

REPORT 10

NAPA STATE HOSPITAL

January 24-28, 2011

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

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

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Acronyms used in Court Monitor reports:

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

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

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

IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IER	Independent External Review
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MAS	Medical Ancillary Services
MBS	Modified barium swallow
MDO	Mentally Disordered Offender
MFT	Marriage and Family Therapist
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital

MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NFA	Neuropsychological Focused Assessment
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician

PD	Personality disorder
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PWT	Program-Wide Trainer
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)

S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
STA	Secure Treatment Area
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
Tx	Treatment

URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L), visited Napa State Hospital (NSH) from January 24 to 28, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

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

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

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

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

In the ratings of compliance, the Monitor uses a scale of non-compliance, partial compliance and substantial compliance. A rating of non-compliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the Court

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

C. Statistical Reporting

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

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

D. Findings

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

1. Key Indicator Data

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

2. Monitoring, mentoring and self-evaluation

- a. Regarding the process of self-assessment, this monitor has requested the following:
 - i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
 - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
 - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
 - A review of the facility's assessment of barriers towards compliance; and
 - A plan of correction.
 - ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
 - iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
- b. NSH presented its self-assessment data and data comparisons as requested above based on the available DMH standardized auditing tools for all applicable sections of the EP. At this juncture, the Court Monitor will accept reduction of the facility's sample sizes if DMH decides that this can be accomplished without compromising the facility's oversight function.
- c. As mentioned repeatedly in earlier reports by this monitor, all facilities must ensure that discipline chiefs and senior executives review the monitoring data (including key indicators) on a monthly basis and use the results of these reviews to enhance service delivery within each facility. The monitoring (including key indicator) data across hospitals should be reviewed quarterly by the DMH so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

3. Implementation of the EP

- a. During this review period, NSH experienced a tragic event in which a staff member was fatally assaulted by an individual. This Court Monitor and experts offer deepest sympathies for this loss and acknowledge the sadness and challenges that the facility faced as a community in the aftermath of this event. We also express deep respect for the courage and commitment that it has taken, individually and collectively, to absorb that loss and to carry on in the facility's vitally important work, especially when tested so soon thereafter by the serious assault against another staff member.
- b. Conducting a review against a backdrop of unfortunate events, which also included four unexpected mortalities of individuals and two suicides that occurred following discharge from the facility, presented a challenge to the Court Monitoring team. The

- challenge is that these events should not influence a) assessment of areas in which the facility has made real improvements in its patient care processes, b) the understanding that certain adverse events can at least partially be explained by some combination of factors independent of clinical performance and c) the fact that no facility can provide an absolute guarantee of safety to its individuals and staff while caring for individuals with histories of involvement in the criminal justice system. However, the Court Monitor also expects that all reasonable measures are made at the facility and DMH levels to minimize harm to individuals and staff, including, but not limited to, an effective quality management function to address these events.
- c. In recent months, the facility's new Executive Director has taken major steps towards the development of an effective quality management system. As part of these efforts, NSH has modified the structure and functions of the Quality Council, improved reporting channels to facilitate the oversight system and initiated effective academic liaison with the University of California at Davis to assist in the data analysis. This has resulted in noticeable improvement in the oversight function as evidenced by:
- i. Identification of important trends and patterns of high risk indicators, primarily aggression trends/patterns;
 - ii. Review and analysis of factors that contributed to these trends/patterns; and
 - iii. Development of data-based and thoughtful suggestions for systemic corrective measures at a variety of levels.
- This work must continue and the pace must accelerate. This monitor expects to receive periodic updates of the status of implementation of the systemic corrective measures.
- d. NSH has maintained progress in many areas of the EP. The most significant achievements have been in the areas of substance abuse assessments and education, cognitive assessments and remediation interventions, psychiatric assessments and reassessments, inter-unit transfer assessments, admission nursing assessments, psychological services, social work assessments and discharge planning, rehabilitation assessments and services, medication management systems and medical care. This progress is outlined in corresponding sections of the EP.
- e. The operational implementation of the risk management system has been seriously inadequate, primarily in the key areas of:
- i. Prioritization of triggers in a manner that increases the efficiency of the system to address high-risk individuals;
 - ii. Timely and adequate reviews by the treating psychiatrists of individuals who reach triggers/thresholds that do not involve the use of seclusion/restraints;
 - iii. Meaningful reviews by the Program Review Committee (PRC), the Enhanced Trigger Review Committee and the Facility Review Committee (FRC); and
 - iv. Utilization of external consultations for individuals who exceed the facility's capacity to meet their needs.
- In addition, this monitor found that the facility does not have a daily morning executive meeting to review high-risk events that require immediate attention by facility leadership. The current schedule of twice-weekly meetings is insufficient.
- f. NSH has implemented appropriate modifications in the operations of its PSR Mall following the above-mentioned assaults on staff members as part of necessary measures to improve safety on hospital grounds.

- g. Those facilities that care for 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.
- h. It is important to reiterate that the EP addresses multiple domains of treatment (of illnesses), rehabilitation (of social skill deficits) and improvement of the quality life of individuals. While all of these domains have significance in mental health systems of care, ultimate success in this process must include, at a minimum, compliance with the requirements that are essential to the safety and well-being of the individuals. Success also requires a self-sustaining system that is driven by formalized, objective processes, a channel for effective dialogue with clinicians and timely action to achieve a reasonable balance between documentation and auditing requirements and time spent in direct care.

4. Staffing

The table below shows the staffing pattern at NSH as of December 31, 2010:

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	4.0	1.0	20%
Assistant Director of Dietetics	4.0	4.0	0.0	0%
Chief Dentist	1.0	1.0	0.0	0%
Chief Physician & Surgeon	1.0	0.0	1.0	100%
Chief Psychologist	1.0	0.0	1.0	100%
Clinical Dietician (see Registered Dietician)	0.0	0.0	0.0	0%
Clinical Laboratory Technologist	3.0	2.0	1.0	33%
Clinical Social Worker	60.4	56.6	3.8	6%
Coordinator of Nursing Services	1.0	1.0	0.0	0%
Dental Assistant	3.0	4.0	-1.0	-33%
Dental Hygienist	1.0	1.0	0.0	0%
Dentist	2.0	3.0	-1.0	-50%
Food Service Technician I	90.0	91.0	-1.0	-1%

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Hospital Worker	4.0	4.0	0.0	0%
Health Record Technician I	11.0	8.0	3.0	27%
Health Record Technician II Sp	1.0	1.0	0.0	0%
Health Record Technician II Sup	1.0	1.0	0.0	0%
Health Record Technician III	1.0	0.0	1.0	100%
Health Services Specialist	29.0	25.0	4.0	14%
Institution Artist Facilitator	1.0	1.0	0.0	0%
Licensed Vocational Nurse	47.0	43.0	4.0	9%
Medical Transcriber	7.0	5.0	2.0	29%
Sr. Medical Transcriber	2.0	2.0	0.0	0%
Nurse Instructor	10.0	10.0	0.0	0%
Nurse Practitioner	7.0	7.0	0.0	0%
Nursing Coordinator	8.0	6.0	2.0	25%
Office Technician	39.5	38.5	1.0	3%
Pathologist	1.0	1.0	0.0	0%
Pharmacist I	13.5	10.0	3.5	26%
Pharmacist II	2.0	1.0	1.0	50%
Pharmacy Services Manager	1.0	1.0	0.0	0%
Pharmacy Technician	15.0	12.0	3.0	20%
Physician & Surgeon	22.0	18.5	3.5	16%
Podiatrist	1.0	0.5	0.5	50%
Program Assistant	5.0	4.0	1.0	20%
Program Consultant (RT, PSW)	1.0	0.0	1.0	100%
Program Director	7.0	7.0	0.0	0%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50%

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Psychiatric Technician*	276.2	259.8	16.4	6%
Psychiatric Technician Assistant	198.7	198.7	0.0	0%
Psychiatric Technician Instructor	4.0	4.0	0.0	0%
Psychologist-HF, (Safety)	52.1	38.2	13.9	27%
Public Health Nurse II/I	3.0	3.0	0.0	0%
Radiologic Technologist	2.0	2.0	0.0	0%
Registered Dietician	10.0	12.0	-2.0	-20%
Registered Nurse**	372.3	355.2	17.1	5%
Registered Nurse, Pre-Registered	0.0	0.0	0.0	0%
Rehabilitation Therapist	65.7	60.1	5.6	9%
Supervising Rehabilitation Therapist	3.0	2.0	1.0	33%
Special Investigator	4.0	4.0	0.0	0%
Supervising Special Investigator	1.0	1.0	0.0	0%
Sr. Psychiatrist	14.3	3.0	11.3	79%
Sr. Psychologist	22.0	18.0	4.0	18%
Sr. Psychiatric Technician (Safety)	49.0	49.0	0.0	0%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0%
Staff Psychiatrist	61.3	56.3	5.0	8%
Supervising Psychiatric Social Worker	3.0	1.0	2.0	67%
Supervising Registered Nurse	13.0	12.0	1.0	8%
Teacher-Adult Educ./Vocational Instructor	6.5	7.0	-0.5	-8%
Unit Supervisor	30.0	26.0	4.0	13%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0%

* Plus 37.1 hourly Psychiatric Technician FTEs

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
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*** Plus 29.5 hourly Registered Nurse FTEs*

Key vacancies at this time include senior psychiatrists and psychologists.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial compliance with any section of the EP for 18 months (four consecutive tours), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Napa State Hospital July 25-29, 2011.
2. The Court Monitor's team is scheduled to tour Metropolitan State Hospital March 7-11, 2011 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. NSH has achieved substantial compliance with almost all EP requirements in Section C.1. However, the facility must address a significant decline in the process of the WRP in a few teams. 2. NSH has achieved substantial compliance with all but one requirement in Section C.2. The facility accelerated progress in the delivery of substance use services and achieved substantial compliance with relevant EP requirements. 3. DMH presented thoughtful suggestions to streamline the content of the WRPs to ensure a reasonable balance between time spent in documentation and direct care and to assist the teams in focusing on most relevant needs of the individuals. DMH must proceed in a timely manner with the proper implementation of these suggestions. <p>Areas of need include:</p> <ol style="list-style-type: none"> 1. <i>The facility needs to ensure WRPC attendance by the core disciplines. Reduced attendance by certain disciplines was explained by the unique circumstances of the review period, but participation decreased for other disciplines without explanation.</i> 2. <i>The current systems implemented by the facility to address refusals are not consistently implemented and the WRPs are not consistently individualized to address the reason for the refusal.</i>

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1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u> Patricia Tyler, MD, Staff Psychiatrist</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Clinical Chart Auditing Form summary data (June to November 2010) 2. NSH WRP Observation Monitoring summary data (June to November 2010) 3. NSH WRP Team Facilitator Observation Monitoring Form summary data (June to November 2010) 4. NSH data regarding staffing ratios on admissions and long-term units (June to November 2010) 5. WRP Conference Schedule for the week of January 24 - 28, 2011 <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit T6) for quarterly review of YL 2. WRPC (Program II, unit T1) for monthly review of RA 3. WRPC (Program II, unit T15) for quarterly review of AS 4. WRPC (Program II, unit T2) for 7 day review of JAZ 5. WRPC (Program III, unit T14) for monthly review of RR 6. WRPC (Program III, unit T14) for quarterly review of RW 7. WRPC (Program III, unit T15) for quarterly review of DFR 8. WRPC (Program IV, unit A10) for quarterly review of EH 9. WRPC (Program IV, unit A4) for monthly review of HV 10. WRPC (Program IV, unit A8) for monthly review of AN 11. WRPC (Program V, unit Q9) for monthly review of SLS 12. WRPC (Program V, unit T3) for quarterly review of AGB 13. WRPC (Program V, unit T4) for monthly review of SE

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<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period. • Continue to monitor this requirement. <p>Findings:</p> <p>The following is a summary of the facility's training and mentoring activities during this review period:</p> <ol style="list-style-type: none"> 1. In October 2010, Debbie McKinney, MD, NSH WRP Master Trainer trained two newly appointed Senior Psychiatrists, including the Acting Assistant Medical Director, individually in two-hour mentoring sessions covering both the process and content of the WRP. From August 2010 through January 2011, Dr. McKinney trained each newly hired Psychologist and Psychiatrist for a minimum of three hours in individualized training sessions with a focus on the clinical content of the WRP document. In addition, when clinically indicated Dr. McKinney worked directly with staff who required additional mentoring to improve performance. Dr. McKinney has since resigned as a WRP Master Trainer. 2. The facility has moved all WRP ongoing mentoring activities from WRP Master Trainers and Senior Mentors to the Program seniors from the core disciplines. 3. The Discipline Seniors provided mentoring to the clinicians in their respective programs and the WRP Master Trainers continued to support the seniors in this role. The WRPTs have received direct feedback utilizing Plato data regarding WRP content and process issues specific to each team. In this venue, the WRP Master Trainers analyzed audit results and met with the WRPTs to identify and remedy problem areas. The appropriate Seniors were included in this process. 4. The NSH Chart Project, which involved intensive review of 24 medical
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		<p>records per program per month, was discontinued at the end of the last review period as this degree of oversight was no longer deemed necessary.</p> <ol style="list-style-type: none"> 5. The facility continued to use the previously described WRP Handouts of March 15, 2010 as a teaching tool and the WRP Access Database (by Psychiatry Seniors) to track and mentor the clinical performance of NSH's psychiatrists. 6. Several "Focus of the Week" topics on Risk Management and Nursing Documentation statements were provided. 7. NSH was in the process of collaborating with DMH in the implementation of a WRP streamlining project intended to decrease duplication of information, more clearly match frequency of conferences to clinical needs of individuals and improve the focus of the content of WRPs to clinically relevant treatment planning. The facility submitted proposals for WRP streamlining in February and August 2010. 8. An interdisciplinary group of NSH WRPT members met with the Court Monitor on December 14 to discuss further streamlining suggestions. <p>Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPCs held each month (June-November 2010):</p> <table border="1" data-bbox="982 1040 1877 1377"> <tr> <td data-bbox="982 1040 1075 1192">1.</td> <td data-bbox="1075 1040 1780 1192"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1780 1040 1877 1192">99%</td> </tr> <tr> <td data-bbox="982 1192 1075 1377">2.</td> <td data-bbox="1075 1192 1780 1377"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1780 1192 1877 1377">94%</td> </tr> </table>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	99%	2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	94%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	99%						
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		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>Other findings: The monitor and his experts attended 13 WRPCs. There was evidence of adequate process in 10 meetings, which is sufficient to maintain substantial compliance with this requirement. However, the facility must address significant decline in the process of the conference in three meetings (AG, EH and RW) as evidenced by inadequate team leadership, lack of review of progress towards discharge criteria and substandard interviewing skills by some core members.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue to monitor this requirement. 3. Ensure that the departure of the Senior Master WRP Trainer, Dr. McKinney, does not result in a decline in the quality of WRP mentoring. 4. Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Improve attendance by team psychiatrists in the WRPCs. • Continue to monitor this requirement. <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 100% based on an average sample of 16% of the</p>

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		<p>quarterly and annual WRPCs held each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 100% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 560 1879 901"> <tr> <td data-bbox="982 560 1081 636">1.</td> <td data-bbox="1081 560 1785 636"><i>The team psychiatrist was present during the WRP conference.</i></td> <td data-bbox="1785 560 1879 636">91%</td> </tr> <tr> <td data-bbox="982 636 1081 747">2.</td> <td data-bbox="1081 636 1785 747"><i>The team facilitator encouraged meaningful participation of all disciplines present during the conference in a professional manner.</i></td> <td data-bbox="1785 636 1879 747">99%</td> </tr> <tr> <td data-bbox="982 747 1081 823">3.</td> <td data-bbox="1081 747 1785 823"><i>The discussion of the clinical data is substantially incorporated into the Present Status section.</i></td> <td data-bbox="1785 747 1879 823">98%</td> </tr> <tr> <td data-bbox="982 823 1081 901">4.</td> <td data-bbox="1081 823 1785 901"><i>The interventions reviewed were linked to the objectives.</i></td> <td data-bbox="1785 823 1879 901">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for items 2, 3 and 4 and improved compliance for item 1 from 81% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present during the WRP conference.</i>	91%	2.	<i>The team facilitator encouraged meaningful participation of all disciplines present during the conference in a professional manner.</i>	99%	3.	<i>The discussion of the clinical data is substantially incorporated into the Present Status section.</i>	98%	4.	<i>The interventions reviewed were linked to the objectives.</i>	95%
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4.	<i>The interventions reviewed were linked to the objectives.</i>	95%												
C.1.c	Function in an interdisciplinary fashion.	Current findings on previous recommendation:												

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		<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 99% based on an average sample of 16% of the quarterly and annual WRPCs held each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Assess and address the decrease in compliance since the previous review period. <p>Findings: Using the DMH WRP Clinical Chart Audit, NSH reported a compliance rate of 99% based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 96% based on an average sample of 16% of the quarterly and annual WRPCs held each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 99% for the review period, based on a 16% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that NSH has maintained a</p>

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		<p>compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPCs held each month during the review period (June-November 2010). The compliance rate was 97% for the indicator regarding the team identifying someone to be responsible for implementing this requirement. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p>

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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.

