually tainted language. Allegation #4 was an allegation of rape by unnamed persons. Allegations #1 and 2 were unfounded based on SS's earlier admission that she was going to fabricate an incident to have the named staff member removed from the unit. Allegations #3 was also unfounded due to lack of evidence, and allegation #4 was unfounded as SS refused a sexual assault exam and would not or could not identify the assailant. In contrast, the allegation of physical abuse made by JM on 7/6/08 stated he was threatened with an IM injection, slammed down on the exam table in the medication room and medicated against his will. The Findings

		and Conclusion section of the investigation report did not address the question of the use of excessive force. **Recommendation 2, September 2008:** Ensure that investigators recognize abuse/neglect/exploitation and investigate it as such. Ensure that corrective actions reflect the seriousness of the substantiated charge. **Findings:** In the investigation of the allegation made in the form of a petition signed by 24 individuals (5/7/08) charging that the named staff member yells, is condescending and unprofessional, and threatens to make negative entries into individuals' records, the investigation substantiated that the named staff member "has not respected the rights and dignity of patients [and has] not provided a safe, therapeutic environment." No disciplinary action was taken and none is reported as pending, according to documentation provided by Human Resources. **Current recommendation**: Ensure that appropriate disciplinary action is taken in the case cited above and in all instances in which a staff member has been found to have engaged in misconduct.
I.1.b.iv.3 (ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The names of all witnesses were identified on the investigation report face sheets reviewed.

		Current recommendation: Continue current practice.
I.1.b.iv.3 (iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** All investigations reviewed identified the alleged victim and alleged perpetrator. **Current recommendation**: Continue current practice.
I.1.b.iv.3 (iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** All of the investigations reviewed identified the names of all persons interviewed. **Current recommendation**: Continue current practice.
I.1.b.iv.3 (v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice.

		Findings: In the investigation of the alleged inappropriate contact between PD and the named staff member, a summary of the interview with JS (one of three individuals interviewed) was not included in the investigation report. In the investigation of the allegation of sexual contact between adults (7/8/08) the victim was not interviewed during the OSI investigation. [Hospital police interviewed him on 7/9/08.] The investigation was terminated because the aggressor was in jail on an unrelated matter. The other investigation reports reviewed contained summaries of the interviews conducted. **Current recommendation**: Ensure that all victims are offered the opportunity to speak with an investigator during an investigation and that all interviews are summarized in the report.
I.1.b.iv.3 (vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** All investigation reports reviewed contained a listing of documents reviewed. All investigation reports contained a copy of the first pages (usually up to the Focus sections) of the individual's WRP. The review found no instances in which the WRP information was used inappropriately to reach conclusions about the individual's behavior. **Current recommendation**: Continue current practice.
I.1.b.iv.3 (vii)	all sources of evidence considered, including previous investigations and	**Current findings on previous recommendation:**

	their results, involving the alleged victim(s) and perpetrator(s);	**Recommendation, September 2008:** Continue current practice. **Findings:** The investigator's review of the incident history of individuals and the incident and/or adverse action history of the named staff members was documented in all of the relevant investigations reviewed. In two investigations, groups of individuals were the alleged victims; their histories were not reviewed. This was not inappropriate. **Other findings:** Seeking expert advice figured in two of the investigations reviewed. In one investigation, the investigator sought expert medical opinion. The allegation of physical abuse and neglect made on 8/22/08 stated that on 8/19/08, FA sustained a broken arm during a restraint and was denied timely access to a physician. An alternate explanation provided by FA was that he sustained the fracture when he fell from a height in a suicide attempt. The investigator interviewed the Medical Director, asking him if the injury was consistent with the allegation that twisting FA's arms behind his back caused the break. The Medical Director concluded that there was "little to no(ne)" chance the injury was caused by the restraint. In a second investigation, the investigator asked the opinion of a Training Officer about a technique used in the 7/25/08 restraint of MJ. The Training Officer concluded that using the waistband of the individual's pants to raise him up on the restraint bed was not improper, so long as there was no intention to cause the individual harm or discomfort. MJ refused to discuss the incident with the investigator. **Current recommendation**: Continue current practice.
I.1.b.iv.3 (viii)	the investigator's findings, including findings related to the substantiation of	**Current findings on previous recommendation:**

	the allegations as well as findings about staff's adherence to programmatic requirements; and	**Recommendation, September 2008:** Continue current practice. **Findings:** All investigation reports reviewed provided a reasonable rationale for the determination (substantiated or not). Some reports also cited violations of policy—such as the policy governing the relationship between individuals and staff. **Current recommendation**: Continue current practice.
I.1.b.iv.3 (ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** There was specific reference in the investigation of the allegation of physical abuse of KL (5/24/08) that the investigator tried to reconcile conflicting evidence by interviewing a witness a second time. In addition, the alleged victim initially refused to be interviewed and the investigator tried again, and again the alleged victim refused. A staff member and another individual witnessed the incident (staff and individual exchanged slaps on the hands twice) and the investigation substantiated the allegation. **Current recommendation**: Continue current practice.
I.1.b.iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the	**Current findings on previous recommendation:**