Findings:

NSH presented core WRPT member attendance data based on an average sample of 16% of quarterly and annual WRPCs held during the review period (June-November 2010):

	Previous review period	Current review period
Individual	85%	87%
Psychiatrist	83%	79%
Psychologist	82%	76%
Social Worker	80%	77%
Rehabilitation Therapist	84%	79%
Registered Nurse	96%	95%
Psychiatric Technician	89%	82%

Other findings:

The facility assessed the decrease in attendance at WRPCs for most disciplines and found that Rehabilitation Therapists and Nursing Staff attended fewer conferences due to the suspension of Grounds Access Cards on October 23, 2010 and the subsequent requirement that all individuals have staff escort to attend off-unit Mall services and medical appointments. These measures were implemented as necessary corrective actions to address a sentinel event involving an individual who fatally assaulted a staff member while on ground privileges. Regarding attendance by Psychiatric Technicians, the facility reported that it did not have sufficient staff to attend the conferences and at the same time provide necessary presence on the unit to ensure safety. In an effort to ensure implementation of this requirement while addressing safety concerns, the facility initiated a requirement to complete a PT/LVN WRP Preparation Worksheet to provide necessary disciplinary input when the PT/LVN is unable to attend the WRPC.

NSH did not address the reasons for decreased attendance by

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		<p>Psychiatrists, Psychologists and Social Workers at the WRPCs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Address decreased attendance by Psychiatrists, Psychologists and Social Workers. 																																				
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Continue efforts to ensure that staffing ratios are met. <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="982 894 1669 1390"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:28</td> <td>1:27</td> </tr> <tr> <td>PhDs</td> <td>1:34</td> <td>1:35</td> </tr> <tr> <td>SWs</td> <td>1:31</td> <td>1:29</td> </tr> </tbody> </table>		Previous review period	Current review period	Admission Units			MDs	1:15	1:15	PhDs	1:15	1:15	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:15	1:15	PTs	1:15	1:15	Long-Term Units			MDs	1:28	1:27	PhDs	1:34	1:35	SWs	1:31	1:29
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		<table border="1" data-bbox="982 190 1669 306"> <tr> <td>RTs</td> <td>1:29</td> <td>1:27</td> </tr> <tr> <td>RNs</td> <td>1:22</td> <td>1:22</td> </tr> <tr> <td>PTs</td> <td>1:22</td> <td>1:22</td> </tr> </table> <p>The data showed improved ratios for Social Workers and Rehabilitation Therapists since the last review, and a modestly improved ratio for Psychiatrists. The facility attributed ongoing difficulty with the ratios for Psychologists to continued delay in hiring freeze exemptions, continued mandated furloughs and increased retirements. However, NSH also reported that the frequency of mandated furloughs were decreased for most bargaining units from three times a month to once a month and that the facility was working with DMH to improve safety at the hospital, which is anticipated to enhance recruitment, retention and morale.</p> <p>Compliance: Substantial. Although NSH continued to have difficulty with the ratios for Psychologists on long-term units, it appeared that this is due primarily to factors beyond the facility's control and that this has not affected their ability to serve the needs of the individuals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Continue corrective measures to improve staffing ratios in long-term units. 	RTs	1:29	1:27	RNs	1:22	1:22	PTs	1:22	1:22
RTs	1:29	1:27									
RNs	1:22	1:22									
PTs	1:22	1:22									
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as C.1.a through C.1.f.</p> <p>Findings: Same as C.1.a through C.1.f.</p>									

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		<p>Compliance: Same as C.1.a through C.1.f.</p> <p>Current recommendation: Same as C.1.a through C.1.f.</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following individual: RD 2. Alice Rivera, RN, SL 3. Amy Davis, LCSW, Coordinator of Substance Recovery Services 4. Beverly Lynn, Acting Senior Rehabilitation Therapist 5. Blea Caernare, RN 6. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 7. Carmen Caruso, Clinical Administrator 8. Deena Rosen, Assistant Director of Dietetics 9. Dolly Matteucci, Interim Executive Director 10. Elsa Nunez, PT 11. Emiko Taki, Clinical Dietitian 12. Gary Silgan 13. Heidi Vogelsang, Clinical Dietitian 14. James Young, MD, Acting Assistant Medical Director 15. Jennie Gilmore, Acting Senior Rehabilitation Therapist 16. Jennifer Deterville, Acting Senior Rehabilitation Therapist 17. Jessica Tuttle, Clinical Dietitian 18. Jonathan Berry, MD, Acting Senior Psychiatrist 19. Josh Slater, PsyD, Mall Director, Senior Psychologist 20. Kathryn Ballatore, Clinical Dietitian 21. Katie Cooper, PsyD, Mall Director 22. Kristen Perkins, PhD, Psychologist 23. Kumiko Kato, Clinical Dietitian 24. Laufey Gunnarsdottir, Clinical Dietitian 25. Linderpal Dhillon, Clinical Dietitian 26. Lynn Wurzel, Clinical Dietitian 27. Lynne Fredricksen, Assistant Director of Dietetics 28. Marco Barragan, RT, Acting Assistant Chief of CPS

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		<p>29. Mary Lake, SRN T2, Program II 30. Noriko Takenawa, Clinical Dietitian 31. Patricia Tyler, MD, Staff Psychiatrist 32. Phyllis Moore, Acting Senior Rehabilitation Therapist 33. Richard Lesch, PhD, By Choice Coordinator, Senior Psychologist 34. Susan Jette, Acting Senior Rehabilitation Therapist 35. T.C. Hulsey, Mall Coordinator 36. Tony Rabin, PhD, Acting Chief of Psychology</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 157 individuals: AA, AB, ABV, AJL, ALT, ALW, AMC, AN, AR, AS, ASD, ATJ, AW, BFL, BH, BM, BMS, BP, BRT, CCS, CD, CDC, CF, CH, CN, CS, CTS, CW, DC, DD, DEC, DFH, DIB, DJE, DK, DLR, DLT, DMB, DPA, DRM, DSK, DWB, EB, EH, ELH, ES, FBG, FP, GB, GDS, GJC, GLH, HC, HHT, HSD, HV, IEJ, IJ, JB, JCR, JCW, JDG, JE, JEL, JG, JJB, JLA, JLL, JLM, JM, JND, JPM, JS, JT, JVM, JW, KB, KGO, KRL, KS, LAL, LAZ, LB, LCA, LDF, LDJ, LEM, LH, LJ, LJA, LJM, LM, LNE, LP, LSB, MBB, MC, MDB, MK, MKS, MLS, MMG, MMP, MP, MRC, NJ, OJR, PDD, PDR, PHH, PLD, QE, RAS, RCF, RCH, REB, REC, REL, REP, RH, RHH, RJC, RJT, RKG, RLM, RR, RRW, RS, RT, RW, RWH, SAG, SJW, SK, SL, SLH, SM, SRA, SRB, SSM, SV, SWH, TAW, TCK, TM, TMC, TMM, TR, TS, VC, VER, VMM, VR, WAN, WLM, WTZ and YR 2. One WRP per team for the following 51 individuals: AB, ADT, AGG, AJA, AMF, AS, ATW, BRC, CCS, CJ, CMS, CWW, DCA, DP, DTG, DTM, GN, GRP, JBW, JD, JHG, JLM, JMC, JSR, JW, LAP, LIH, LKL, LLM, LNE, LR, MDC, MFK, MSA, PHH, PMA, REL, REP-1, REP-2, RGK, RGR, RHH, RJF, SAG, SRB, SRT, TAW, VMM, WA, WAS, and WLM 3. NSH WRP Observation Monitoring summary data (June to November 2010) 4. NSH Clinical Chart Auditing Form summary data (June to November 2010) 5. NSH Chart Auditing Form summary data (June to November 2010)
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		<ol style="list-style-type: none"> 6. Document comparing current and previous review period; number, hours and types of cognitive remediation groups and summary of process changes. 7. NSH documents regarding Cognitive Rehabilitation Services: <ul style="list-style-type: none"> • Cognitive Rehabilitation Services - Neuropsychology program • Neuropsychology Groups: Quick Reference Guide • Cognitive Rehabilitation Course Outlines, Course Tracks • Cognitive Rehabilitation Services group assignment flow chart, map, referral worksheet • Lesson Plans: Cognitive Awareness: Daily Living Skills, Cognitive Skills Development: Know Your Abilities, Cognitive Rehabilitation: Memory and Learning, Cognitive Rehabilitation: Problem Solving, 8. Lesson Plans for the following Cognitive Remediation Groups: <ul style="list-style-type: none"> • Reality Orientation for FBG • Cognitive Awareness: Daily Living Skills (Lesson plan also used for Cognitive Awareness/News Group) for JE • Coping Skills for JLL • Cognitive Rehabilitation: Memory and Learning for CTS • Cognitive Skills Development for MBB and CD 9. Current WRP with corresponding Focus 1 PSR Mall progress notes for the following six individuals: AA, MFK, PHH, RAS, SAG, and SSM 10. List of Substance Recovery Services groups schedule for the week 11. Explanation of Clinical Outcome for NSH Substance Recovery Services 12. Substance Recovery Maintenance Interview form 13. NSH Staging Questionnaire form 14. Summary data substance abuse process and clinical outcomes 15. NSH Consumer Satisfaction Survey summary data 16. NSH WRP Substance Abuse Auditing Form summary data (June to November 2010) 17. Data regarding medication education groups and individuals enrolled 18. By Choice training data 19. Cognitive Remediation Plans
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		<p>20. Lesson plan for Master Your ADLs for ALW 21. Lesson plans for Substance Abuse Recovery 22. List of enrichment activities offered during this review period 23. List of exercise groups/activities offered during this review period 24. List of individuals who in need of family therapy 25. List of scheduled exercise groups 26. List showing scheduled and cancelled medical appointments 27. PSSC/ETRC Meeting Minutes 28. Review of MAPP lists for Mall hours schedule 29. Supplemental Activity List 30. Supplemental Activity: Training and development roster</p> <p><u>Observed:</u></p> <p>1. PSR Mall Group: Enhancing Motivation/Substance Recovery (pre-contemplative stage) Kristen Perkins, PhD, facilitator 2. PSR Mall Group: Substance Recovery (pre-contemplative/contemplative stage) Wei Lin Ku, Rehabilitation Therapist, facilitator 3. PSR Mall Group: Substance Recovery (preparation/action stage) Jack Aamot, PhD and Michael Glasser, MD, facilitators</p> <p>1. PSR Mall Group: Impulse Control 2. PSR Mall Group: Wellness and Recovery Orientation 3. PSR Mall Group: Understanding Your Mental Illness 4. WRPC (Program 3, unit T14) for review of RR 5. WRPC (Program 3, unit T14) for review of RW 6. WRPC (Program 3, unit T15) for review of AS 7. WRPC (Program 4, unit A8) for review of AN</p>
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 97% based on an average sample of 16% of the WRPCs held each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Same as in C.1.a.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (June-November 2010). Based on an average sample of 20% of the A-WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 20% of the 7-day WRPs, the facility reported a mean compliance rate of 100% with this requirement. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>C.2.b.iii</p>	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 488 1650 716"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>15%</td> <td>100%</td> </tr> <tr> <td>Monthly</td> <td>15%</td> <td>98%</td> </tr> <tr> <td>Quarterly</td> <td>16%</td> <td>100%</td> </tr> <tr> <td>Annual</td> <td>17%</td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for the 14-day, monthly and annual WRP reviews. The compliance rate for quarterly reviews was 88% in the previous period.</p> <p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	15%	100%	Monthly	15%	98%	Quarterly	16%	100%	Annual	17%	99%
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Annual	17%	99%															
<p>C.2.c</p>	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</p>	<p>Current findings on previous recommendations:</p>															

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	<p>thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> Continue to monitor this requirement. Provide a summary of the number and type of group interventions that address cognitive impairment during the review period compared to the last review period. Include information regarding any qualitative changes in the content of these interventions during the review period. <p>Findings: NSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 23% to 85% of the relevant population for each sub-indicator during the review period (June-November 2010).</p> <table border="1" data-bbox="991 711 1885 1230"> <tr> <td data-bbox="991 711 1087 894">2.</td> <td data-bbox="1087 711 1791 894"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 711 1885 894">95%</td> </tr> <tr> <td data-bbox="991 894 1087 1008">2.a</td> <td data-bbox="1087 894 1791 1008"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 894 1885 1008">95%</td> </tr> <tr> <td data-bbox="991 1008 1087 1122">2.b</td> <td data-bbox="1087 1008 1791 1122"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1008 1885 1122">94%</td> </tr> <tr> <td data-bbox="991 1122 1087 1230">2.c</td> <td data-bbox="1087 1122 1791 1230"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1122 1885 1230">96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	95%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	95%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	94%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	96%
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		<p>Other findings:</p> <p>This monitor reviewed the charts of six individuals diagnosed with seizure disorders (BMS, EH, ELH, HHT, LJA and OJR) and eight individuals diagnosed with cognitive impairments (ALW, CD, CTS, FBG, GDS, JE, JLL and MBB). The reviews found that the facility has maintained adequate practice as summarized below:</p> <ol style="list-style-type: none"> 1. The WRPTs reviewed the seizure activity during the interval in all cases; 2. The objectives for individuals receiving old-generation anticonvulsant medications emphasized the side effects of treatment, when appropriate; 3. The objectives addressed compliance with treatment, as clinically applicable; 4. The objectives for individuals with seizure disorders addressed factors that trigger seizure activity; 5. The interventions related to seizure management were adequately linked to the treatment objectives; 6. The WRPTs reviewed the cognitive status of individuals diagnosed with cognitive impairments in all cases; 7. In general, the objectives related to cognitive impairments were appropriate to the individual's needs; 8. Almost all individuals diagnosed with cognitive impairments were assigned to groups that offered formal or informal cognitive remediation or social skill training as appropriate; 9. The lesson plans for the above-mentioned groups were appropriate to the individuals' needs; and 10. Individuals with cognitive impairments were referred to and received adequate neuropsychological testing as indicated. <p>The review found that the WRPs did not address the cognitive disorder in an individual diagnosed with Cognitive Disorder NOS (JLL) and another individual diagnosed with Mental Retardation (GDS). In the case of JLL,</p>
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		<p>the WRP included a treatment objective that did not appear to be appropriate to the individual's clinical status.</p> <p>This monitor reviewed the facility's data regarding the number and hours of cognitive rehabilitation groups and lesson plans of groups offered to some individuals who suffered from cognitive impairments. The number of total offerings was 89 (107 hours) in November 2010 compared to 86 (104 hours) in July 2010.</p> <p>The core groups consisted of the following:</p> <ol style="list-style-type: none">1. Cognitive Awareness;2. Cognitive Skills Development;3. Cognitive Rehabilitation: Memory and Learning;4. Cognitive Rehabilitation: Problem Solving; and5. New Start Program. <p>Other groups that include a cognitive skill training component included Academic offerings, Life Skills: Choices (an extension of the New Start Curriculum) and specified reality orientation groups offered by providers with relevant skills.</p> <p>The review found that NSH continued to provide adequate services to its individuals in need of cognitive interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to monitor this requirement.2. Provide a summary of changes in the number, range and content of cognitive rehabilitation interventions during the review period
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C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	Compliance: Substantial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH reported a compliance rate of 100% based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Other findings: This monitor reviewed one WRP per team for the following 51 individuals: AB, ADT, AGG, AJA, AMF, AS, ATW, BRC, CCS, CJ, CMS, CWW, DCA, DP, DTG, DTM, GN, GRP, JBW, JD, JHG, JLM, JMC, JSR, JW, LAP, LIH, LKL, LLM, LNE, LR, MDC, MFK, MSA, PHH, PMA, REL, REP-1, REP-2, RGK, RGR, RHH, RJF, SAG, SRB, SRT, TAW, VMM, WA, WAS, and WLM. The review found general evidence of substantial compliance with this requirement of the EP.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	97%. Comparative data indicated improvement from 86% in the previous review period.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.