	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.	**Recommendation, September 2008:** Investigation Supervisors should ensure that all allegations of abuse/neglect, sexual assault and serious injury incidents are investigated. **Findings:** The investigation reports reviewed were all signed by a supervisor. Any problems detected by this reviewer are discussed in the relevant cells. **Current recommendation**: Continue current practice.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Follow recommendations for disciplinary action and training closely and document their implementation. **Findings:** The HR Office tracks disciplinary actions. It has also been responsible for contacting the program and advising the Director of any other recommendations made by the IRC following its review of an incident. The minutes of the IRC, as cited in I.1.b.iv.3, are not a reliable mechanism for tracking recommendations. The advisability of having HR communicate non-HR related recommendations has been discussed in the IRC. It was determined that the IRC would communicate these recommendations directly, underscoring the need for clear communication with programs before procedures are put in place for following recommendations to completion. **Recommendation 2, September 2008:** Ensure that at a minimum, all staff who have been found not to have

		reported an incident in a timely manner be required to review reporting responsibilities. **Findings:** Recently the facility has determined that staff members who fail to report abuse/neglect or fail to report in a timely manner will, at a minimum, be counseled. See I.1.a.v for instances in the reporting period in which no action was taken. **Recommendation 3, September 2008:** Consider the appropriate corrective measure for staff members who fail to cooperate in an investigation. **Findings:** See above. **Other findings:** The Incident Review Committee, which is charged with making recommendations for programmatic changes brought to its attention through the incidents it reviews, is frequently reviewing incidents months after they occurred. In the case of very serious incidents, this means that implementation of IRC recommendations for avoiding recurrence of similar incidents follows many months after the incident. This situation requires correction. The purpose of the IRC, with its composition of clinical and administrative facility leaders, is to bring together the persons best able to identify corrective measures and ensure their implementation. The delay in completing investigations and getting them before the Committee is thwarting the IRC's purpose. **Compliance:** Partial.

		Current recommendation: Develop procedures whereby the IRC is informed of serious incidents and reviews them expeditiously with the information available, recognizing that the investigation may not be complete. A second review may occur when the investigation is completed.
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:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue work on the statewide incident management system and with the vendor of the Record Management System, so the facilities develop the ability to track incident patterns and trends. **Findings:** This work continues. The statewide incident management system is expected to be operational by June—July 2009. **Recommendation 2, September 2008:** Produce and distribute on a regular basis more current information on incident type, using the revised definitions. **Findings:** The facility provided a listing by type of the number of incidents and the percent of the total for each type. No analysis accompanied the figures. Peer-to-peer physical aggression (19.05%), aggressive acts to self (14.79%) and aggressive acts to staff (10.53%) accounted for 44% of all incidents during the period 8/1/08—1/31/09. No other incident types accounted for 10% or more of the total.

		Other findings: Dividing the review period into two three-month phases (August through October and November through January) the total number of allegations of abuse/neglect/exploitation and rights violations remained essentially unchanged. Phase 1=34 allegations, Phase 2=36 allegations. The facility prepared graphed data on the number of individuals in restraint and seclusion for the six-month review period that shows little use of seclusion and a significant drop in the number of individuals in restraint beginning in October 2008. Length of time individuals spent in restraint and seclusion also dropped significantly in October 2008. **Current recommendations**: 1. As with all of the tracking/tending required by the EP, the facility needs to document the review of this material and actions flowing from that review. 2. Provide analysis of incident data and comparison with historical data.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue work on the statewide incident reporting system and work with the vendor of the Record Management System to determine if it can produce pattern reports. **Findings:** This work continues. **Recommendation 2, September 2008:** Produce tracking and trending reports on the variables required by this section of the Enhancement Plan. If these are not available, indicate progress toward meeting this goal.

		Findings: The facility is not able to present data on the staff members involved and present during investigations. The listing of Client Incidents by Type (produced using the SIR database) does not contain the names of staff members. For example, under the incident type "Alleged Abuse-Physical" the individual who is the victim is named, but the staff member is not identified. **Current recommendation**: Produce tracking and trending reports on the variables required by this section of the Enhancement Plan. If these are not available, indicate progress toward meeting this goal.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Identify methods for evaluating whether the findings of studies and tracking and trending are informing treatment decisions. **Findings:** See I.2.a.ii. **Other findings:** The listing of Client Incidents by Type identifies individuals in their roles as victims, aggressors, involved, and witness. The SIR database was also used to prepare the list of individuals who have been victims as required by the Risk Management Special Order. See I.2.b.ii. **Current recommendation**: Continue identifying those individuals at high risk based on their involvement in incidents. Continue providing this information to the programs for their review and response.