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<p>C.2.e</p>	<p>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, NSH reported a compliance rate of 99% based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the records of 13 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.e. Twelve records were in substantial compliance (JJB, KGO, KRL, LDJ, LSB, NJ, QE, REP, RJC, SM, SRB and SV) and one record was in partial compliance (TAW).</p> <p>This monitor also reviewed the records of 15 individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Thirteen records were in substantial compliance (ATJ, BH, CF, CN, DRM, LNE, MKS, MRC, RCF, REC, RH, WTZ and YR) and two records were not in compliance (BF and JCR).</p> <p>Finally, this monitor reviewed the records of 15 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p>
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, NSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (June-November 2010). The facility reported a mean compliance rate of 100% with the requirement of this cell. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AB, JPM, RAS, RLM, SAG and SSM). The review found substantial compliance in all cases.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals (AB, JPM, RAS, RLM, SAG and SSM) found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p>

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		<p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AB, JPM, RAS, RLM, SAG and SSM). The review found substantial compliance in five charts and partial compliance in one (RAS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Chart reviews found substantial compliance in four charts (AB, JPM, RAS and RLM) and partial compliance in two (SAG and SSM).</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Chart reviews found substantial compliance in all cases (AB, JPM, RAS, RLM, SAG and SSM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH presented the following data for the review period (June through November 2010):</p>

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		<table border="1"> <thead> <tr> <th colspan="3">Number of individuals by category</th> </tr> <tr> <th></th> <th>Mean scheduled hours</th> <th>Mean attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1143</td> <td>1143</td> </tr> <tr> <td>Hours:</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>55</td> <td>560</td> </tr> <tr> <td>6-10</td> <td>271</td> <td>292</td> </tr> <tr> <td>11-15</td> <td>437</td> <td>226</td> </tr> <tr> <td>16-20</td> <td>380</td> <td>73</td> </tr> </tbody> </table>		Number of individuals by category				Mean scheduled hours	Mean attended hours	N	1143	1143	Hours:			0-5	55	560	6-10	271	292	11-15	437	226	16-20	380	73
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		<table border="1"> <thead> <tr> <th colspan="3">Mall Attendance</th> </tr> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>478</td> <td>560</td> </tr> <tr> <td>6-10 hours</td> <td>276</td> <td>292</td> </tr> <tr> <td>11-15 hours</td> <td>270</td> <td>226</td> </tr> <tr> <td>16-20+ hours</td> <td>107</td> <td>73</td> </tr> </tbody> </table>		Mall Attendance				Previous period	Current period	Mean number of individuals			0-5 hours	478	560	6-10 hours	276	292	11-15 hours	270	226	16-20+ hours	107	73			
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		<p>The data in the tables above show a reduction in the hours scheduled and attended in comparison with the previous review period. This reduction in scheduled and attended hours at the higher category (11 hours to 20 hours) was due to the challenges NSH faced in holding Mall groups and in having individuals transition to Mall hours, due to staff and patient safety concerns from a death in the facility due to violence.</p> <p>This monitor reviewed the charts of nine individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found a very high correspondence between the Mall hour scheduled in the individuals' WRPs and the MAPP data. The following table summarizes the monitor's findings:</p>																									

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		<table border="1" data-bbox="991 228 1604 647"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> </tr> </thead> <tbody> <tr> <td>ALW</td> <td>15</td> <td>14</td> </tr> <tr> <td>ASD</td> <td>11</td> <td>11</td> </tr> <tr> <td>DMB</td> <td>10</td> <td>10</td> </tr> <tr> <td>JDG</td> <td>9</td> <td>10</td> </tr> <tr> <td>JVM</td> <td>13</td> <td>13</td> </tr> <tr> <td>MMG</td> <td>14</td> <td>14</td> </tr> <tr> <td>MMP</td> <td>9</td> <td>9</td> </tr> <tr> <td>RWH</td> <td>19</td> <td>19</td> </tr> <tr> <td>VER</td> <td>10</td> <td>10</td> </tr> </tbody> </table> <p data-bbox="991 691 1864 797">NSH assigns individuals to Mall programming using a graduated system ensuring that the hours conform to the individual's mental status and physical health.</p> <p data-bbox="991 841 1140 906">Compliance: Substantial.</p> <p data-bbox="991 950 1457 1015">Current recommendation: Continue to monitor this requirement.</p>	Individual	WRP scheduled hours	MAPP scheduled hours	ALW	15	14	ASD	11	11	DMB	10	10	JDG	9	10	JVM	13	13	MMG	14	14	MMP	9	9	RWH	19	19	VER	10	10
Individual	WRP scheduled hours	MAPP scheduled hours																														
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MMG	14	14																														
MMP	9	9																														
RWH	19	19																														
VER	10	10																														
C.2.f.vii	<p data-bbox="373 1062 966 1279">maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p data-bbox="991 1062 1577 1094">Current findings on previous recommendation:</p> <p data-bbox="991 1138 1457 1203">Recommendation, July 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1247 1885 1424">Findings: Using the DMH WRP Chart Auditing Form, NSH assessed its compliance based on a mean sample of 85% of individuals eligible for off-site PSR Mall activities in the review period (June through November 2010), and reported a mean compliance rate of 95%. Comparative data indicated</p>																														

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that NSH maintained a compliance rate of at least 90% from the previous review period.

A review of the charts of six individuals who were admitted under civil commitment found substantial compliance in all six (AW, BM, HC, LJ, MK and TS):

ID	Off-site program	Psychiatric diagnoses	Status
AW	Yes	Schizophrenia, hypertension	
BM	No	Elopement, schizo-affective, substance abuse, suicide risk	Safety issues
HC	No	Schizoaffective, BPD, walks around in diaper, aggression	In community re-entry program. Team is waiting for individual to learn skills before off-site program
LJ	No	Dementia, epilepsy, aggression, head injury, hydrocephalus	Not appropriate for off-site program
MK	No	Aggression, dyskinesia	Safety issues
TS	Yes	Schizophrenia, elopement, voyeurism	

The table above shows that two of the six individual are in off-site learning programs. The remaining four currently have one or more challenging and/or safety issues. One of these individuals is in preparation for off-site programming when challenging behaviors have improved; it is doubtful that off-site activities can be appropriate for the others.

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on a mean sample of 18% of the quarterly and annual WRPs due each month for the review period (June through November 2010), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of ten individuals found substantial compliance in nine (AW, BM, FP, HC, JG, JM, LJ, LM and VR) and partial compliance in one (TS).</p> <p>Compliance: Substantial</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of</p>	<p>Please see sub-cells for compliance findings.</p>

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	identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: A review of the charts of six individuals (AB, JPM, PHH, RAS, SAG and SSM) found substantial compliance in the five cases to which this requirement was applicable (AB, JPM, PHH, RAS and SAG).</p> <p>This monitor also reviewed the records of six individuals receiving direct therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently	Current findings on previous recommendation:

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	<p>if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 97% based on an average sample of 100% of individuals placed in seclusion and/or restraints each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the documentation in the WRP Present Status section of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The following table outlines the chart reviews:</p> <table border="1" data-bbox="991 857 1906 1198"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> <th>Date of psychiatric progress note</th> </tr> </thead> <tbody> <tr> <td>ABV</td> <td>11/20/10</td> <td>11/30/10</td> <td>11/20/10</td> </tr> <tr> <td>DFH</td> <td>10/14/10</td> <td>10/22/10</td> <td>10/28/10</td> </tr> <tr> <td>DLT</td> <td>10/8/10</td> <td>10/12/10</td> <td>10/8/10</td> </tr> <tr> <td>LDJ</td> <td>11/30/10</td> <td>12/7/10</td> <td>11/30/10</td> </tr> <tr> <td>RRW</td> <td>11/29/10</td> <td>12/16/10</td> <td>11/29/10</td> </tr> <tr> <td>RT</td> <td>11/30/10</td> <td>12/15/10</td> <td>11/30/10</td> </tr> </tbody> </table> <p>The review found substantial compliance in five charts and partial compliance in one (ABV).</p> <p>Compliance: Substantial.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	Date of psychiatric progress note	ABV	11/20/10	11/30/10	11/20/10	DFH	10/14/10	10/22/10	10/28/10	DLT	10/8/10	10/12/10	10/8/10	LDJ	11/30/10	12/7/10	11/30/10	RRW	11/29/10	12/16/10	11/29/10	RT	11/30/10	12/15/10	11/30/10
Individual	Date of seclusion and/or restraint	Date of applicable WRP review	Date of psychiatric progress note																											
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LDJ	11/30/10	12/7/10	11/30/10																											
RRW	11/29/10	12/16/10	11/29/10																											
RT	11/30/10	12/15/10	11/30/10																											

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 98% based on an average sample of 16% of the quarterly and annual WRPCs held each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AB, JPM, PHH, RAS, SAG and SSM). The review focused on the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). There was evidence of substantial compliance in five charts (AB, JPM, PHH, RAS and SAG). The documentation of the team's discussion of progress towards discharge was not applicable in the chart of SSM, who was newly admitted to the facility.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs. <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 96% based on an average sample of 16% of the quarterly and annual WRPCs each month during the review period. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in four (JPM, RAS, SAG and SSM) and partial compliance in two (AA and PHH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p>Compliance: Substantial.</p>

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<p>C.2.i.i</p>	<p>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 100% of quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 16 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in 13 of the WRPs in the charts (FP, IEJ, JG, JM, JND, LB, LM, MC, RAS, RW, TM, TMM and VR). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining three WRPs (AA, ALW and JDG).</p> <p>Other findings: This monitor reviewed the records of 13 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Audit Form, NSH assessed its compliance based on an average sample of 16% of quarterly and annual WRPs due each month during the review period (June through November 2010):</p> <table border="1" data-bbox="991 561 1887 673"> <tr> <td data-bbox="991 561 1087 673"></td> <td data-bbox="1087 561 1793 673"><i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i></td> <td data-bbox="1793 561 1887 673">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that all six of the WRPs in the charts contained objectives written in a measurable/observable manner (DJE, DLT, JDG, MMP, RW and VER).</p> <p>A review of the records of 11 individuals found that the objectives in eight of the WRPs in the charts were directly linked to a relevant focus of hospitalization (DJE, DLT, JDG, JVM, MMP, RW, RWH and VER) and one or more objectives were not directly linked to a focus in three WRPs (ALW, RAS, and TMM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	99%
	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	99%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p>			

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		<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.f.viii.</p> <p>Current recommendation: See C.2.f.viii.</p>			
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 8% of Mall group facilitators each month during the review period (June through November 2010):</p> <table border="1" data-bbox="993 894 1887 971"> <tr> <td data-bbox="993 894 1087 971">15.</td> <td data-bbox="1087 894 1793 971"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 894 1887 971">99%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor observed five Mall groups (Substance Recovery, Enhancing Motivation, Pre-contemplation; Substance Recovery, Pre-Contemplation and Contemplation; Impulse Control; Wellness and Recovery Orientation; and Understanding Your Mental Illness). The providers in these groups were aware of the strengths of the individuals in their groups (most of the providers were also WRPT members of the individuals attending their groups), and were able to state them to this monitor when questioned on specific individuals.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	99%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	99%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on an average sample of 18% of quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 98%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of five individuals found that the individual's vulnerabilities were documented in the case formulation section in all five of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (FP, JG, JM, LM and VR). One of the vulnerabilities cited across individuals is medication non-adherence.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Facilitator Mall Observation Monitoring Form, NSH assessed its compliance based on an average sample of 8% of the Mall</p>

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		<p>group facilitators each month during the review period (June through November 2010), and reported a mean compliance rate of 97%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that cognitive screening had been conducted in six cases as part of the Integrated Assessment: Psychology Section or as part of a Neuropsychological assessment (AN, AS, DC, DLT, RR and RW). Cognitive screening had not been conducted for the remaining three individuals (CH, CS and DJE) because they were unable or unwilling to participate in the screening/testing.</p> <p>A review of the documented cognitive levels of six individuals (AS, AN, TM, RR, RW, and DC) and Mall groups listed in their Mall schedules found that all six individuals were enrolled in Mall groups serving individuals at the relevant cognitive levels.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported the following data, where N equals the number of progress notes due for 20% of the individuals in each Program for November 2010 and n equals the number of progress notes received by the WRPTs:</p>

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		<table border="1" data-bbox="991 228 1793 383"> <thead> <tr> <th></th> <th>P1</th> <th>P2</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>720</td> <td>774</td> <td>818</td> <td>640</td> <td>644</td> <td>719</td> </tr> <tr> <td>n</td> <td>590</td> <td>658</td> <td>736</td> <td>589</td> <td>547</td> <td>624</td> </tr> <tr> <td>%C</td> <td>82</td> <td>85</td> <td>90</td> <td>92</td> <td>85</td> <td>87</td> </tr> </tbody> </table> <p data-bbox="991 427 1906 529">A review of the charts of five individuals found that all five contained progress notes (CS, DJE, DLT, MMP and RW), and the progress notes had been reviewed and incorporated into the Present Status of their WRPs.</p> <p data-bbox="991 573 1906 824">Other findings: This monitor reviewed the records of 13 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.vii. Twelve records were in substantial compliance (JJB, KGO, KRL, LDJ, LSB, NJ, QE, REP, RJC, SM, SRB and SV) and one record was in partial compliance (TAW).</p> <p data-bbox="991 868 1457 935">Current recommendation: Continue to monitor this requirement.</p>		P1	P2	P3	P4	P5	Mean	N	720	774	818	640	644	719	n	590	658	736	589	547	624	%C	82	85	90	92	85	87
	P1	P2	P3	P4	P5	Mean																								
N	720	774	818	640	644	719																								
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C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	<p data-bbox="991 984 1577 1011">Current findings on previous recommendation:</p> <p data-bbox="991 1055 1360 1122">Recommendation, July 2010: Continue current practice.</p> <p data-bbox="991 1166 1906 1308">Findings: NSH continues to provide PSR Mall services. However, it is apparent that the facility has made some significant short-term changes to address issues caused by the recent event at the facility.</p> <p data-bbox="991 1352 1906 1419">The table below shows the hours of Mall Groups provided by the facility during this review period. The hours had dropped for the months of</p>																												

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		<p>October and November, but has picked up in December.</p> <table border="1" data-bbox="1003 264 1837 456"> <thead> <tr> <th colspan="8">Hours of Mall Groups PROVIDED</th> </tr> <tr> <th></th> <th>June</th> <th>July</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1146</td> <td>1140</td> <td>1137</td> <td>1141</td> <td>1147</td> <td>1145</td> <td>1143</td> </tr> <tr> <td>Hours provided</td> <td>1892</td> <td>1972</td> <td>1894</td> <td>1898</td> <td>1423</td> <td>1009</td> <td>1681</td> </tr> </tbody> </table> <p>The facility was forced to cut back on providing the maximum hours scheduled due to the staffing shortage caused by the need to use staff to escort individuals during transition from their units for whatever reason, and according to the Mall Director at times two staff were needed to transition one individual.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Hours of Mall Groups PROVIDED									June	July	Aug	Sept	Oct	Nov	Mean	N	1146	1140	1137	1141	1147	1145	1143	Hours provided	1892	1972	1894	1898	1423	1009	1681
Hours of Mall Groups PROVIDED																																		
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Hours provided	1892	1972	1894	1898	1423	1009	1681																											
C.2.i.ix	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Ensure that bed-bound individuals receive appropriate services per EP requirements including hours of services.</p> <p>Findings: Treatment offered to bed-bound individuals is adapted to available means of communication, e.g., sustained eye contact, non-verbal cues. Course objectives are made appropriate to the individual's current abilities and realistic goals including increasing sustained attention, developing adaptive functioning, and gaining or maintaining orientation. Bed-bound individuals are offered supplemental activities at their bedside.</p> <p>A review of the documentation for the two individuals (ES and HV) presented as being "bed-bound" found that these two individuals were on</p>																																

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		<p>bed-bound status during changing health conditions for short periods. Chart review data was in agreement with the facility's findings. These two individuals were not in a bed-bound condition during this monitor's visit. Chart reviews of these individuals found that they had been participating in regular Mall hours outside of their short-term bed-bound status.</p> <table border="1" data-bbox="991 451 1885 594"> <thead> <tr> <th colspan="8">Monthly Hours of Active Treatment Scheduled/Delivered</th> </tr> <tr> <th>Individual</th> <th>6/10</th> <th>7/10</th> <th>8/10</th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>ES</td> <td>-</td> <td>0</td> <td>1</td> <td>-</td> <td>-</td> <td>-</td> <td></td> </tr> <tr> <td>HV</td> <td>-</td> <td>-</td> <td>16</td> <td>-</td> <td>1</td> <td>7</td> <td>6</td> </tr> </tbody> </table> <p>Current recommendation: Continue to monitor this requirement.</p>	Monthly Hours of Active Treatment Scheduled/Delivered								Individual	6/10	7/10	8/10	9/10	10/10	11/10	Mean	ES	-	0	1	-	-	-		HV	-	-	16	-	1	7	6
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ES	-	0	1	-	-	-																												
HV	-	-	16	-	1	7	6																											
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Ensure that Mall group activities routinely take place as scheduled.</p> <p>Findings: NSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 1040 1915 1305"> <thead> <tr> <th></th> <th>6/10</th> <th>7/10</th> <th>8/10</th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>1856</td> <td>1929</td> <td>1937</td> <td>1902</td> <td>1920</td> <td>1905</td> <td>1908</td> </tr> <tr> <td>Groups cancelled</td> <td>464</td> <td>308</td> <td>271</td> <td>266</td> <td>365</td> <td>819</td> <td>416</td> </tr> <tr> <td>Cancellation rate</td> <td>25%</td> <td>16%</td> <td>14%</td> <td>14%</td> <td>19%</td> <td>43%</td> <td>22%</td> </tr> </tbody> </table> <p>As shown in the table above, the mean PSR Mall cancellation for this review period was 22%. There was a very high cancellation rate of 43%.</p>		6/10	7/10	8/10	9/10	10/10	11/10	Mean	Groups scheduled	1856	1929	1937	1902	1920	1905	1908	Groups cancelled	464	308	271	266	365	819	416	Cancellation rate	25%	16%	14%	14%	19%	43%	22%
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for the month of November. Still the mean rate of 22% is lower than the 32% cancellation rate in the previous review period. NSH plans to normalize Mall operations as soon as possible.

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

Average weekly hours provided by discipline		
	Previous review period	Current review period
Psychiatry Admissions (2)	2	2
Psychiatry Long-Term (4)	2	2
Psychology Admissions (5)	3	3
Psychology Long-Term (10)	3	4
Social Work Admissions (5)	2	3
Social Work Long-Term (10)	4	4
Rehab Therapy Admissions (7)	4	6
Rehab Therapy Long-Term (15)	7	11
Nursing (10)	2	2
Administration (?)		

Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled
Psychiatry	113	59	52%
Psychology	239	133	56%
Social Work	285	167	59%
Rehab Therapy	474	339	72%
Nursing	961	629	65%
Other	1026	713	69%
Administration	113	59	52%

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		<p>As shown in the table above, Mall group provision by the various disciplines ranged between 52% and 72%. According to the Mall Director, there has been a chronic shortage of staff for Mall provision due to the homicide event at the facility. NSH modified the Mall session beginning in October 2010 owing to the need for staff to escort individuals in transition from their units to Mall group settings. Currently, only a few core specialty groups are held in the Central Mall areas (examples of groups held in Central Mall areas are Substance Abuse and Spanish Education). Two hundred individuals in both the AM and PM Mall schedules are escorted to and from the individual's residence and Mall areas. Meanwhile, the rest are provided Mall groups within self contained units (e.g. admission, geriatric, and Program 4).</p> <p>Recommendation 2, July 2010: Implement the plan to assist individuals not going to assigned treatment activities.</p> <p>Findings: According to NSH, a number of steps were being taken to address PSR Mall non-adherence, including the following:</p> <ul style="list-style-type: none"> • Meeting with individuals and WRPT staff members during office hours; • Non-adherence list distributed monthly to CMT members; • WRPTs scheduling Mall hours according to the individual's readiness; • Utilization of privileges as incentive to participate in Mall groups (e.g. Grounds Access); and • Ensure that individuals have a personal copy of their Mall schedules. <p>The facility presented the following data on individuals non-adherent to treatment (i.e. individuals who fail to attend their scheduled Mall hours for 30 days):</p>
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Number of Individuals Non-Adherent to the WRP							
	Jun	July	Aug	Sep	Oct	Nov	Mean
Avg Monthly Census	1146	1142	1143	1144	1144	1153	1145
Zero Attendance	75	68	88	80	80	99	82
%C	7%	6%	8%	7%	7%	9%	7%

NSH did not present data on how many individuals reflected in the 7% non-adherence rate are being served through various strategies to motivate them to attend their PSR Mall groups. NSH's progress report indicated that 23 individuals were enrolled in Narrative Restructuring Therapy (NRT), as presented in C.2.w. That still leaves out services for the remaining 59 individuals. Furthermore, there must be individuals who aren't attending Mall groups regularly but have not met the trigger threshold. NSH should track, monitor, and provide services to all individuals meeting the trigger threshold. In addition, NSH should analyze the reasons for the individual's non-adherence and match interventions to their reasons/functions. For example, a number of steps taken by NSH to address Mall attendance might serve some individuals and not others (i.e. giving individuals schedules will only help those who do not know their group types, times, and location, and giving privileges will only assist individuals who lack the motivation to attend their groups; these two steps might not be effective with those who do not see the benefit of the group or have attended the groups previously at NSH or at another facility), thus it is important to identify reasons for non-adherence. WRPTs tend to simply state that an individual does not attend groups (e.g. ASD) and this is unsatisfactory. NSH should train WRPTs to document the reason(s) an individual is not attending his/her Mall groups (reasons as identified by the staff or given by the individual) in the Present Status section of the individual's WRP. Such information will assist in addressing non-adherence.

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		<p>Current recommendation: Ensure that Mall group activities routinely take place as scheduled.</p>																																
C.2.i.xi	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: Staff interview found that NSH had to make a number of adaptations to its supplemental and enrichment activities. Activities had to be limited due to the weather and recent events for safety and security issues. However, limited activities resulted in an increase in the number of individuals participating in each activity with the potential for other safety and security concerns (e.g. fire codes). Special event activities (e.g. concerts, dancers, bingo, harp players, etc.) conducted by outside providers (e.g. volunteers) were affected since all evening activities had to be moved to daytime due to security and safety issues, as these outside providers were working members and were unable to attend during the daytime. No new activities were added and activities were primarily limited to unit-based activities. According to the Supplemental Activity Coordinator, the program does not have any resource issues.</p> <p>The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 1117 1879 1356"> <thead> <tr> <th></th> <th>6/10</th> <th>7/10</th> <th>8/10</th> <th>9/10</th> <th>10/10</th> <th>11/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>2104</td> <td>2153</td> <td>2187</td> <td>2104</td> <td>2215</td> <td>2008</td> <td>2129</td> </tr> <tr> <td>Hours offered</td> <td>2329</td> <td>2353</td> <td>2411</td> <td>2214</td> <td>2453</td> <td>2108</td> <td>2311</td> </tr> <tr> <td>Compliance rate</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> </tr> </tbody> </table>		6/10	7/10	8/10	9/10	10/10	11/10	Mean	Hours scheduled	2104	2153	2187	2104	2215	2008	2129	Hours offered	2329	2353	2411	2214	2453	2108	2311	Compliance rate	>100%	>100%	>100%	>100%	>100%	>100%	>100%
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		<p>Documentation review and staff interview found that NSH continues to provide activities in the evenings and weekend, giving the individuals additional opportunities to enhance their quality of life. Observation found that activity schedules were posted in the units. NSH had presented training to staff in all units on the organization and management of enrichment/supplemental activities.</p> <p>Current recommendation: Continue current practice.</p>																								
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, NSH assessed its compliance based on observations of an average sample of 100% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 971 1885 1421"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>72%</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td>80%</td> </tr> <tr> <td>3.</td> <td><i>There are unit recognition programs.</i></td> <td>90%</td> </tr> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>91%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>93%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>84%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>74%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and</i></td> <td>94%</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	72%	2.	<i>Some staff in the milieu are interacting with individuals, not simply observing them.</i>	80%	3.	<i>There are unit recognition programs.</i>	90%	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	91%	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	93%	6.	<i>Staff respect confidentiality.</i>	84%	7.	<i>Some staff are actively engaged in listening.</i>	74%	8.	<i>Staff interact with individuals in a respectful and</i>	94%
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p>																														

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		<p>Findings: The facility presented the following data:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>242</td> <td>257</td> <td>272</td> <td>262</td> <td>267</td> <td>338</td> </tr> <tr> <td>Number of groups needed @ 1x/wk</td> <td>56</td> <td>62</td> <td>62</td> <td>72</td> <td>75</td> <td>75</td> </tr> <tr> <td>Offered/needed</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> </tr> </tbody> </table> <p>The facility also presented the following data:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>456</td> <td>360</td> <td>78%</td> </tr> <tr> <td>31 - 35</td> <td>274</td> <td>220</td> <td>80%</td> </tr> <tr> <td>36 - 40</td> <td>133</td> <td>111</td> <td>83%</td> </tr> <tr> <td>>40</td> <td>81</td> <td>74</td> <td>91%</td> </tr> </tbody> </table> <p>As the tables above show, NSH offers sufficient number of exercise groups for individuals to participate to improve their health (physical and mental). However, the facility is not enrolling all individuals with high BMIs to exercise groups. NSH should enroll all individuals with high BMIs to one or more exercise groups, or provide the rationale for not doing so (e.g. physical health issues).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Exercise Groups Offered vs. Needed								Jun	Jul	Aug	Sep	Oct	Nov	Number of groups offered	242	257	272	262	267	338	Number of groups needed @ 1x/wk	56	62	62	72	75	75	Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	456	360	78%	31 - 35	274	220	80%	36 - 40	133	111	83%	>40	81	74	91%
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<p>C.2.k</p>	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH C2k Family Therapy Auditing Form, NSH assessed its compliance using the following indicators (size of sample as a percentage of relevant population noted in parentheses):</p> <table border="1" data-bbox="991 561 1885 1157"> <tr> <td data-bbox="991 561 1066 711">1.</td> <td data-bbox="1066 561 1755 711"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1755 561 1885 711">98% (98%)</td> </tr> <tr> <td data-bbox="991 711 1066 935">2.</td> <td data-bbox="1066 711 1755 935"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1755 711 1885 935">100% (19%)</td> </tr> <tr> <td data-bbox="991 935 1066 1157">3.</td> <td data-bbox="1066 935 1755 1157"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1755 935 1885 1157">100% (100%)</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of seven charts (DD, DMB, GB, JT, JVM, JW and MC) found that all individuals and their families with an assessed need family therapy were offered a variety of family therapy activities, once consent</p>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	98% (98%)	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	100% (19%)	3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100% (100%)
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		<p>was obtained. For example, the SW staff is in contact with DMB's grandmother and is providing "educational information to benefit the family system"; staff is also in communication with JVM's sisters to inform about his treatments and changes to his conditions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Include monitoring items that are now included in the IC monitoring tools addressing refusals in the monitoring tool used for auditing all refusals to ensure consistency and quality in the WRPs.</p> <p>Findings: Since the last review, NSH has decided not to assign risk levels for refusals. The facility basically has two systems addressing refusals. The system that addresses refusals for lab work, dental appointments, assessments, and treatments includes the use of the newly implemented Refusal Log, which is kept on each unit and is reviewed by the case managers. When an individual refuses a procedure, the refusal is noted in the Refusal Log and the shift lead is designated to talk with the individual to determine the reason for the refusal and document this on the Refusal Log form. The Case Manager is assigned to take this information to the WRPT so that they can develop strategies to address the refusal. The second system, which the facility uses to address refusals of in-house and outside medical appointments, is through Medical Ancillary Services (MAS). Although done informally, Dr. Rumano reviews all refusals and screens these for any high-risk refusals and alerts the</p>

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		<p>individual's physician and team to these refusals. At the time of the review, there was no formal screening of the Refusal Logs for refusals that had a health risk potential.</p> <p>Recommendation 2, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, NSH assessed its compliance based on a 18% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (June-November 2010):</p> <table border="1" data-bbox="991 672 1887 1049"> <tr> <td data-bbox="991 672 1087 748">1.</td> <td data-bbox="1087 672 1793 748"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1793 672 1887 748">99%</td> </tr> <tr> <td data-bbox="991 748 1087 824">2.</td> <td data-bbox="1087 748 1793 824"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1793 748 1887 824">99%</td> </tr> <tr> <td data-bbox="991 824 1087 901">3.</td> <td data-bbox="1087 824 1793 901"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1793 824 1887 901">99%</td> </tr> <tr> <td data-bbox="991 901 1087 977">4.</td> <td data-bbox="1087 901 1793 977"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1793 901 1887 977">99%</td> </tr> <tr> <td data-bbox="991 977 1087 1049">5.</td> <td data-bbox="1087 977 1793 1049"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1793 977 1887 1049">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the WRPs of 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that NSH has continued to make improvements in this area since the last review from the ongoing training and mentoring. The majority of the WRPs reviewed for Focus 6</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	99%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	99%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	99%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	99%	5.	<i>There are appropriate interventions for each objective.</i>	99%
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		<p>included appropriate objectives and interventions, which comports with NSH's data.</p> <p>NSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p> <table border="1" data-bbox="993 488 1887 599"> <tr> <td data-bbox="993 488 1087 599">6.</td> <td data-bbox="1087 488 1793 599"><i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></td> <td data-bbox="1793 488 1887 599">91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals who refused an appointment (BRT, DIB, GJC, GLH, JS, LCA, LEM, PDR, SLH, SWH, TR and WAN) found that all WRPs contained documentation of the refusal in the Present Status section and an open focus addressing refusals. However, only five WRPs were individualized and addressed the individual's reasons for refusing the appointment (DIB, LEM, PDR, SWH and WAN). The current systems implemented by the facility are very promising, but are not consistently implemented and the WRPs are not consistently individualized to address the reason for the refusal.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementing and formalize facility-wide systems addressing and tracking non-adherence issues. 2. Ensure that WRPs addressing refusals are individualized, address the reason for refusals. 	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	91%
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		3. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation2:</p> <p>Recommendations 1-3, July 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide a summary of any modifications in current Administrative Directives and/or procedures that address the screening of individuals for substance use disorders. • Same as C.2.o. <p>Findings: During this review period, NSH did not formally modify the Administrative Directives or Mall procedures related to substance use services. However, the facility was in the process of making revisions in the following:</p> <ol style="list-style-type: none"> 1. AD 764: Drug Test to include a treatment protocol to ensure appropriate utilization of this screening method; 2. Relevant Mall services procedures in preparation for a transition from the URICA to the Expanded Readiness Ruler as used by Patton State

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		<p>Hospital for screening for the individual's stage of change relevant to substance use; and</p> <p>3. Mall Procedure 9.4: Hospital Wide AA/NA regarding permissible times and places for AA/NA meetings.</p> <p>In addition, the facility was in the process of procuring and distributing sufficient materials to allow for unit-based, individual-led AA/NA groups during evening supplemental times.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide a summary of any modifications in current Administrative Directives and/or procedures that address the screening of individuals for substance use disorders. 3. Same as 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.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Provide process and clinical outcome data for substance abuse services during the review period.</p> <p>Findings: The following is a summary of NSH's process outcome data:</p> <table border="1" data-bbox="993 1227 1902 1414"> <thead> <tr> <th>Indicators</th> <th>Jan-Mar 10</th> <th>Apr-Jun 10</th> <th>Jul-Sep 10</th> <th>Oct-Dec 10</th> </tr> </thead> <tbody> <tr> <td>Total Individual with Substance Abuse Diagnosis</td> <td>720</td> <td>721</td> <td>717</td> <td>705</td> </tr> <tr> <td>Total Individuals Screened</td> <td>231</td> <td>160</td> <td>198</td> <td>41</td> </tr> </tbody> </table>	Indicators	Jan-Mar 10	Apr-Jun 10	Jul-Sep 10	Oct-Dec 10	Total Individual with Substance Abuse Diagnosis	720	721	717	705	Total Individuals Screened	231	160	198	41
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Total Individual with Substance Abuse Diagnosis	720	721	717	705													
Total Individuals Screened	231	160	198	41													

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		including admission URICA (1)				
		Individuals Screened in alternate languages	23	20	14	0
		Number of individuals receiving additional/Expanded Screenings with Addiction Severity Index	50	15	8	5
		Number of individuals to be screened (2)	31	28	26	39
		Number/Hours of group interventions offered per week (excluding NA/AA) (3&4):	85/15 8	87/15 3	84/14 6	87/14 0
		• Pre-contemplation groups	60	50	44	43
		• Contemplation groups	57	43	35	33
		• Preparation groups	16	23	24	18
		• Action groups	16	23	22	18
		• Maintenance groups	5	4	6	8
		• All Stages groups	0	5	12	17
		• Monolingual Spanish groups	4	5	3	3
		• AA/NA groups	3	3	4	3
		Group interventions scheduled	1031	983	1041	1002
		Group interventions held	821 (80%)	686 (70%)	650 (62%)	681 (68%)
		Number of individuals enrolled in group interventions (excluding AA/NA):	619	583	633	686
		• P Pre-contemplation	235	223	235	257
		• Contemplation	162	174	162	164
		• Preparation	64	68	64	96
		• Action	82	91	82	117

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		<ul style="list-style-type: none"> • Maintenance 	62	14	62	34
		<ul style="list-style-type: none"> • Monolingual Spanish 	14	13	14	18
		<ul style="list-style-type: none"> • AA/NA (average weekly attendance) 	37	43	65	30
		<ul style="list-style-type: none"> • AA/NA (# of non-distinct individuals attending AA/NA) 	692	693	853	354
		Hours of staff training	18	14	27	116
		# of staff trained	73	156	65	58
		# monitored for fidelity	13	35	35	5
		<p>The following is a summary of NSH's clinical outcome data during this review period (July to December, 2010) compared to the previous period (January to June 2010):</p>				
		Indicators	Jan-Mar 10	Apr-Jun 10	Jul-Sep 10	Oct-Dec 10
		Number enrolled on first day of quarter	619	583	633	632
		Advanced at least one stage of change or sustained in maintenance	62/10%	44/8%	26/4%	18/3%
		<ul style="list-style-type: none"> • Refused treatment or regressed at least one stage of change 	37/6%	16/3%	13/2%	5/1%
		<ul style="list-style-type: none"> • Did not advance in stage of change 	366/59%	384/66%	553/87%	482/76%
		<ul style="list-style-type: none"> • Out to Court/Other/Discharged 	154/25%	139/24%	41/7%	127/20%
		Number of individuals completing curriculum with	15	20	42	0