I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Update the information presented to cover the current review period. **Findings:** The facility produced a listing of the number and percentage of incidents by location. No analysis accompanied the list. The list indicates that in the review period (8/1/08—1/31/09), hallways figure in incidents more often than any other location (23.11%), followed by bedrooms (18.99%) and day halls (17.51%). The facility also produced a table demonstrating the location of incidents by type. [This table fails to count one suicide.] The table indicates that approximately 60% of the physical aggression between individuals occurs in hallways and day halls. Similarly, staff members are most at risk in these two locations, as 57% of the physical aggression toward staff occurred there during the study period. **Other findings**: There is no documentation in the IRC minutes that the Committee reviewed the material described above. **Current recommendation**: The IRC should review and make recommendations related to the trending and pattern reports presented to it.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Update this report with more current information and provide some analysis. **Findings:** The facility's data on time of day that incidents occurred revealed that

		the morning hours (9 am – 11 am), the afternoon hours (3 pm – 5 pm) and the evening hour (6 pm – 7pm) saw the greatest number of incidents during the review period. Information on days of the week was not provided. **Current recommendations**: 1. Provide data on incident occurrence sorted by days of the week. 2. Knit day and time data with type and location as the means to do so become available. 3. The facility should ensure the incident data, with analyses, is reviewed in the appropriate forums.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Use the Incident Review Committee as a vehicle for the discussion of questions raised in the Headquarters Reportable briefs. **Findings:** Since the Headquarters Briefs ask for the identification of contributing factors, this recommendation was made in the belief that the persons who comprise the IRC would be in a position to identify factors that contributed to an incident, since they would have read the investigation report. It is apparent that the tardiness of many of the investigations is hampering investigators in identifying contributing factors, such as unit routines, noise level, conditions that might have diverted staff attention, etc. Consequently, it is difficult for the IRC to identify these factors and it is unreasonable to expect the staff person assigned to complete the briefs to be able to fill in the missing information. Until everyone who prepares SIRs, investigates cases, and reviews cases is cognizant of the kind of information needed to complete a Headquarter Reportable Brief, the problem will remain uncorrected.

		Recommendation 2, September 2008: Take whatever other measures are necessary to complete the briefs in the timeframe required. **Findings:** As reported, none of the Headquarters Reportable Briefs for November incidents had been completed at the time of the tour. These briefs were due 60 working days after the report of the incident. **Current recommendation**: Acquaint Unit Supervisors and others who routinely complete SIRs, investigators, and members of the IRC with the kinds of information required to complete a Headquarters Reportable Brief. Request their assistance in gathering this information.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, September 2008:** As soon as practicable, use the Record Management System to produce reports for the Incident Review Committee and other relevant bodies. **Findings:** The Record Management System is not yet used by MSH to produce tracking and trending reports for review by the IRC. The WaRMSS incident data information system, expected to come online in June-July 2009, will be able to produce these reports once it has sufficient data entered. The Investigations log does include the names of the individuals involved, the incident date, date received by the Hospital Police or OSI, the date closed and the disposition (outcome). Review of this log for incidents occurring in November and December 2008 (N=27) reveals that 17 remained open as of 3/9/09; two were sustained; four not sustained; three unfounded; and one death investigation simply listed as closed.

		Current recommendation: Use the SIR and specific purpose facility databases to produce trend and pattern reports as required by the EP for review by the IRC and other relevant committees.
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 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.	**Current findings on previous recommendation:** **Recommendation, September 2008:** As annual performance evaluations are received in the HR office, review the staff member's personnel file to ensure that criminal background clearance is present and take appropriate action. **Findings:** The findings from the review of the personnel files for 19 staff members for criminal background checks suggests that this recommendation has not yet been implemented. **Other findings:** See the table in I.1.a.iv. There was no documentation of criminal background check clearance in six of the 19 staff members' personnel files. One of these staff members was hired in 1979 but the remaining five were hired in the 1990s. **Compliance:** Partial. **Current recommendation**: Take the necessary and appropriate steps to secure the required background information on all staff members.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** <u>Interviewed</u>: 1. Alex Honigman, Unit 401 social worker 2. Amanze Iwuanyanwu, RN, Unit 414 nurse 3. Amber Inman, RN, Unit 401 supervisor 4. Andrea Sillas, Unit 401 rehabilitation therapist 5. Armanda Pruitt, Unit 419 psychiatric social worker 6. C. Rivera, Standards Compliance 7. Cheryl Kempinsky, Ph.D., Unit 419 psychologist 8. Cynthia Fajardo, Unit 419 dietician 9. D. Quinn Callicott, Unit 414 social worker 10. Foresteen Forbes, PsyD, Unit 412 psychologist 11. Grace Bulafu, Unit 401 psychiatric technician 12. Heather Spencer, Unit 412 social worker 13. Jeff Bookman, Unit 401 rehabilitation therapist 14. Jeffery Coker, PsyD, Unit 401 psychologist 15. Jennifer Gaskell, Unit 412 rehabilitation therapist 16. Jocelyn Agtarap, RN, Unit 419 supervisor 17. John Nallira, Unit 412 supervisor 18. John Pyle, Unit 414 rehabilitation therapist 19. Joseph James, MD, Unit 412 psychiatrist 20. L. Dieckmann, Lead Psychologist, Standards Compliance 21. M. Nunley, Director, Standards Compliance 22. Mahfoozie Hassan, MD, Unit 419 psychiatrist 23. Michele Detrinidad, RN, Unit 419 nurse 24. Moheb Beshay, MD, Unit 401 psychiatrist 25. Nerissa Sibal, MD, Unit 414 psychiatrist 26. Quan Luong, Unit 419 dietician 27. Rachel Potts, Unit 414 supervisor 28. Ruzette Castillo, Unit 419 rehabilitation therapist 29. Stacy Weeks, PsyD, Unit 414 psychologist

		30. Sung Kim, RN, Unit 401 nurse 31. Teneese Nguyen, MD, Unit 419 physician <u>Reviewed</u>: 1. 15 clinical records for recording of trigger response 2. Program Review Committee Tracking forms for Program III 3. Follow-up in seven clinical records on trigger responses 4. Aggregate trigger data 5. Risk Management Training Material 6. Facility Risk Management Committee minutes for February 2009 7. Repeat aggressor study findings 8. Quality Council minutes 9. Metropolitan State Hospital Failure Mode Effects Analysis (FMEA), Falls Prevention 10. The charts of five individuals (BE, JG, MC, RR and SW) to review implementation of the process and clinical application of Special Order 262 <u>Observed</u>: 1. Program Review Committee meeting for Program II 2. Medical Risk Management Committee meeting
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue to undertake studies of high-risk situations and individuals. Review implementation of interventions for effectiveness with specific

individuals.

Findings:
The hospital reported that it continues to study high-risk individuals and take measures to reduce their risk. Specifically, the hospital described the identification of 12 individuals as high priority for behavioral guidelines or PBS plans. Three more individuals were added later. Of the 15 individuals, the hospital reported that seven had no incidents in December and January. See also I.2.a.ii for a December study of repeat aggressors.

Other findings:
Analysis of data provided by MSH on "High Risk Categories" for the review period yields the following:

	Aug—October 08			Nov 08—Jan 09		
Peer to peer incidents of aggression	207			229		
Individuals (aggressors and victims) involved in peer-peer altercations	Aug 162	Sep 120	Oct 138	Nov 158	Dec 154	Jan 121
A/N allegations	34			36		
Substantiated A/N/E	4			5		

As demonstrated below, the High Risk data related to victims of A/N/E does not match the Trigger data for A/N/E allegations.

High Risk Categories Data						
Individuals who were alleged victims of A/N/E one or more times	Aug 1	Sep 1	Oct 0	Nov 0	Dec 1	Jan 2
Trigger Data						
Individuals with any	Aug	Sept	Oct	Nov	Dec	Jan

		alleged A/N/E: 10, 5, 4, 5, 8, 5 **Current recommendation**: Determine the source of the discrepancy in the High Risk data and the Trigger Data and correct any misinformation that may have been distributed.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue working with the other state facilities to develop and implement a risk management system that aligns interventions with the level of risk. **Findings:** All committees established by the Risk Management Special Order are functioning and have met at least twice. The facility provides guidance to WRPTs on a hierarchy of interventions on the trigger response form for Level 1 triggers related to PRN medication, 1:1 observation, aggressive acts and restraint and seclusion. Analysis of data presented by the facility indicates that in 92% of the triggers sampled related to aggressive acts, the WRPT responded that it had implemented an intervention from the hierarchy. Similar response rates were reported for 1:1 observation (95%), PRN meds (92%), Stat meds (90%), restraint (100%) and seclusion (100%). The samples for restraint and seclusion were very small—three and two respectively. The samples for the other triggers ranged between 68 and 158. **Recommendation 2, September 2008:** Continue the current practice of reviewing specific high-risk individuals to provide longitudinal data to the WRPT and assistance in planning interventions.

Findings:
The facility reported on a small study (N=10) conducted in December 2008 to determine if the WRPs of repeat aggressors listed aggression as a risk factor, had an open focus with objectives and interventions and included behavior guidelines or PBS plans. It reported the following results: seven of the 10 had an open focus for aggression with objectives and interventions and six had behavior guidelines or a PBS plan. Senior mentors were notified of deficiencies and asked to work with the teams to address them.

Other findings:
The facility has begun implementation of the Risk Management Special Order. The facility has developed the infrastructure to track individuals whose care requires review beyond the program level. Furthermore, the facility has done small studies to evaluate the response rate of WRPTs to triggers and the implementation of the proposed responses. Lists of individuals at high risk for a limited number of triggers have been developed and the lists promulgated to the programs. Specific examples of the work done by the facility in meeting the requirements of the Risk Management Special Order are provided in the succeeding cells.

Review of the WRPs of seven individuals who had reached triggers found that all proposed interventions had been implemented:

Indiv.	Trigger	WRP Response	Implementation
JR	Peer aggression	Adjust medication	Yes
		TRC consult	Yes
		Psychopharmacology consult	Yes
RS	Peer aggression	Adjust medication	Yes
CW	Peer	Adjust medication	Yes

	aggression		
LS	Peer aggression	Adjust medication	Yes
KC	Peer aggression	Add/modify focus	Yes
		Add/modify objective	Yes
		Add/modify interventions	Yes
RU	Peer aggression	Adjust medication	Yes
NB	Alleged A/N/E and aggression to self	Modify focus	Yes

See I.2.a.iii. Implementation of the facility's own recommendation would facilitate monitoring of WRPT responses to triggers which would, in turn, facilitate the work of the higher-level review committees.

The minutes of the first Medical Risk Management Meeting (2/4/09) describe recommendations for a change in medication administration time with the objective of reducing drowsiness and consequently the risk of falls for SB, an individual at high risk for falls. The second meeting of this committee addressed metabolic syndrome in an individual and provided training applicable to all individuals at risk for the syndrome.