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		repeat measures																																																						
		Pre/Post-Test Increase Score Mean	14%	9%	5%	No Data																																																		
		<p>The clinical outcome data were limited by the following factors:</p> <ol style="list-style-type: none"> 1. The original curriculum can take several terms to complete, thereby delaying the post-test results, which was being addressed by splitting the curriculum in half; 2. While 62 new pre-tests were administered and returned to SRS, matching post-tests were not completed for October to December term (due to the modification of Mall services following the homicidal assault on a staff member); 3. Some individuals advanced to a new stage of change prior to completing the curriculum, thus the pre-test and post-test were different and could not serve as basis for data comparisons; and 4. Decreased willingness of individuals to complete multiple measures at the end of the term. <p>The following is a summary of the facility's consumer satisfaction surveys:</p>																																																						
		<table border="1"> <thead> <tr> <th data-bbox="976 971 1381 1047">Indicators</th> <th data-bbox="1381 971 1514 1047">Jan- Mar 10</th> <th data-bbox="1514 971 1646 1047">Apr-Jun 10</th> <th data-bbox="1646 971 1778 1047">Jul-Sep 10</th> <th data-bbox="1778 971 1932 1047">Oct- Dec 10</th> </tr> </thead> <tbody> <tr> <td data-bbox="976 1047 1381 1084">Learned new skills</td> <td data-bbox="1381 1047 1514 1084"></td> <td data-bbox="1514 1047 1646 1084"></td> <td data-bbox="1646 1047 1778 1084"></td> <td data-bbox="1778 1047 1932 1084"></td> </tr> <tr> <td data-bbox="976 1084 1381 1122">• Agree</td> <td data-bbox="1381 1084 1514 1122">83</td> <td data-bbox="1514 1084 1646 1122">101</td> <td data-bbox="1646 1084 1778 1122">124</td> <td data-bbox="1778 1084 1932 1122">36</td> </tr> <tr> <td data-bbox="976 1122 1381 1159">• Disagree</td> <td data-bbox="1381 1122 1514 1159">11</td> <td data-bbox="1514 1122 1646 1159">13</td> <td data-bbox="1646 1122 1778 1159">15</td> <td data-bbox="1778 1122 1932 1159">6</td> </tr> <tr> <td data-bbox="976 1159 1381 1196">Group was helpful</td> <td data-bbox="1381 1159 1514 1196"></td> <td data-bbox="1514 1159 1646 1196"></td> <td data-bbox="1646 1159 1778 1196"></td> <td data-bbox="1778 1159 1932 1196"></td> </tr> <tr> <td data-bbox="976 1196 1381 1234">• Agree</td> <td data-bbox="1381 1196 1514 1234">91</td> <td data-bbox="1514 1196 1646 1234">117</td> <td data-bbox="1646 1196 1778 1234">134</td> <td data-bbox="1778 1196 1932 1234">39</td> </tr> <tr> <td data-bbox="976 1234 1381 1271">• Disagree</td> <td data-bbox="1381 1234 1514 1271">6</td> <td data-bbox="1514 1234 1646 1271">7</td> <td data-bbox="1646 1234 1778 1271">5</td> <td data-bbox="1778 1234 1932 1271">3</td> </tr> <tr> <td data-bbox="976 1271 1381 1308">Understood information</td> <td data-bbox="1381 1271 1514 1308"></td> <td data-bbox="1514 1271 1646 1308"></td> <td data-bbox="1646 1271 1778 1308"></td> <td data-bbox="1778 1271 1932 1308"></td> </tr> <tr> <td data-bbox="976 1308 1381 1346">• Agree</td> <td data-bbox="1381 1308 1514 1346">89</td> <td data-bbox="1514 1308 1646 1346">110</td> <td data-bbox="1646 1308 1778 1346">129</td> <td data-bbox="1778 1308 1932 1346">40</td> </tr> <tr> <td data-bbox="976 1346 1381 1390">• Disagree</td> <td data-bbox="1381 1346 1514 1390">8</td> <td data-bbox="1514 1346 1646 1390">4</td> <td data-bbox="1646 1346 1778 1390">10</td> <td data-bbox="1778 1346 1932 1390">2</td> </tr> </tbody> </table>					Indicators	Jan- Mar 10	Apr-Jun 10	Jul-Sep 10	Oct- Dec 10	Learned new skills					• Agree	83	101	124	36	• Disagree	11	13	15	6	Group was helpful					• Agree	91	117	134	39	• Disagree	6	7	5	3	Understood information					• Agree	89	110	129	40	• Disagree	8	4	10	2
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		<p>respectively in the previous period.</p> <p>Other findings: During this review period, NSH Substance Recovery Service (SRS) has implemented a variety of the following improvements:</p> <ol style="list-style-type: none"> 1. Expanded the Substance Recovery Advisory Committee to include a larger membership and a greater breadth of professional expertise. The committee received referrals from WRPTs for expert recommendations in response to substance-related treatment issues. Responses included interview of the individuals, meetings with staff, and written documentation. 2. Provided on-site consultation to units to provide education, materials, debriefings, and other services as appropriate when requested following substance-related events. 3. Initiated revision of the core substance recovery curricula to ensure completions within a single term and more regular pre- and post-testing measures. 4. Simplified the grammar and vocabulary utilized in the pre- and post-tests to better match the modal levels of scholastic achievement and cognitive functioning of the individuals. 5. Explored resources for Spanish-language 12-step meetings. 6. Clarified lines of communication regarding management of chronic pain and positive urine drug screens. 7. Facilitated interventions on units for individuals with positive drug screens and provided increased treatment opportunities on those units. 8. Added SRS to the notification list for any confirmed positive urine drug screens. 9. Increased communication with members of the hospital police force and provided education regarding the management of individuals who engage in illicit activities. This resulted in the establishment of a new SRS group for individuals with a history of positive urine drug screens.
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		<p>10. Scheduled trainings for admission social workers and substance recovery providers on the use of the Readiness Ruler, a new screening tool.</p> <p>11. Provided training to social workers on admission units on assessment of substance abuse, brief interventions and establishment of discharge plans related to substance use (as a result of a recent mortality review).</p> <p>12. Developed and distributed a resource guide for community substance abuse services available upon the discharge of individuals.</p> <p>13. Provided recommendations to the facility's management team for systemic changes to address the No Smoking policy as a contributor to violence. The recommendations included the following:</p> <ol style="list-style-type: none"> a. Consideration of either moving to a harm reduction model with limited approved tobacco use or increasing security with more thorough searches for smuggled tobacco; b. Provision of pharmacological interventions for smoking cessation (e.g., nicotine patches); c. Provision of psychoeducational material regarding smoking to all individuals; d. Development of a substance recovery-specific unit to provide more intensive treatment related to substance use and abuse on a time-limited basis; and e. Increasing security for medication carts, including evaluation of systems of accountability for substances that can be sought for abuse and materials that can be utilized to administer substances (e.g. needles). <p>This monitor reviewed the charts of six individuals to assess the linkage between WRPs and the individuals' stage of change related to substance use. Refer to C.2.f.iv for results of this review.</p> <p>This monitor and one of his experts observed three PSR Mall Groups that provided substance use education: Enhancing Motivation/Substance</p>
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		<p>Recovery: pre-contemplative stage, Substance Recovery: pre-contemplative/ contemplative stage, and Substance Recovery: preparation/action stage. There was general evidence of adequate engagement of the individuals, content of instruction, knowledge of the group facilitators and use of instructional materials.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide process and clinical outcome data for substance abuse services during the review period. 2. Continue to monitor this requirement. 3. Continue to provide a summary of any process improvements in the delivery of SRS. 																				
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form. NSH assessed its compliance based on an average sample of 8% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (June through November 2010):</p> <table border="1" data-bbox="989 1190 1883 1421"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>95%</td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>94%</td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>97%</td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>95%</td> <td>98%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	95%	99%	2.	<i>Course structure</i>	94%	98%	3.	<i>Instructional techniques</i>	97%	99%	4.	<i>Learning process</i>	95%	98%
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		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form NSH assessed its compliance from observation of an 8% sample of all facilitators during the review months (June through November 2010):</p> <table border="1"> <tr> <td>1.</td> <td><i>Session starts and ends on time.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Facilitator greets participants to begin the session.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>There is a brief review of work from prior session.</i></td> <td>94%</td> </tr> <tr> <td>4.</td> <td><i>Facilitator introduces the day's topic and goals.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Facilitator shows familiarity with lesson plan and materials.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Facilitator attempts to engage each participant in the session.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Facilitator attempts to keep all participants "on task" during the session.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Facilitator shows a presentation style that keeps some/all participants attentive and interested.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i></td> <td>98%</td> </tr> <tr> <td>10.</td> <td><i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i></td> <td>99%</td> </tr> <tr> <td>11.</td> <td><i>At conclusion, the facilitator summarizes the work done in the session.</i></td> <td>97%</td> </tr> <tr> <td>12.</td> <td><i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i></td> <td>99%</td> </tr> <tr> <td>13.</td> <td><i>The room is arranged in a way that is as conducive to</i></td> <td>99%</td> </tr> </table>	1.	<i>Session starts and ends on time.</i>	96%	2.	<i>Facilitator greets participants to begin the session.</i>	99%	3.	<i>There is a brief review of work from prior session.</i>	94%	4.	<i>Facilitator introduces the day's topic and goals.</i>	100%	5.	<i>Facilitator shows familiarity with lesson plan and materials.</i>	99%	6.	<i>Facilitator attempts to engage each participant in the session.</i>	100%	7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	100%	8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested.</i>	99%	9.	<i>Facilitator tests and evaluates participants' understanding through questions, role play, or other means.</i>	98%	10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	99%	11.	<i>At conclusion, the facilitator summarizes the work done in the session.</i>	97%	12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	99%	13.	<i>The room is arranged in a way that is as conducive to</i>	99%
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C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p data-bbox="991 946 1581 979">Current findings on previous recommendation:</p> <p data-bbox="991 1019 1455 1084">Recommendation, July 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1166 1915 1385">Findings: The facility reported that providers are certified for the group/stage at which they facilitate. Staff interviews and documentation review found that all Substance Recovery groups have lesson plans, and the staff is certified to the group/stage at which they facilitate. In addition, NSH had conducted the following activities during this review period:</p>						

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		<ul style="list-style-type: none"> • Staff training on the Substance Recovery Curriculum at the pre-contemplative and contemplative stages of change; • Staff training on Motivational Interviewing; • Training on Addiction and Pain management for 25 staff from Pharmacy, Physical Therapy, and Dietetic departments; • New employee training on addiction and substance recovery treatment, dual diagnosis, and motivational interviewing per DMH plan, and the SAMHSA Tips; • Specialized training on addiction by two SRS staff; • SRS provider training on screening tools and outcome tracking and monitoring during the quarterly SR provider meetings; and • A full-day training at NSH on substance abuse and pain management by Dr. Steven Grinstead (June 2010). <p>NSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="991 820 1873 974"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>75</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>73</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>97%</td> </tr> </table> <p>This monitor observed two substance abuse recovery Mall groups, at the pre-contemplative and pre-contemplative/contemplative stages. The providers of these two groups were certified as Substance Abuse Counselors. The providers were well-prepared, organized, and facilitated the groups well, engaging the individuals using appropriate methodology and material.</p> <p>Compliance: Substantial.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	75	Number of certified SAR providers/co-providers	73	Percentage of SAR providers/co-providers who are certified	97%
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		<p>Current recommendation: Continue to monitor this requirement.</p>																																																											
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="991 636 1854 1062"> <thead> <tr> <th colspan="6">Missed Appointments Monitoring - Medical Services</th> </tr> <tr> <th rowspan="2"></th> <th colspan="2">Appointments</th> <th colspan="3">Reasons for Cancellation</th> </tr> <tr> <th>Sched- uled</th> <th>Cancelled</th> <th>Staffing</th> <th>Transpor- tation</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Jun</td> <td>930</td> <td>67</td> <td>0</td> <td>0</td> <td>67</td> </tr> <tr> <td>Jul</td> <td>1051</td> <td>87</td> <td>0</td> <td>2</td> <td>85</td> </tr> <tr> <td>Aug</td> <td>1154</td> <td>102</td> <td>1</td> <td>1</td> <td>100</td> </tr> <tr> <td>Sep</td> <td>1220</td> <td>130</td> <td>1</td> <td>0</td> <td>129</td> </tr> <tr> <td>Oct</td> <td>1122</td> <td>161</td> <td>7</td> <td>0</td> <td>154</td> </tr> <tr> <td>Nov</td> <td>1104</td> <td>136</td> <td>7</td> <td>1</td> <td>128</td> </tr> <tr> <td>Total</td> <td>6581</td> <td>683</td> <td>16</td> <td>4</td> <td>663</td> </tr> </tbody> </table> <p>As the table above shows, there were a total of 20 cancelled appointments owing to staffing and transportation matters. However, a larger number (663) of appointments were cancelled for other reasons. NSH should take steps to identify and analyze the reasons for these cancellations, and intervene to enable the individuals to receive the needed services. It cannot be ruled out that at least some of these individuals experience irritability, frustration, pain, and challenging behaviors as a function of their medical/physical ailments.</p>	Missed Appointments Monitoring - Medical Services							Appointments		Reasons for Cancellation			Sched- uled	Cancelled	Staffing	Transpor- tation	Other	Jun	930	67	0	0	67	Jul	1051	87	0	2	85	Aug	1154	102	1	1	100	Sep	1220	130	1	0	129	Oct	1122	161	7	0	154	Nov	1104	136	7	1	128	Total	6581	683	16	4	663
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		<p>According to the Clinical Administrator, the facility reschedules the appointments for those who have critical medical needs, and ensures that appointments are not scheduled when individuals have activities they would not want to miss. These steps are a good start, but a more comprehensive analysis of the reasons needs to be conducted as there are sure to be other reasons for the individuals to cancel their scheduled appointments. Counseling by the nursing staff, as is being conducted currently, would be more effective if the reasons for cancellations were known.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for 11 individuals found that nine of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses</p>

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		<p>and cognitive levels (AS, CS, DJE, DLT, JB, LB, MC, RW and TM). The remaining two (ASD and DMB) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 97%. Comparative data indicated improvement in compliance from 78% in the previous review period.</p> <p>A review of the WRPs for eight individuals found that seven of the WRPs met the elements of this requirement (AA, ALW, IEJ, JDG, JND, RAS and TMM) and the remaining WRP (MMG) was missing one or more elements or did not satisfy the criteria for this recommendation.</p> <p>A review of WRPs found that many WRPTs now state the date on which</p>

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		<p>the objectives were developed and implemented as part of the objective. This acts as a prompt for the WRPTs to attend to this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																									
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: According to the Mall Director, NSH uses a number of groups as part of educating the individual in their recovery process (e.g. Wellness and Recovery Orientation, Personal Wellness, and Wellness and Recovery Action Planning).</p> <p>The facility provided the following data:</p> <table border="1" data-bbox="991 1005 1824 1382"> <thead> <tr> <th colspan="5">Individuals in need of WRP Education during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Jan - Mar 2010</th> <th>Apr - Jun 2010</th> <th>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>1138</td> <td>1140</td> <td>1143</td> <td>1154</td> </tr> <tr> <td>Receiving service</td> <td>852</td> <td>962</td> <td>987</td> <td>954</td> </tr> <tr> <td>% receiving service</td> <td>75%</td> <td>84%</td> <td>86%</td> <td>83%</td> </tr> </tbody> </table>	Individuals in need of WRP Education during the current and previous three Mall terms						Jan - Mar 2010	Apr - Jun 2010	Jul-Sept 2010	Oct-Dec 2010	With identified need	1138	1140	1143	1154	Receiving service	852	962	987	954	% receiving service	75%	84%	86%	83%
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		<p>A review of the records of seven individuals found that six individuals were enrolled in a WRAP group (ALW, ASD, DMB, MMG, MMP, and VER), and one was not (JVM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																				
C.2.v	<p>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to provide data regarding the number of individuals identified as in need of medication education, the number individuals scheduled for medication education, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 1008 1873 1271"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>852</td> <td>508</td> <td>643</td> <td>640</td> </tr> <tr> <td># of individuals receiving service</td> <td>852</td> <td>423</td> <td>562</td> <td>559</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>	Individuals Needing and Provided Medication Education Groups						Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	# of individuals needing service	852	508	643	640	# of individuals receiving service	852	423	562	559
Individuals Needing and Provided Medication Education Groups																						
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Current recommendation: Continue to provide data regarding the number of individuals identified as in need of medication education, the number individuals scheduled for medication education, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p>
C.2.w	<p>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH's progress report data showed a mean non-adherence rate of 7% for Mall groups. Staff interview and documentation review found that NSH uses a variety of strategies to address non-adherence. The facility uses motivational interviewing, nursing counseling, By Choice point allocation and other reinforcement strategies such as grounds privileges, Narrative Restructuring Therapy, and adjusting the number and types of Mall groups according to the individual's readiness. According to the Acting Chief of Psychology, all individuals identified as non-adherent receive one or more of the said strategies. However, data was not available for review, except for the 23 individuals enrolled in NRT.</p> <p>NSH should consider matching interventions by reasons for non-adherence for better outcomes and a more effective means of effecting behavior change. Furthermore, WRPTs should document the reasons for Mall non-adherence and the type of interventions in place.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement the plan to assist individuals not going to assigned treatment activities [described in cell C.2.i.x].2. Continue to monitor this requirement.
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Section D: Integrated Assessments

D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses: NSH has attained or maintained compliance with all but two of the requirements in Section D.1 and achieved compliance with the requirement regarding the inter-unit transfer assessments.</p> <p><i>Areas of need include:</i> <i>Compliance with the requirements regarding timely completion of the integrated psychiatric assessments and the weekly psychiatric reassessments (during the first 60 days of hospitalization) has declined since the last review.</i></p> <p>Summary of Progress on Psychological Assessments: As of the July 2010 tour, NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Nursing Assessments: NSH has maintained substantial compliance with the requirements of this section.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments: NSH has maintained substantial compliance with the requirements of Section D.4, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: NSH has maintained substantial compliance with the requirements of Section D.5 and should continue to improve and enhance current practice.</p>