This monitor and his experts interviewed WRPTs who supported individuals who had crossed established risk management triggers. The following summarizes these episodes:

Individual	Unit	Indicator	Trigger	Date(s)
BE	401	Aggressive act to others	Two or more aggressive acts within seven days	WRPT notified on 1/15/09

JG	414	Aggressive act to others	Peer-to-peer aggression with major injury	11/4/08
MC	419	Falls	None	11/15/08 and 12/02/08
RR	414	Aggressive act to others	Aggression to others (not specified) with major injury	1/13/09
SW	412	Aggressive act to self	Aggression to Self with Major Injury	12/31/08 and 1/11/09

In regards to process, the interviews revealed the following. MSH implemented the Risk Management Special Order during this review period. WRPT members appeared knowledgeable in regards to the Risk Management procedures, particularly the response required at the first level. They had some difficulty articulating the feedback mechanisms from the second level. This paralleled practice in that the WRPs discussed the incidents but lacked a discussion of the enhanced trigger committees' recommendations. The team members also had some difficulty locating information in the individuals' records, which decreases the utility of the record as a method of communication between team members. Lack of familiarity with the record could also contribute to team members failing to consistently document (in the record) corrective actions that occurred within 24 hours of incidents.

In regards to clinical care, some areas of progress were noted:

1. In all applicable cases, WRPTs had initiated or revised behavioral intervention plans.
2. In most cases, the psychologists had outcome data in the form of

		data summary and graphs. 3. In one case (RR), the WRPT had developed, implemented, and revised behavioral interventions prior to the index incident. The behavior guidelines were revised again following the incident. 4. One WRPT reassigned the individual (RR) to mall groups more appropriate for learning the needed skills to develop appropriate social skills and coping skills (for example, Coping Skills through Art) following the episode. However, several areas of deficiencies were noted: 1. In some cases (JG and RR), PRNs were utilized as interventions without subsequent optimization of regular medication regimen. 2. A number of behavior guidelines presented during the review were deficient in a number of aspects: a) Prevention strategies did not align with the stated functions of the target behaviors. b) Setting events, triggers, and precursors were not targeted for prevention strategies. c) Many of the prevention strategies were similar across guidelines. d) A number of strategies listed under the intervention section were prevention strategies. e) Many of the behavior guidelines did not include active/reactive interventions. f) A number of the psychologists involved in developing the intervention plans were unsure of what active/reactive interventions were. **Current recommendations**: 1. Continue implementing Special Order 262. 2. Continue the practice of conducting small look-behind studies of high-risk individuals or situations. 3. Ensure that the risk management database includes the date of the

		incident, the date of WRPT notification and proper classification of episodes (e.g., minor vs. serious injury). 4. Ensure timeliness of notification from the risk management department to the WRPTs of occurrence of triggers. 5. Ensure that the second-level review meets all requirements articulated in the Special Order. 6. Develop a formalized method for the WRPTs to receive information from the second-level Enhanced Trigger Review Committee and to document the team's response to the recommendations 7. Ensure that all behavior guidelines meet generally accepted guidelines.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue the work being done by Standards Compliance in studying high-risk situations and individuals. **Findings:** The facility has provided graphed data on specific high-risk individuals to the individual's WRPT. For example, the graph of AB's self-harm and suicide threats and attempts reveals that the episodes of self-harm show wide variability over the 17-month period from August 2007 to January 2009. January 2009 saw the greatest number of these incidents. Graphed data related to aggressive acts toward others for RL for the April 2008—January 2009 period shows a continuing decrease in aggressive episodes from July, with no aggression in November, December and January. The February Facility Risk Management Committee minutes document tracking of the risk types and actions for NB. Completed items include clarification of her diagnosis. Items still to be accomplished include integrating the revisions of behavioral guidelines into the WRP and the

		need to provide NB with a DBT environment. The Program III Review Committee tracking sheet shows that the team received notification of individuals on the high-risk list for aggressive acts to self. In addition to this list, the facility has produced lists of individuals at high risk for metabolic syndrome, property destruction and frequent victimizations. These lists are shared with the Program Directors. **Recommendation 2, September 2008:** Report recommendations from studies and the review of reports like those described above [in the same cell in the previous report] from the Performance Improvement Committee to the Executive Risk Management Committee for distribution and action. **Findings:** The functions of the Performance Improvement Committee have been assumed by the committees designated in the Risk Management Special Order. The functioning of the Risk Management system, although still newly organized, is described in various cells in this section of the report. **Recommendation 3, September 2008:** Develop strategies to ensure that WRPTs are using the information made available through these studies to inform treatment interventions. **Findings:** In order to more efficiently track the interventions enacted by WRPTs in response to an individual reaching a trigger, Standards Compliance, in a memo dated 12/30/08, directed teams to identify the trigger and the intervention under Risk Factors in the Present Status section of the WRP. Review of the records of 15 individuals who had reached a trigger in January 2009 found that 13 of the 15 records contained mention of the trigger in the Present Status section. The two that did not mention

		the trigger were the WRP for KO who reached the AWOL/Escape trigger on 1/31/09 and the WRP for RS who reached the osteoporosis trigger on 1/31/09. In only one of the WRPs reviewed was the intervention directed at the trigger recorded in the Present Status section. The single plan in compliance with the Standards Compliance directive was that for SB, suicide attempt 1/12/09. **Current recommendation**: Implement the directive from Standards Compliance requiring WRPs to identify the trigger and the intervention in the Present Status section of the WRP.
I.2.b	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:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Continue efforts to provide guidance to WRPTs in implementing a hierarchy of interventions as the risk level for an individual rises. **Findings:** The facility has provided training to WRPTs on procedures for implementing the Risk Management strategies identified in the Special Order. Training has included written guidance, PowerPoint presentations available on the facility intranet and Standards Compliance staff ready to answer questions and offer assistance. **Recommendation 2, September 2008:** DMH should continue efforts to develop the Protection from Harm Special Order that will provide the foundation for a hierarchy of

<table>
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<td>interventions by clinical teams that correspond to triggers and thresholds.

Findings:
The Special Order has been finalized and the facility has begun implementation.

Other findings:
Review of facility data on responses to the Suicide Attempt and Suicide Threat triggers for the period May 1, 2008 through January 31, 2009 found that a response identifying an intervention was received in 92% of the suicide attempt triggers and 88% of the suicide threat triggers.

<table>
<tr><td></td><td>Suicide attempts</td><td>Suicide threats</td></tr>
<tr><td>Total number</td><td>26</td><td>76</td></tr>
<tr><td>Number with no response from the WRPT</td><td>2</td><td>9</td></tr>
</table>

Now that Programs are meeting weekly to discuss triggers and their recommendations are being documented, one would expect that no triggers that require weekly review will go unaddressed.

Current recommendation:
Continue with plans for the full implementation of the Risk Management Special Order, including adoption of the ASH information system.</td>
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<tr>
<td>I.2.b.ii</td>
<td>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</td>
<td>Current findings on previous recommendation:

Recommendation, September 2008:
Ensure that WRPTs receive information on repeat aggressors and repeat victims and other study findings relevant to the individuals they support, with the expectation that they will document their discussions of the problems and their responses, including consultations with senior</td>
</tr>
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clinicians and the use of enhanced psychology services.

Findings:
The facility provided a list of 34 individuals at high risk for victimization (updated 2/13/09). Individuals were first put on the list on 12/16/08 and added as they reached criteria. One individual was deleted from the list when she was discharged. The list was shared with WRPTs along with an explanation of the criteria for inclusion (as specified in the Risk Management Special Order), instructions to the WRPs, and sample foci, objectives and interventions. The facility reports that Risk Managers to be hired shortly will be attending trigger meetings and offering suggestions on interventions for individuals who are repeat victims.

Other findings:
The facility reviewed the responses from WRPTs for the period August 2008 through January 2009 for triggers related to peer aggression, 1:1 observation, PRN and Stat medications, restraint and seclusion. In each of the categories, the WRPTs responded to 90% or more of the triggers. However, the number of triggers cited in this review for each month does not match the numbers for the same months provided in the DOJ Monthly Key Indicator Report. Below is one example.

	Aug	Sept	Oct	Nov	Dec	Jan
Number of 1:1 triggers reported in study	17	19	17	14	15	16
Number of 1:1 triggers reported in Key Indicator Report	14	13	13	11	14	17

The facility completed a study of WRPs for individuals who were repeat aggressors that included monitoring of the implementation of the proposed action. The findings revealed that in the six-month review period (August 2008 through January 2009), 65% of the proposed actions had been implemented. Findings ranged from 34% in November to

		75% in December. See the table in I.2.a.ii for this reviewer's findings, which are much more positive. **Current recommendations**: 1. Expand sample monitoring to include review of the implementation of the interventions. 2. Determine the source of the variation in the data between the study numbers and the Key Indicator Report and correct any problems identified.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, September 2008:** The Senior Psychiatrist should review the [trigger tracking] form, ensuring that it is complete and that the interventions identified are adequate and commensurate with the level of risk. **Findings:** This recommendation will be met during the weekly Program Review Committee meetings since the psychiatrist will be participating. Second-level meetings should review the effectiveness of interventions that have been implemented and offer additional recommendations as appropriate. This work will be facilitated if the facility follows its own directive to identify the trigger and intervention in the Present Status section of the WRP. **Other findings:** The facility's system for notifying WRPTs when an individual reaches a trigger is functioning well. **Current recommendation**: Continue implementation of the Risk Management Special Order.

I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Increase the number of trigger responses monitored and provide direct feedback to the teams of the results of the monitoring. **Findings:** See monitoring results in other cells. **Recommendation 2, September 2008:** Report patterns and trends to the Performance Improvement Committee in order to elicit suggestions for improving performance to be forwarded to the Executive Risk Management Committee for approval and implementation. **Findings:** The Performance Improvement Committee is no longer meeting. Many of its functions have been taken over by the Quality Council. **Other findings:** The facility is using a database developed by ASH to track individuals as they are reviewed by committees under Risk Management procedures. This should increase the accuracy of the tracking and serve as an aid to the WRPTs. **Current recommendation:** Expand monitoring efforts related to implementation of proposed actions and share the results with the WRPTs.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, September 2008:** See I.2.b.iv.