Section D: Integrated Assessments

		<p>Summary of Progress on Social History Assessments: NSH has maintained substantial compliance with the requirements of Section D.2 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Court Assessments: As of the tour conducted in July 2010, NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Anish Shah, MD, Acting Medical Director 2. James Young, MD, Acting Assistant Medical Director 3. Jonathan Berry, MD, Acting Senior Psychiatrist 4. Patrick Nolan, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 35 individuals: AA, AB, ABV, BB, BL, BTM, CB, CCS, CW, DFH, DLT, GCP, GVA, JAY, JLM, JTS, LDJ, LK, LP, MAM, MHJ, MK, NBP, OJR, RDR, REL, REP, RHH, RJC, RJR, RKG, RRW, RS, VMM, and WMD 2. Monthly Psychiatric Progress Note for the following 49 individuals: ABV, AC, ADT, AF, AH, BC, CCS, CD, CDB, CSB, CN, DES, DFC, DR, DWA, EM, HH, JAB, JG, JJM, JL, JLH, JLM, JMR, LG, LLB, LM, MA, MAB, MCA, MMP, PL, RL, RLM, MJ, MNR, RB, RK, RLH, RRC, RWE, SH, SS, TAB, TB, TG, TLR, WBM, and YV 3. Copy of CME training on Adverse Drug Reactions 4. NSH Admission Psychiatric Assessment summary data (June to November 2010) 5. NSH Integrated Assessment: Psychiatric Section summary data (June to November 2010) 6. NSH Admission Medical Assessment Auditing summary (June to November 2010) 7. NSH Monthly PPN Audit summary data (June to November 2010) 8. NSH Weekly PPN Auditing summary data (June to November 2010) 9. NSH Physician Transfer Note Auditing summary (June to November 2010)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and	Current findings on previous recommendation:

Section D: Integrated Assessments

	<p>Statistical Manual of Mental Disorders (“DSM”) for reaching the most accurate psychiatric diagnoses.</p>	<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (June–November 2010). The average samples were 44% of admission assessments, 33% of integrated assessments and 14% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 597 1887 675"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>100</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 824 1887 1203"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Psychiatric history, including review of present and past history include diagnosis and medications given at previous facility</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 1349 1887 1425"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.b</td> <td><i>Timely and justifiable updates of diagnosis and</i></td> <td>99%</td> </tr> </tbody> </table>	Admission Assessment			4.	<i>Admission diagnosis is documented</i>	100	Integrated Assessment			2.b	<i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information</i>	100%	2.d	<i>Psychiatric history, including review of present and past history include diagnosis and medications given at previous facility</i>	100%	7.	<i>Diagnostic formulation</i>	100%	8.	<i>Differential diagnosis</i>	98%	9.	<i>Current psychiatric diagnoses</i>	100%	Monthly PPN			3.b	<i>Timely and justifiable updates of diagnosis and</i>	99%
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		<table border="1"> <tr> <td></td> <td><i>treatment, as clinically indicated</i></td> <td></td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>treatment, as clinically indicated</i>													
	<i>treatment, as clinically indicated</i>																
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.															
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Provide data regarding the number of all FTE psychiatrists and FTE psychiatrists providing direct care comparing the last month of the review period with the last month of the last review period.</p> <p>Findings: The facility's report on the number and type of positions is summarized below:</p> <table border="1"> <thead> <tr> <th>Psychiatric positions (FTE)</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Direct care</td> <td>54.25</td> <td>54.3</td> </tr> <tr> <td>Supervisory</td> <td>9.75</td> <td>10.2</td> </tr> <tr> <td>Board-certified</td> <td>40</td> <td>44</td> </tr> <tr> <td>Board-eligible</td> <td>21</td> <td>24</td> </tr> </tbody> </table>	Psychiatric positions (FTE)	Previous Period	Current Period	Direct care	54.25	54.3	Supervisory	9.75	10.2	Board-certified	40	44	Board-eligible	21	24
Psychiatric positions (FTE)	Previous Period	Current Period															
Direct care	54.25	54.3															
Supervisory	9.75	10.2															
Board-certified	40	44															
Board-eligible	21	24															

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide information of the current status of implementation of the facility's method of assessing staff competence. <p>Findings: NSH reported that all psychiatrists (#16) who were scheduled for reprivileging during this review period as per the facility's policy were reprivileged using the indicators in the Physician Quality Performance Profile (PPQPP) that were reviewed in the previous report. The performance data are reviewed quarterly for each psychiatrist and kept in the Medical Staff Office in each provider's Credentials File.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Provide information of the number and percentage of psychiatrists who were reprivileged during the review period using the current PPQPP
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>

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D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, NSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 76% of admissions each month during the review period (June-November 2010). The facility reported a mean compliance rate of 99% with the 24-hour requirement. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found substantial compliance in 11 charts and partial compliance in one (CCS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.2	medical history;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.i.3	physical examination;	<table border="1" data-bbox="991 228 1887 305"> <tr> <td data-bbox="991 228 1087 266">4.</td> <td data-bbox="1087 228 1793 266"><i>Physical examination</i></td> <td data-bbox="1793 228 1887 266">99%</td> </tr> <tr> <td data-bbox="991 266 1087 305">5.</td> <td data-bbox="1087 266 1793 305"><i>Rectal examination</i></td> <td data-bbox="1793 266 1887 305">99%</td> </tr> </table> <p data-bbox="991 347 1915 418">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	4.	<i>Physical examination</i>	99%	5.	<i>Rectal examination</i>	99%
4.	<i>Physical examination</i>	99%						
5.	<i>Rectal examination</i>	99%						
D.1.c.i.4	diagnostic impressions; and	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.5	management of acute medical conditions	<table border="1" data-bbox="991 607 1887 906"> <tr> <td data-bbox="991 607 1087 753">7.</td> <td data-bbox="1087 607 1793 753"><i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i></td> <td data-bbox="1793 607 1887 753">99%</td> </tr> <tr> <td data-bbox="991 753 1087 906">8.</td> <td data-bbox="1087 753 1793 906"><i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i></td> <td data-bbox="1793 753 1887 906">99%</td> </tr> </table> <p data-bbox="991 948 1915 1019">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i>	99%	8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	99%
7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i>	99%						
8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	99%						
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p data-bbox="991 1062 1579 1089">Current findings on previous recommendation:</p> <p data-bbox="991 1133 1360 1161">Recommendation, July 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1247 1100 1274">Findings: Using the DMH Admission Psychiatric Assessment Audit, NSH reported a compliance rate of 100% based on an average sample of 44% of admissions each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of</p>						

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		<p>at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found substantial compliance in ten charts and partial compliance in two (MK and RS). The admission suicide assessment was incomplete in the chart of RS.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.ii.6	consultations ordered; and	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, NSH reported a compliance rate of 97% based on an average sample of 33% of Integrated Assessments due each month during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of 12 individuals admitted during the review period (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) found substantial compliance in nine charts and partial compliance in one (RS). No assessments were found in the charts of JLM and RKG.</p> <p>Compliance: Partial.</p>

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		Current recommendation: Continue to monitor this requirement and ensure completion of the integrated assessments in all cases.
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 6	diagnostic formulation;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 7	differential diagnosis;	98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 9	psychopharmacology treatment plan; and	98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.																									
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Increase attendance at and provide documentation of continuing medical education (CME) to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation. • Provide data on the number and disciplines of attendees at CME programs. <p>Findings: During this review period, NSH provided/facilitated CME programs that were adequate in range and appropriate to facility's needs. The following table outlines these activities:</p> <table border="1" data-bbox="989 857 1902 1414"> <thead> <tr> <th data-bbox="989 857 1144 930">Date</th> <th data-bbox="1144 857 1444 930">Title</th> <th data-bbox="1444 857 1738 930">Speaker/ affiliations</th> <th data-bbox="1738 857 1902 930">MD Attendees</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 930 1144 1045">6/9/10</td> <td data-bbox="1144 930 1444 1045">Suicidality in People Taking Antiepileptic Drugs - Part III</td> <td data-bbox="1444 930 1738 1045">J. Eyerman, MD NSH/Journal Club</td> <td data-bbox="1738 930 1902 1045">2</td> </tr> <tr> <td data-bbox="989 1045 1144 1120">6/10/10</td> <td data-bbox="1144 1045 1444 1120">Program 5 Case Consultation</td> <td data-bbox="1444 1045 1738 1120">C. Scott, MD & A. Nanton, MD</td> <td data-bbox="1738 1045 1902 1120">5</td> </tr> <tr> <td data-bbox="989 1120 1144 1230">6/16/10</td> <td data-bbox="1144 1120 1444 1230">Suicidality in People Taking Antiepileptic Drugs - Part IV</td> <td data-bbox="1444 1120 1738 1230">J. Eyerman, MD, NSH/Journal Club</td> <td data-bbox="1738 1120 1902 1230">6</td> </tr> <tr> <td data-bbox="989 1230 1144 1305">6/23/10</td> <td data-bbox="1144 1230 1444 1305">Mindfulness Based Interventions</td> <td data-bbox="1444 1230 1738 1305">J. Eyerman, MD NSH/Journal Club</td> <td data-bbox="1738 1230 1902 1305">4</td> </tr> <tr> <td data-bbox="989 1305 1144 1414">6/30/10</td> <td data-bbox="1144 1305 1444 1414">Numbing the Pain: Substance Abuse and Trauma</td> <td data-bbox="1444 1305 1738 1414">K. Johnson, LCSW Outside Provider</td> <td data-bbox="1738 1305 1902 1414">18</td> </tr> </tbody> </table>		Date	Title	Speaker/ affiliations	MD Attendees	6/9/10	Suicidality in People Taking Antiepileptic Drugs - Part III	J. Eyerman, MD NSH/Journal Club	2	6/10/10	Program 5 Case Consultation	C. Scott, MD & A. Nanton, MD	5	6/16/10	Suicidality in People Taking Antiepileptic Drugs - Part IV	J. Eyerman, MD, NSH/Journal Club	6	6/23/10	Mindfulness Based Interventions	J. Eyerman, MD NSH/Journal Club	4	6/30/10	Numbing the Pain: Substance Abuse and Trauma	K. Johnson, LCSW Outside Provider	18
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		7/7/10	Toronto Mindfulness Scale-Part I	J. Eyerman, MD NSH/Journal Club	5
		7/14/10	Toronto Mindfulness Scale-Part II	J. Eyerman, MD NSH/Journal Club	2
		8/4/10	Toronto Mindfulness Scale Validation-Part I	J. Eyerman, MD NSH/Journal Club	2
		8/11/10	JC-Toronto Mindfulness Scale Validation-Part Two	J. Eyerman, MD NSH/Journal Club	5
		8/12/10	UCD Case Consultation-Program III	C. Scott, MD & H. Bender, MD, UCD	8
		8/18/10	Bipolar Summit I	J. Eyerman, MD NSH/Journal Club	3
		8/25/10	Bipolar Summit II	J. Eyerman, MD NSH/Journal Club	2
		9/1/10	Bipolar Summit III: Targeting residual symptoms during maintenance therapy reduces recurrences of affective syndromes	J. Eyerman, MD NSH/Journal Club	2
		9/8/10	Bipolar Summit IV The use of antidepressants is obsolete in treatment	J. Eyerman, MD NSH/Journal Club	5
		9/15/10	Bipolar Summit V ADHD	J. Eyerman, MD NSH/Journal Club	6
		9/16/10	PTSD: Nightmares in Court, Part One	H.E. Bender, MD & C. Wadsworth, MD	20

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		9/22/10	Summit VI: 2nd Generation Antipsychotic and Effective Mood Stabilizers	H. Yuo, MD NSH/Journal Club 3
		9/23/10	PTSD: Nightmares in Court, Part Two	C. Scott and William Neuman UC D 22
		10/6/10	Deficient Emotional Self Regulation in Adults with ADHD - Part II	J. Eyerman, MD NSH/Journal Club 2
		10/8/10	Adverse Drug Reactions Treatment and Reporting Responsibilities	A. Shah, MD NSH 16
		10/12/10	Adverse Drug Reactions Awareness, Treatment and Reporting Responsibilities	A. Shah, MD NSH 21
		10/13/10	ADHD: The Relative Contributions to Adaptive Impairments	J. Eyerman, MD NSH/Journal Club 3
		10/14/10	Adverse Drug Reactions Awareness, Treatment and Reporting Responsibilities	A. Shah, MD NSH 37
		10/20/10	Future of Psychopharmacology of Depression	J. Eyerman, MD NSH/Journal Club 5
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			Trial of N-Methyl-D-Aspartate Antagonist in Treatment Resistant Bipolar Depression	NSH/Journal Club	
		11/10/10	Bipolar Disorders and Violent Crimes - Part I	J. Eyerman, MD NSH/Journal Club	4
		11/18/10	Bipolar Disorders and Violent Crimes - Part Two	J. Eyerman, MD NSH/Journal Club	4
		11/22/10	Personality Disorders and Their Impact on the Delivery of Health Care	Michael Champion, MD Outside Provider	24
		11/24/10	Mood Disorders - Part I	J. Eyerman, MD NSH/Journal Club	5
		12/1/10	Mood Disorders - Part II	J. Eyerman, MD NSH/Journal Club	4
		12/7/10	Tardive Dyskinesia	L. Zhang, MD, PhD UCD	34
		12/8/10	Mood Disorders - Part III	J. Eyerman, MD NSH/Journal Club	4
		12/15/10	Mood Disorders - Part IV	J. Eyerman, MD NSH/Journal Club	5
		12/20/10	Developing a Peaceful Treatment Milieu	G. Sancier, PhD; J. Horton, MD and J. Holt Outside Providers	14
		12/22/10	Mood Disorders - Part V	J. Eyerman, MD NSH/Journal Club	4
		12/29/10	Dissociative Disorders: An	H. Yuo, MD NSH/Journal Club	4

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">Overview</td> <td style="width: 33%;"></td> </tr> </table> <p>Recommendation 3, July 2010: Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for more than 60 days during the review period compared with the last period.</p> <p>Findings: The facility provided the following data on the number of individuals with unresolved diagnoses for more than 60 days after admission:</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 33%;">Diagnostic category</th> <th style="width: 33%;">Previous Period</th> <th style="width: 33%;">Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2">Number of individuals in category for more than 60 days</td> </tr> <tr> <td>Rule Out</td> <td>11</td> <td>11</td> </tr> <tr> <td>Deferred</td> <td>2</td> <td>2</td> </tr> <tr> <td>NOS</td> <td>76</td> <td>67</td> </tr> </tbody> </table> <p>The above data indicate that the facility has maintained adequate practice since the last review.</p> <p>Other findings: The following table outlines chart reviews of 13 individuals who have received diagnoses listed as NOS for three or more months during this review period:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>BB</td> <td>Dementia NOS</td> </tr> <tr> <td>CB</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>GCP</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>GVA</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>JAY</td> <td>Cognitive Disorder NOS</td> </tr> </tbody> </table>		Overview		Diagnostic category	Previous Period	Current Period		Number of individuals in category for more than 60 days		Rule Out	11	11	Deferred	2	2	NOS	76	67	Initials	Diagnosis (NOS)	BB	Dementia NOS	CB	Psychotic Disorder NOS	GCP	Cognitive Disorder NOS	GVA	Cognitive Disorder NOS	JAY	Cognitive Disorder NOS
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WMD	Depressive Disorder NOS																	
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p data-bbox="993 1206 1577 1239">Current findings on previous recommendation:</p> <p data-bbox="993 1287 1360 1352">Recommendation, July 2010: Same as in D.1.a and D.1.d.i.</p>																

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		<p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	"no diagnosis" is clinically justified and documented.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Provide information regarding the facility's review of the charts of all individuals who have received "No Diagnosis" on Axis I (during the review period) to determine clinical justification.</p> <p>Findings: NSH reported that no individual received "no diagnosis" on Axis I during this review period.</p>

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		<p>Other findings: Based on chart reviews by this monitor, there was no evidence that any individual has received "no diagnosis" on Axis I.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p>
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, NSH reported a compliance rate of 98% based on an average sample of 22% of individuals with length of stay less than 60 days during the review period (June-November 2010). Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>NSH also used the DMH Monthly PPN Audit to assess compliance, reporting a compliance rate of 100% based on an average sample of 14% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>Other findings: This monitor reviewed the charts of 12 individuals (AA, AB, CCS, JLM, LP, MK, REL, REP, RHH, RKG, RS and VMM) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in six charts (AA, MK, REL, REP, RS and VMM) and partial compliance in six (AB, CCS, JLM, LP, RHH and RKG). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all charts.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement and ensure timely completion of the weekly psychiatric reassessments (during the first 60 days of hospitalization).</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that the administration of PRN/Stat medication is based on specific indications and tailored to target symptoms consistent with the individual's diagnosis. <p>Findings: NSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 14% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p>

		<p>Recommendation 3, July 2010: Improve the clinical oversight function of psychiatric services.</p> <p>Findings: NSH reported the following actions:</p> <ol style="list-style-type: none"> 1. The Medical Director and Assistant Medical Director met with all staff psychiatrists (on July 29 and August 20, 2010) and provided training on appropriate assessment and documentation requirements regarding PRN and Stat Medication use. 2. Senior psychiatrists were trained by the Chief Psychiatrist and Medical Director regarding expectations of monthly review of individuals on high-risk medications. 3. The medical director established clinical coverage procedure for long-term absences utilizing second positions and Senior Psychiatrists. The procedure included a revised sign-out sheet, and Off-Service and On-Service note templates to facilitate and standardize exchange of information. <p>Other findings: This monitor reviewed monthly psychiatric progress notes for the following 49 individuals: ABV, AC, ADT, AF, AH, BC, CCS, CD, CDB, CSB, CN, DES, DFC, DR, DWA, EM, HH, JAB, JG, JJM, JL, JLH, JLM, JMR, LG, LLB, LM, MA, MAB, MCA, MMP, PL, RL, RLM, MJ, MNR, RB, RK, RLH, RRC, RWE, SH, SS, TAB, TB, TG, TLR, WBM and YV. The reviews found general evidence of substantial compliance with this requirement.</p> <p>In addition, this monitor reviewed the charts of five individuals who experienced the use of seclusion and/or restraints during the review period (ABV, DFH, DLT, LDJ and RRW). The review focused on the use of PRN/Stat medications prior to and following the application of seclusion and/or restraints (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and</p>
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		<p>F.1.b. The review found substantial compliance in four charts and partial compliance in one (ABV). The main deficiency in the chart of ABV was generic assessment of the individual's response to the use of Stat medication.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure adequate assessment of the individual's response to the use of Stat medications. 			
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1" style="width: 100%;"> <tr> <td style="width: 5%;">5.</td> <td style="width: 85%;"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td style="width: 10%; text-align: center;">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%			
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls)	97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.			