		Findings: See cells above. In the recent past, the facility has done more monitoring of whether WRPTs have responded to triggers with a proposed action. The facility has done some limited reviews of whether the actions were implemented. It has issued a directive requiring that the action be documented in the Present Status section of the WRPT, believing that this would be helpful both to the team and to the auditors. Additionally, use of the ASH database should facilitate auditing of implementation. **Current recommendation**: Continue with plans to expand oversight of the implementation of trigger responses.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue work on implementing the plan. **Findings:** The Quality Council has been meeting monthly since January 2009. Review of the minutes reveals that much of its work is directed toward successful implementation of the Risk Management system. Specific items receiving attention include: • Addressing BMI and WRP non-adherence on a system rather than individual level; • Identifying the data that needs to be collected and its source in order to prepare lists of individuals at high risk for various behavioral and medical reasons; • WRPT training on the role of the team in Risk Management; and • Review of the minutes of all of the other committees meeting under

		the Risk Management procedures. **Compliance:** Partial. **Current recommendation**: The Quality Council should continue facilitating and monitoring the implementation of the Risk Management system and the facility's compliance with the Enhancement Plan.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: Several individuals during tours The following staff members accompanied this monitor on the unit tours and provided information and answered questions, but were not interviewed separately: 1. B. Langley, Health and Safety RTW 2. G. Hahn, Hospital Administrator 3. H. Mears, Chief of Hospital Police 4. K. Moran, General Services Supervisor 5. R. Thomas, Chief, Plant Operations Reviewed: 1. DMH revised Incontinence Monitoring Form and Instructions 2. Incontinence monitoring data 3. Sexual incidents monitoring data 4. WRPs of nine individuals as they relate to incontinence 5. Review of seven clinical records as they related to sexual incidents Toured: 1. Four units: 407, 412, 413 and 414, 2. OT/PT clinic module
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, September 2008:** Consider solutions to the ventilation placement problem.

		Findings: The air vent screens, particularly those over stationary objects that facilitate access, remain a suicide hazard. The facility reports that placement of the ventilation screens above toilets and other permanent objects that would serve as a means to access the screens is still under review. ASH has found a solution that results in smaller vent holes but does not interfere with airflow. This may be a viable option for Metro and the facility will confer with ASH. **Recommendation 2, September 2008:** Secure the Rehabilitation building and allow individuals to fully participate in rehabilitation therapies until a permanent solution is provided. **Findings:** Effective about April 1, a module OT/PT clinic will be equipped and ready for use within the compound. This will enable individuals within the compound to access the clinic and use the equipment without restraints. **Other findings:** The facility is in the process of replacing lockers with three-drawer dressers that were present in several units visited. This will reduce another suicide hazard. Showerheads and shower on/off valves have been replaced with safe fixtures. A room presently used as a restraint/seclusion room on Unit 407 will soon be converted to a reflection room. Several other units are expected to make a similar change. **Compliance:** Substantial—based on limited information regarding resource availability.

		Current recommendation: Continue with current plans to reduce suicide hazards.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Replace unit thermometers for measuring water temperature. **Findings:** The water temperature was appropriate in the sinks tested during the tour. The facility reports that new thermometers for measuring water temperature were purchased in March 2009. **Other findings:** The facility data on work orders related to ambient temperature on treatment program units indicates they were addressed and the situations corrected on the same day. All units visited were comfortable in temperature. No individuals complained of uncorrected temperature problems. In general, the bedrooms and bathrooms visited on the units toured were clean and odor-free. The exception was a five-bed bedroom on Unit 407 where one bed was quite dirty and a urinal needed to be emptied and cleaned. **Compliance:** Substantial—as related to ambient temperature. **Current recommendation**: Continue current practice of responsiveness to temperature-related work orders.

I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue providing mentors to nurses in using the WaRMSS system for completing interventions in WRPs, including methods for addressing incontinence in Focus 6. **Findings:** The facility reports that the mentoring of nurses in contributing appropriate interventions related to the problem of incontinence is continuing. DMH has revised the Incontinence Monitoring form and provided step-by-step instructions for completing it. **Other findings:** Review of the clinical records of nine individuals identified as having the problem of incontinence found that the problem was identified in Focus 6 with appropriate objectives and interventions. In instances in which the individual required total care, interventions noted the need to be cognizant of maintaining the individual's privacy. In other instances bladder training exercises, flow sheets to show progress, and training on other methods of decreasing the frequency of incontinence were cited.

Individual	Dx or on Medical Problem list?	Focus 6	Objective and Interventions
AA	Yes	Yes	Yes
AB	No	Yes	Yes
AC	No	Yes	Yes
FN	Yes	Yes	Yes
KG	Yes	Yes	Yes
LW	No	Yes	Yes
NA	Yes	Yes	Yes
SH	Yes	Yes	Yes
VF	Yes	Yes	Yes

		These findings are consistent with the facility's audit findings that in the last three months of the report period (Nov 2008—Jan 2009), incontinence was identified in Focus 6 for 95% of the 188 individuals sampled. In that same period, facility data shows that 74% of these individuals had objectives that promoted dignity and encouraged self-reliance. For the month of January 2009, that figure rose to 91% (based on of a sample of 63 individuals). **Compliance:** Substantial. **Current recommendation**: Continue current mentoring and monitoring of this portion of the EP.
I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue efforts to train staff members of specific disciplines on their responsibilities in response to sexual incidents. **Findings:** This training has been integrated into the Hospital Annual Update training. **Other findings:** Review of the treatment response to sex-related allegations yielded mixed findings as presented below.

Allegation date	Response
Allegation of rape 9/15/08	Individual assured of her safety and given support. Examined by MSH physician. Sent to

				the hospital for rape exam. IDN on the next day states individual had no symptoms of psychological trauma or unusual behavior. WRP the following week notes the allegation in Present Status. Also noted in physician's monthly note.
			Allegation that individual raped a peer 12/28/08	Aggressor refused to comment on the allegation. Later denied the incident. Claims victim approached him. Counseled re: sexual behavior and STDs. Provided emotional support. Transferred to an all-male unit. No mention in Present Status of WRP when transferred.
			Allegation of sexual assault 11/20/08	Initially alleged sexually assault by male peer. Taken to the hospital. Refused to answer questions in the ER. Taken to rape clinic. Later rescinded allegation. Notes continue for several days regarding providing the individual with support. Present Status of next WRP does not mention incident, and incident not included in the list of incidents under Risk Factors.
			Allegation of sexual abuse 11/26/08	No IDN regarding allegation. No mention of incident in Present Status of next WRP.
			Allegation that individual was aggressor in sexual assault 10/9/08	IDN states directive to hold grounds pass due to allegation. No further mention. Incident not noted in RN weekly note. Not mentioned in next WRP.
			Sex between adults 11/20/08	IDN states that a female student reported the individual grabbed her breasts. Quarterly nursing summary (11/22/08) cites the incident and explains that the individual is cognitively impaired and continues to exhibit disorganized

		speech even in his native language.
		Allegation that individual inappropriately touched victim 12/23/08 — Victim alleged that the individual followed her into the shower room and attempted to touch her. No mention of education, limit setting in alleged aggressor's record. WRP (12/24) cites the incident in the Present Status and the aggressor's continued denial. Also states that aggressor has continued to be sexually inappropriate for the past 14 days. WRP does not address sexually inappropriate behavior, but there is a sticker "sexually inappropriate" on the front of her record.
		The facility reports that between September 2008 and January 2009, it monitored 44 sexual incidents and found that the incident under review was discussed by 84% of the WRPs, sexual education was provided in 98% of the incidents, and an RN assessment and documentation was present in 75% of the incidents. **Compliance:** Partial. **Current recommendation**: Continue measures to ensure that staff members document in IDNs, physician notes and WRPs all measures taken in response to a sex-related incident.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in	**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:**

	incidents are properly trained to work with individuals with mental health concerns.	The facility reports that it continues to use the MAPP scheduler to identify staff who need training provided in the Hospital Annual Update. Specific information on the number of staff members found to need training who received this training was not provided. **Compliance:** Partial. **Current recommendation**: Provide data specific to this requirement of the EP, specifically the training records for non-clinical staff leading Mall groups.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The Individual Council continues to conduct orderly meetings focusing on current items of interest or concern. Members report that facility leaders listen to them and return with answers or plans for remedying situations. 2. The Council continues to recognize and express appreciation for the cooperation it receives from the facility leadership. Members continue to speak about the changes that the facility has made that have improved the quality of their lives.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals during unit tours 2. Asked questions and listened to individuals at the Senate meeting <u>Reviewed</u>: January 2009 Individual Council Survey results <u>Observed:</u> Senate meeting
J		**Current findings on previous recommendation:** **Recommendation, September 2008:** Continue current practice. **Findings:** The Individual Council members spoke positively of the Council's relationship with the leadership at the facility. Speakers stated that facility executives often attend the meetings and are responsive to their concerns, either presenting a solution, a plan to address the problem, or

promising to look into the issue. This was evidenced at the meeting this monitor attended in which the Senate leadership acknowledged progress in getting free in-house phone calls, increasing the number of caffeinated drinks allowed daily and fewer instances of individuals being locked out of their bedrooms. Administrators shared that the facility is pricing electronic law library reference materials. Individuals were reminded of the resources available to them and the special events planned to introduce the smoke-free campus.

Other findings:
The 100 survey forms returned in January 2009 revealed the following selected results:

Question	% positive answers
Feel safe?	72%
Environment clean & safe?	77%
Have access to personal hygiene supplies?	90%
Treated with respect?	92%
Assisted in meeting wellness and recovery goals?	90%
Able to communicate freely w/family, attorneys and advocates?	80%
Taught what constitutes abuse & neglect?	75%
Can report abuse/neglect?	86%
Staff tried to calm you before using restraint or seclusion?*	81%
Released from restraint/seclusion when calm?*	79%
Taught about medications, results and common and serious side effects? *	92%

Those questions followed by an asterisk showed substantial improvement over the prior survey results.

		The mean positive response to the 27-question survey was 78% for the current period and 83% for the previous period. **Compliance:** Substantial. **Current recommendation**: Continue current practice.