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	including appropriate and timely monitoring of individuals and interventions to reduce risks;				
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<table border="1"> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	97%
5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	97%			
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall 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.	95%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.			

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<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that the transfer assessments from the transferring unit include an adequate plan of care that ensures continuity in treatment. <p>Findings: NSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 37% of the individuals who experienced inter-unit transfer per month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 673 1885 906"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>87%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>91%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>91%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>90%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>90%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>91%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for items 2-6. The compliance rate of item 1 was greater than 90% in the previous period.</p> <p>In October 2010, the facility implemented a revised Transfer Note template that included a Plan of Care section.</p> <p>Other findings: The inter-unit transfer assessments of six individuals were reviewed (see table below):</p>	1.	<i>Psychiatric course of hospitalization,</i>	87%	2.	<i>Medical course of hospitalization,</i>	91%	3.	<i>Current target symptoms,</i>	91%	4.	<i>Psychiatric risk assessment,</i>	90%	5.	<i>Current barriers to discharge,</i>	90%	6.	<i>Anticipated benefits of transfer.</i>	91%
1.	<i>Psychiatric course of hospitalization,</i>	87%																		
2.	<i>Medical course of hospitalization,</i>	91%																		
3.	<i>Current target symptoms,</i>	91%																		
4.	<i>Psychiatric risk assessment,</i>	90%																		
5.	<i>Current barriers to discharge,</i>	90%																		
6.	<i>Anticipated benefits of transfer.</i>	91%																		

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		<table border="1" data-bbox="991 228 1476 500"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>BL</td> <td>1/21/11</td> </tr> <tr> <td>BTM</td> <td>11/10/10</td> </tr> <tr> <td>CW</td> <td>11/24/10</td> </tr> <tr> <td>MAM</td> <td>11/22/10</td> </tr> <tr> <td>RDR</td> <td>1/20/11</td> </tr> <tr> <td>RJR</td> <td>11/4/10</td> </tr> </tbody> </table> <p data-bbox="991 540 1906 756">This review found significant improvement in the quality of the assessments compared to the last review period, particularly in the review of course of hospitalization and plan of care. There was evidence of substantial compliance in five charts and partial compliance in one (BL). The inter-unit transfer assessment of BL included inadequate description of current target symptoms.</p> <p data-bbox="991 800 1140 865">Compliance: Substantial.</p> <p data-bbox="991 911 1457 976">Current recommendation: Continue to monitor this requirement.</p>	Initials	Date of transfer	BL	1/21/11	BTM	11/10/10	CW	11/24/10	MAM	11/22/10	RDR	1/20/11	RJR	11/4/10
Initials	Date of transfer															
BL	1/21/11															
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MAM	11/22/10															
RDR	1/20/11															
RJR	11/4/10															

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

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	generally accepted professional standards of care, shall:	
D.2.d.i	expressly state the clinical question(s) for the assessment;	
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	
D.2.d.iv	be based on current, accurate, and complete data;	
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	
D.2.d.vi	include the implications of the findings for interventions;	
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	
D.2.d.	Use assessment tools and techniques	

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viii	appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric	

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	diagnosis; and	
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	
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.	

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3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michelle Patterson, RN, ACNS 2. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Nursing Admission Assessment Monitoring Audit summary data, June-November 2010 2. NSH Nursing Integrated Assessment Monitoring Audit summary data, June-November 2010 3. NSH's training rosters 4. Admission and integrated assessments and WRPs for the following 40 individuals: AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 26% mean sample of admissions each month during the review period (June-November 2010), and reported a</p>

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		<p>mean compliance rate of 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that NSH has maintained the quality of the assessments and all 40 were found to be in substantial compliance. These findings comport with NSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 26% mean sample of admissions each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 743 1887 894"> <tr> <td data-bbox="991 743 1087 894">1.</td> <td data-bbox="1087 743 1793 894"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 743 1887 894">97%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that NSH had also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings comport with NSH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	97%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	97%			

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D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 266 1887 563"> <tr> <td data-bbox="991 266 1087 563">2.</td> <td data-bbox="1087 266 1793 563"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 266 1887 563">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 786 1887 972"> <tr> <td data-bbox="991 786 1087 972">2.</td> <td data-bbox="1087 786 1793 972"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 786 1887 972">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%						
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <p>NSH reported a mean compliance rate of 97%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <p>NSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>						

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

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

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

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<p>D.3.d.i</p>	<p>Initial nursing assessments are completed within 24 hours of the individual's admission;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 26% mean sample of admissions each month during the review period (June-November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that all were timely completed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>D.3.d.ii</p>	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 26% mean sample of admissions each</p>

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		<p>month during the review period (June-November 2010), and reported a mean compliance rate of 95%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that all were timely completed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Ensure that the attendance of PTs is documented in the WRPCs.</p> <p>Findings: NSH has shared the findings for this requirement at the bimonthly Nursing Coordinators, Program Directors, and Clinical Administrator's meetings for follow-up and to emphasize that PTs attend and sign the WRPs. The Program Managers and Nursing Coordinators continue to monitor this requirement.</p> <p>Recommendation 2, July 2010: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on a mean sample of 16% of WRPCs observed each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 375 1915 529"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>96%</td> <td>95%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>89%</td> <td>82%</td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (AJL, ALT, AMC, AR, BP, CCS, DEC, DK, DLR, DSK, DWB, EB, EH, HSD, JCW, JLA, JLM, LAL, LAZ, LDF, LH, LJM, MDB, MLS, MP, PDD, PLD, RCH, REB, RH, RJC, RJT, RWH, SJW, SK, SL, SRA, TCK, TMC and WLM) found that an RN attended the WRPC in 39 cases and a PT attended the WRPC in 38 cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	96%	95%	<i>Psychiatric Technician attendance at WRPC</i>	89%	82%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	96%	95%									
<i>Psychiatric Technician attendance at WRPC</i>	89%	82%									

4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 3. Jennie Gilmore, Acting Senior Rehabilitation Therapist 4. Jennifer Deterville, Acting Senior Rehabilitation Therapist 5. Phyllis Moore, Acting Senior Rehabilitation Therapist 6. Susan Jette, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA:RTS assessments from June through November 2010 2. Records of the following 12 individuals who had IA:RTS assessments from June through November 2010: AH, CN, DA, DRM, GAT, JSR, LAP, RCF, REC, RJC, SMH and YR 3. List of individuals who had Occupational Therapy assessments from June through November 2010 4. Records of the following eight individuals who had Occupational Therapy assessments from June through November 2010: ATJ, BMS, CAD, CC, DLZ, MRC, MVP and NJ 5. List of individuals who had Physical Therapy assessments from June through November 2010 6. Records of the following seven individuals who had Physical Therapy assessments from June through November 2010: BLA, CEN, JCL, JCR, MPB, MPC and WTZ 7. List of individuals who had Speech Therapy assessments from June through November 2010 8. Records of the following six individuals who had Speech Therapy assessments from June through November 2010: BFL, JEL, LAJ, MD, RH and RM

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		<p>9. List of individuals who had Vocational Rehabilitation assessments from June through November 2010</p> <p>10. Records of the following eight individuals who had Vocational Rehabilitation assessments from June through November 2010: CDS, GNS, JS, LNE, MKS, MMF, RQZ and SE</p> <p>11. List of individuals who had CIPRTA assessments from June through November 2010</p> <p>12. Records of the following four individuals who had CIPRTA assessments from June through November 2010: BH, CF, DHB and MS</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to improve and enhance current practice.</p> <p>Findings: Integrated and focused assessment tools should be revised, updated, and streamlined based on review and analysis of audit data, clinician recommendations for improving clinical utility, and changes in systemic needs and evolving standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p>

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		<p>Findings:</p> <p>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with timeliness (seven calendar days from admission) based on an average sample of 33% of Integrated Rehabilitation Therapy Assessments due each month for the review period June through November 2010 (total of 90 out of 276), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness (fourteen days from referral) based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June through November 2010 (total of 19), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 89% of Physical Therapy Focused Assessments due each month for the review period June through November 2010 (total of 80 out of 92), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p>
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		<p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 99% of Speech Therapy Focused Assessments due each month for the review period June through November 2010 (total of 47 out of 48), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness (30 days from referral) based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June through November 2010 (total of 63), and reported a mean compliance rate of 98%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 100% of CIPRTA assessments due each month for the review</p>
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		<p>period June through November 2010 (total of 25), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 33% of Integrated Rehabilitation Therapy Assessments due each month for the review period June through November 2010 (total of 90 out of 276), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring</p>

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		<p>Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June through November 2010 (total of 19), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 89% of Physical Therapy Focused Assessments due each month for the review period June through November 2010 (total of 80 out of 92), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 99% of Speech Therapy Focused Assessments due each month for the review period June through November 2010 (total of 47 out of 48), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in</p>
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		<p>substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June through November 2010 (total of 63), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June through November 2010 (total of 25), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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<p>D.4.b.ii</p>	<p>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, July 2010: During the maintenance period, continue efforts to ensure that assessments provide a meaningful comprehensive overview of each individual's functional status in order to inform optimal treatment planning.</p> <p>Findings: A review of 29 focused assessments, including vocational rehabilitation, physical therapy, occupational therapy, speech therapy and comprehensive integrated rehabilitation assessments found that 27 out of 29 included a meaningful description of functional status that could be used to inform treatment planning; the remaining two assessments were in partial compliance.</p> <p>Recommendation 2, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 33% of Integrated Rehabilitation Therapy Assessments due each month for the review period June through November 2010 (total of 90 out of 276), and reported a mean compliance rate of 100% for both items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p>
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		<p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June through November 2010 (total of 19), and reported a mean compliance rate of 100% for both items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 89% of Physical Therapy Focused Assessments due each month for the review period June through November 2010 (total of 80 out of 92), and reported a mean compliance rate of 100% for both items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 99% of Speech Therapy Focused Assessments due each month for the review period June through November 2010 (total of 47 out of 48), and reported a mean compliance rate of 100% for both items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to assess compliance of Speech</p>
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Section D: Integrated Assessments

		<p>Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June through November 2010 (total of 63):</p> <table border="1" data-bbox="991 524 1890 675"> <tr> <td data-bbox="991 524 1087 599">3.</td> <td data-bbox="1087 524 1776 599"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 524 1890 599">99%</td> </tr> <tr> <td data-bbox="991 599 1087 675">4.</td> <td data-bbox="1087 599 1776 675"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 599 1890 675">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June through November 2010 (total of 25), and reported a mean compliance rate of 100% for both items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found all records in substantial compliance.</p>	3.	<i>Identifies the individual's current functional status, and</i>	99%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	99%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%						

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 33% of Integrated Rehabilitation Therapy Assessments due each month for the review period June through November 2010 (total of 90 out of 276), and reported a mean compliance rate of 100% for all three items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period June through November 2010 (total of 19), and reported a mean compliance rate of 100% for all three items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>

Section D: Integrated Assessments

		<p>A review of the records of eight individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 89% of Physical Therapy Focused Assessments due each month for the review period June through November 2010 (total of 80 out of 92):</p> <table border="1" data-bbox="991 597 1890 714"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 99% of Speech Therapy Focused Assessments due each month for the review period June through November 2010 (total of 47 out of 48), and reported a mean compliance rate of 100% for all three items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	99%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
5.	<i>Identifies the individual's life goals,</i>	100%									
6.	<i>Strengths, and</i>	99%									
7.	<i>Motivation for engaging in wellness activities.</i>	100%									

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		<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period June through November 2010 (total of 63), and reported a mean compliance rate of 100% for all three items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, NSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period June through November 2010 (total of 25), and reported a mean compliance rate of 100% for all three items. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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Section D: Integrated Assessments

<p>D.4.c</p>	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice for training new employees on assessment protocols.</p> <p>Findings: The facility reported that one occupational therapist required training on the occupational therapy focused assessment and was trained to competency on 10/12/10.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice and provide training on updated integrated and focused assessment tools.</p>
<p>D.4.d</p>	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of the January 2010 tour.</p> <p>Compliance: Substantial.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Deena Rosen, Assistant Director of Dietetics 2. Emiko Taki, Clinical Dietitian 3. Heidi Vogelsang, Clinical Dietitian 4. Jessica Tuttle, Clinical Dietitian 5. Kathryn Ballatore, Clinical Dietitian 6. Kumiko Kato, Clinical Dietitian 7. Laufey Gunnarsdottir, Clinical Dietitian 8. Linderpal Dhillon, Clinical Dietitian 9. Lynn Wurzel, Clinical Dietitian 10. Lynne Fredricksen, Assistant Director of Dietetics 11. Noriko Takenawa, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for December 2009-May 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from December 2009-May 2010 for each assessment type 3. Record of the following individual with type D.5.a assessment from June-November 2010: RRJ 4. Record of the following two individuals with type D.5.b assessments from June-November 2010: JLM and PS 5. Record of the following two individuals with type D.5.c assessments from June-November 2010: CF and RKG 6. Record of the following three individuals with type D.5.d assessments from June-November 2010: JLA, KS and RKH 7. Records of the following six individuals with type D.5.e assessments from June-November 2010: BH, GT, JCC, RS, TLB and VC 8. Records of the following five individuals with type D.5.f assessments from June-November 2010: AR, CC, SMH, SV and TT

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		<p>9. Records of the following eight individuals with type D.5.g assessments from June-November 2010: CB, JLL, KB, KDC, KR, LDW, RC and SL</p> <p>10. Records of the following four individuals with type D.5.i assessments from June-November 2010: CW, JEL, JO and SMC</p> <p>11. Records of the following eight individuals with type D.5.j.i assessments from June-November 2010: AJT, CDC, DP, JD, JW, KJ, MC and MO</p> <p>12. Records of the following seven individuals with type D.5.j.ii assessments from June-November 2010: DS, FP, HLA, JT, KC, MM and RM</p>																		
D.5.a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Continue to monitor this requirement in the event the assessment is performed.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period June through November 2010 (total of one):</p> <table border="1" data-bbox="991 1042 1885 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
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<p>D.5.b</p>	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Continue to monitor this requirement in the event the assessment is performed.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b assessments due each month for the review period June through November 2010 (total of eight):</p> <table border="1" data-bbox="987 633 1890 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when</i>	100%
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13.	<i>Food/fluid consistency is addressed when</i>	100%																																							

Section D: Integrated Assessments

		<table border="1" data-bbox="991 188 1887 459"> <tr> <td></td> <td><i>actual/potential aspiration/dysphagia is present</i></td> <td></td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p data-bbox="991 500 1829 570">Comparative data were not available as NSH reported no type D.5.b Nutrition assessments during the previous review period.</p> <p data-bbox="991 610 1839 716">A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance.</p> <p data-bbox="991 756 1140 826">Compliance: Substantial.</p> <p data-bbox="991 867 1457 937">Current recommendation: Continue to monitor this requirement.</p>		<i>actual/potential aspiration/dysphagia is present</i>		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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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.	<p data-bbox="991 984 1591 1015">Current findings on previous recommendations:</p> <p data-bbox="991 1055 1362 1086">Recommendation, July 2010: Continue to monitor this requirement in the event the assessment is performed.</p> <p data-bbox="991 1208 1881 1382">Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c assessments due each month for the review period June through November 2010 (total of four):</p>																		

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	1.	<i>Assessment is completed on time per policy</i>	100%
	2.	<i>All required subjective concerns are addressed</i>	100%
	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
	7.	<i>Nutrition education is documented</i>	100%
	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
	11.	<i>Recommendations are appropriate and complete</i>	100%
	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
	15.	<i>Assessment utilizes approved abbreviations</i>	100%
	16.	<i>Assessment is concise</i>	100%
	17.	<i>Assessment is legible</i>	100%
	18.	<i>Each page of the assessment is signed</i>	100%
<p>Comparative data were not available as NSH reported no type D.5.c Nutrition assessments during the previous review period.</p>			

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		<p>A review of the records of two individuals to assess compliance with Nutrition type D.5.c criteria found both records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.d	<p>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period June through November 2010 (total of 14):</p> <table border="1" data-bbox="991 971 1892 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention</i>	100%
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D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7	Current findings on previous recommendation:																																	

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	<p>days of admission.</p>	<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period June through November 2010 (total of 64):</p> <table border="1" data-bbox="991 524 1887 1349"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	98%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	96%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period June through November 2010 (total of 19):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	95%	2.	<i>All required subjective concerns are addressed</i>	100%									
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		<p>Nutrition type D.5.f criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g assessments due each month for the review period June through November 2010 (total of 161):</p> <table border="1" data-bbox="991 894 1890 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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		<table border="1"> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to enhance current practice.</p>																														

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		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 41% of Nutrition assessments (all types) due each month of the review period June through November 2010 (684 out of 1652). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 48 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 28% of Nutrition Type D.5.i assessments due each month for the review period June through November 2010 (total of 214 out of 764):</p> <table border="1" data-bbox="991 1263 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
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2.	<i>All required subjective concerns are addressed</i>	100%									
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%									

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		4. <i>Estimated daily needs for nutrients specified are appropriate</i>	100%
		5. <i>Assessment utilizes findings from subjective and objective data</i>	100%
		6. <i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
		7. <i>Nutrition education is documented</i>	100%
		8. <i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%
		9. <i>Progress is monitored, measured, and evaluated</i>	100%
		10. <i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11. <i>Recommendations are appropriate and complete</i>	100%
		12. <i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13. <i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14. <i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
		15. <i>Assessment utilizes approved abbreviations</i>	100%
		16. <i>Assessment is concise</i>	100%
		17. <i>Assessment is legible</i>	100%
		18. <i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p>	
		<p>A review of the records of four individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p>	

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																														
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i assessments due each month for the review period June through November 2010 (total of 71):</p> <table border="1" data-bbox="991 821 1885 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%																												
D.5.j.ii	Every individual will be assessed annually.	<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of eight individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its</p>																											

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		<p>compliance based on an average sample of 23% of Nutrition Type D.5.j.ii assessments due each month for the review period June through November 2010 (total of 128 out of 546):</p>
1.	<i>Assessment is completed on time per policy</i>	100%
2.	<i>All required subjective concerns are addressed</i>	100%
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	99%
5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
7.	<i>Nutrition education is documented</i>	100%
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
9.	<i>Progress is monitored, measured, and evaluated</i>	100%
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
11.	<i>Recommendations are appropriate and complete</i>	100%
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13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
15.	<i>Assessment utilizes approved abbreviations</i>	100%
16.	<i>Assessment is concise</i>	100%
17.	<i>Assessment is legible</i>	100%
18.	<i>Each page of the assessment is signed</i>	100%

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		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following individual: RD 2. Andrea Parsons, CSW, Acting Senior Social Worker 3. Carmen Caruso, Clinical Administrator 4. Delores Matteucci, Acting Executive Director 5. John Wyman, Acting Senior Social Worker 6. Malia Haas, LCSW, Acting Senior Social Worker 7. Monique Jansma, LCSW, Acting Chief Social work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following six individuals: CH, JHK, REB, RJR, SSM and WB 2. DMH Social History Assessments Monitoring Form summary data, June-November 2010 3. List of individuals assessed to need family therapy 									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 47% of the Integrated Assessments: Social Work Section due each month during the review period (June through November 2010):</p> <table border="1" data-bbox="993 1304 1892 1416"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%									
2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at</i>	100%									

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		<table border="1" data-bbox="993 190 1892 305"> <tr> <td data-bbox="993 190 1094 305"></td> <td data-bbox="1094 190 1793 305"><i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 190 1892 305"></td> </tr> </table> <p data-bbox="993 347 1892 415">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 457 1892 565">A review of the records of six individuals to evaluate the Integrated Assessments: Social Work Sections found that all six assessments were current and comprehensive (CH, JHK, REB, RJR, SSM and WB).</p> <p data-bbox="993 607 1892 750">Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 41% of the 30-Day Psychosocial Assessments due each month during the review period (June through November 2010):</p> <table border="1" data-bbox="993 786 1892 1013"> <tr> <td data-bbox="993 786 1094 824">1.</td> <td data-bbox="1094 786 1793 824"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1793 786 1892 824">100%</td> </tr> <tr> <td data-bbox="993 824 1094 863">2.</td> <td data-bbox="1094 824 1793 863"><i>Current, and</i></td> <td data-bbox="1793 824 1892 863">100%</td> </tr> <tr> <td data-bbox="993 863 1094 1013">3.</td> <td data-bbox="1094 863 1793 1013"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1793 863 1892 1013">100%</td> </tr> </table> <p data-bbox="993 1055 1892 1123">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 1166 1892 1273">A review of the records of six individuals to evaluate the 30-Day Psychosocial Assessments found that all six assessments were timely and comprehensive (CH, JHK, REB, RJR, SSM and WB).</p> <p data-bbox="993 1315 1136 1383">Compliance: Substantial</p>		<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>		1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
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3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%												

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		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 41% of the 30-Day Psychosocial Assessments due each month during the review period (June through November 2010):</p> <table border="1" data-bbox="993 711 1892 863"> <tr> <td data-bbox="993 711 1087 784">4.</td> <td data-bbox="1087 711 1793 784"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1793 711 1892 784">100%</td> </tr> <tr> <td data-bbox="993 784 1087 824">5.</td> <td data-bbox="1087 784 1793 824"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1793 784 1892 824">100%</td> </tr> <tr> <td data-bbox="993 824 1087 863">6.</td> <td data-bbox="1087 824 1793 863"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1793 824 1892 863">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of six individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all six assessments identified and resolved factual inconsistencies (CH, JHK, REB, RJR, SSM and WB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
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5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

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<p>D.6.c</p>	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 47% of Integrated Assessments: Social Work Section due each month during the review period (June through November 2010):</p> <table border="1" data-bbox="991 597 1890 638"> <tr> <td data-bbox="991 597 1087 638">7.</td> <td data-bbox="1087 597 1793 638"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 597 1890 638">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to evaluate timeliness of the Social Work Integrated Assessment found that all six assessments were timely (CH, JHK, REB, RJR, SSM and WB).</p> <p>Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 41% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="991 1081 1890 1122"> <tr> <td data-bbox="991 1081 1087 1122">8.</td> <td data-bbox="1087 1081 1793 1122"><i>Fully documented by 30th day of admission</i></td> <td data-bbox="1793 1081 1890 1122">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that four assessments were timely (JHK, REB, RJR and SSM) and two were untimely (CH and WB).</p>	7.	<i>Is included in the 7-day integrated assessment</i>	99%	8.	<i>Fully documented by 30th day of admission</i>	99%
7.	<i>Is included in the 7-day integrated assessment</i>	99%						
8.	<i>Fully documented by 30th day of admission</i>	99%						

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, NSH assessed its compliance based on an average sample of 47% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 857 1887 1045"> <tr> <td data-bbox="993 857 1087 932">9.</td> <td data-bbox="1087 857 1793 932"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1793 857 1887 932">100%</td> </tr> <tr> <td data-bbox="993 932 1087 1045">10.</td> <td data-bbox="1087 932 1793 1045"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1793 932 1887 1045">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all six assessments included this information (CH, JHK, REB, RJR, SSM and WB).</p> <p>Using the DMH Social History Assessments Monitoring Form, NSH</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%						

Section D: Integrated Assessments

		<p>assessed its compliance based on an average sample of 41% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 302 1890 492"> <tr> <td data-bbox="993 302 1087 378">9.</td> <td data-bbox="1087 302 1795 378"><i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i></td> <td data-bbox="1795 302 1890 378">100%</td> </tr> <tr> <td data-bbox="993 378 1087 492">10.</td> <td data-bbox="1087 378 1795 492"><i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i></td> <td data-bbox="1795 378 1890 492">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to evaluate documentation of the individual's social factors and educational status in the 30-day Psychosocial Assessments found that all six assessments included this information (CH, JHK, REB, RJR, SSM and WB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%	10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%
9.	<i>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors</i>	100%						
10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%						

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress: NSH has maintained substantial compliance with the requirements of this section. The facility should pay special attention to the documentation of discussion of discharge barriers with the individual, including the individual's input and feedback.</p>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following individual: RD 2. Andrea Parsons, CSW, Acting Senior Social Worker 3. Carmen Caruso, Clinical Administrator 4. John Wyman, LCSW, Acting Senior Social Worker 5. Malia Haas, LCSW, Acting Senior Social Worker 6. Monique Jansma, LCSW, Acting Chief of Social Work <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 21 individuals: AA, ALW, AN, AS, CL, CS, DJE, DLE, DLT, DPA, IEJ, JAB, JB, JND, MMG, RAS, RED, RRW, RW, TJM and TMM 2. DMH Discharge Planning and Community Integration Auditing Form summary data, June-November 2010 3. List of individuals who have met discharge criteria and are still hospitalized 4. List of individuals assessed to need family therapy 5. List of individuals under civil commitment <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program 3, unit T14) for review of RW 2. WRPC (Program 3, unit T15) for review of AS 3. WRPC (Program 4, unit A8) for review of AN

Section E: Discharge Planning and Community Integration

E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that five WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AA, IEJ, JND, RAS and TMM). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining one WRP (ALW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that all six WRPs included the individual's psychosocial functioning in the Present Status section (AA, ALW, IEJ, JND, RAS and TMM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of</p>

Section E: Discharge Planning and Community Integration

		<p>97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor observed three WRPCs (AN, AS and RW). The WRPTs for AN and AS discussed discharge barriers with the individual, and the team for RW did not. However, the WRPs do not reflect the WRPC proceedings with regard to the discharge discussions. Only one (JND) of six charts reviewed (AA, ALW, IEJ, JND, RAS and TMM) contained documentation of the discussion with the individual on discharge barriers. WRPTs should document the discussion they had with the individual about discharge barriers and document the individual's responses to each of the discharge criteria and the progress towards compliance with those discharge criteria (e.g., individual did not understand his/her discharge criteria, did not agree with the discharge conditions, etc.). Interventions can be designed to address the individual's lack or poor understanding of his/her discharge barriers.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of</p>

Section E: Discharge Planning and Community Integration

		<p>98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals found that five WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (ALW, IEJ, JND, RAS and TMM). The remaining one WRP did not (AA).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The documentation to this requirement is similar to that presented above (E.1.c). Observation of three WRPCs found that the individual was an active participant in the discharge planning process. However, documentation in the individuals' WRPs does not reflect the proceedings of the conference. Only two (IEJ and RAS) of six WRPs reviewed (AA,</p>

Section E: Discharge Planning and Community Integration

		<p>ALW, IEJ, JND, RAS and TMM) contained documentation indicating that the individual was an active participant in the discharge process.</p> <p>A review of the records of 13 individuals found that ten WRPs contained measurable objectives and interventions to address the individual's discharge criteria (ALW, AN, AS, CL, DLE, DPA, JAB, JB, JND and RAS) and partial compliance in the remaining three (AA, IEJ and TMM).</p> <p>A review of the records of seven individuals found that all seven WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (AN, AS, CL, CS, DPA, JAB and RED).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations:	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing</p>

Section E: Discharge Planning and Community Integration

		<p>Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of 11 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in nine WRPs (AS, DLE, DPA, IEJ, JAB, JND, RAS, RED and TMM). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining two WRPs (AA and ALW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of ten individuals found that all ten WRPs identified the staff member responsible for the interventions (AA, ALW,</p>

Section E: Discharge Planning and Community Integration

		<p>CS, DJE, IEJ, JAB, JND, RAS, TJM and TMM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.c	<p>The time frames for completion of the interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals found that six WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AA, ALW, IEJ, JND, RAS and TMM) and one WRP did not (MMG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	Compliance: Substantial.						
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH continues to take steps to ensure that individuals referred for discharge are placed in the community depending on their legal status and availability of suitable placements.</p> <p>Documentation review and interview of the SW Chief and senior SW staff found that NSH had discharged 57 individuals during this review period. Fifty-two individuals had met their discharge criteria and are being processed for referral for discharge. Fifty-seven individuals referred for discharge are still hospitalized and NSH is working with outside agencies to resolve barriers and find placement for these individuals. Only nine of the 57 individuals have been hospitalized for more than six months following their referral date, and the remaining 48 individuals were referred for discharge within this review period (June through November 2010). The table below shows the status and the reasons for continued hospitalization of the nine individuals still hospitalized for more than six months following referral for discharge:</p> <table border="1" data-bbox="989 1192 1900 1370"> <thead> <tr> <th data-bbox="989 1192 1094 1304">Individual</th> <th data-bbox="1094 1192 1255 1304">Discharge Referral Date</th> <th data-bbox="1255 1192 1900 1304">Status/Reasons for continued hospitalization</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1304 1094 1370">JH</td> <td data-bbox="1094 1304 1255 1370">3/12/10</td> <td data-bbox="1255 1304 1900 1370">CONREP denial in August 2010. Waiting to resubmit.</td> </tr> </tbody> </table>	Individual	Discharge Referral Date	Status/Reasons for continued hospitalization	JH	3/12/10	CONREP denial in August 2010. Waiting to resubmit.
Individual	Discharge Referral Date	Status/Reasons for continued hospitalization						
JH	3/12/10	CONREP denial in August 2010. Waiting to resubmit.						

Section E: Discharge Planning and Community Integration

		RO	3/12/10	County unwilling to consider discharge due to violence risk. Team is to reassess and develop a plan with RO and resubmit for discharge. .
		HV	3/23/10	Court ordered Conditional Outpatient Treatment. Awaiting placement.
		TW	4/5/10	TW was moved to an open unit prior to placement in a lower level of care (e.g. Sylmar). It was then discovered that TW had inoperable throat cancer. Discharge plan was put on hold.
		FR	4/7/10	Forensic Community Liaison Office (FCLO) met with team and developed a treatment plan. FCLO is waiting for information that individual has met criteria relative to developed plan. FR has applied for transfer to PSH even though she has met discharge criteria. FCLO reports that PSH will not take her if she is pending discharge.
		CR	5/4/10	CR refused discharge (on 12/2010). CR does not feel he is ready and wants to wait till June 2011. County is in support of individual's choice to remain at NSH.
		BJ	5/5/10	County reported reservations due to past assaults in previous placements, or for CONREP placement. Potential discharge is still being assessed by County.
		IJ	5/19/10	Placement was denied on 12/22/10. IJ has requested a court date via a writ.
		RC	5/20/10	Chris Chappa from San Francisco approved placement on 12/12/10. Waiting for Forensic Community Liaison Office to set up interview.
		<p>According to the Chief of Social Work, she meets with unit Social Work staff on a weekly basis to review and discuss the status of individuals referred for discharge, and to problem-solve barriers to placement. The</p>		

Section E: Discharge Planning and Community Integration

		<p>facility continues to face external barriers that contribute to the delay in discharge including LA County's reluctance in placing individuals under certain penal codes such as sex offenders.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, NSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (June through November 2010), and reported a mean compliance rate of 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that seven WRPs contained documentation of the assistance needed by the individual in the new setting (AA, ALW, DLT, IEJ, JND, RRW and TMM). The remaining one WRP did not (RAS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to NSH as it does not serve children and adolescents.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	

Section E: Discharge Planning and Community Integration

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.	
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F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services: NSH has achieved substantial compliance with the requirements of Section F.1. In order to maintain this achievement, the facility needs to ensure adequate correction of the deficiencies outlined by this monitor in subsections F.1.d and F.1.e.</p> <p>Summary of Progress on Psychological Services: NSH has maintained substantial compliance with the requirements of this section.</p> <p>Summary of Progress on Nursing Services: NSH has maintained substantial compliance with the requirements pertaining to documentation of PRN and Stat medications.</p> <p>Areas of need include:</p> <ol style="list-style-type: none"><i>1. NSH needs to critically focus on implementing effective strategies addressing the consistent problematic issues regarding changes in status to ensure that the nursing assessments and documentation are clinically adequate and appropriate. In addition, NSH's auditing data has not accurately reflected the problems that exist in this area that have been consistently found during reviews.</i><i>2. Problems were found regarding safe medication administration practices on Unit A4, which must be promptly addressed for the facility to come back into substantial compliance in this area.</i> <p>Summary of Progress on Rehabilitation Therapy Services: NSH has attained substantial compliance with all requirements of Section F.4, and should continue to enhance and improve current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on Nutrition Services: NSH has maintained substantial compliance with all requirements of Section F.5 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Pharmacy Services: As of the tour conducted in July 2010, NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on General Medical Services: NSH has maintained substantial compliance with the requirements in this section. However, the facility must address the deficiencies outlined in subsection F.7.a in order to maintain gains in this area, and ensure vigilance in the oversight of practitioners' delivery of adequate care.</p> <p>Summary of Progress on Infection Control: NSH has maintained substantial compliance with the requirements of this section.</p> <p>Summary of Progress on Dental Services NSH's Dental Department has continued to maintain substantial compliance in all but one area of the Enhancement Plan--refusals. Concentrated efforts, especially by the CNS, are being directed at individualizing the WRPs and this area should come into substantial compliance by the next review period.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Evelyn Neldoza, RN, Central Nursing Services 2. James Young, MD, Acting Assistant Medical Director 3. Jonathan Berry, MD, Acting Senior Psychiatrist 4. Patrick Nolan, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 42 individuals: AB-1, AB-2, AH, ALF, AS, BAH, CCS, CMK, CMS, CRH, CSB, DLH, DLT, DM, DRZ, ERM, JCC, JCR, JFL, JHC, JND, JSR, JTC, KS, KVV, LG, LSB, MBD, MD, MER, MLD, MNR, RAB, RL, RLH, RSS, SHL, SLH, TB, TDL, TLP and WCF 2. NSH Admission Psychiatric Assessment Auditing summary data (June to November 2010) 3. NSH Integrated Assessment: Psychiatry Section Auditing summary data (June to November 2010) 4. NSH Monthly PPN Audit summary data (June to November 2010) 5. NSH PRN and Stat monitoring summary data (June to November 2010) 6. NSH Movement Disorder Monitoring summary data (June to November 2010) 7. NSH Polypharmacy database 8. NSH Tardive Dyskinesia database 9. Tardive Dyskinesia Samples for Focus 6 10. Revised AIMS Assessment form 11. AD 560, Tardive Dyskinesia, revised December 2010 revision 12. DMH Psychotropic Medication Policy Addenda: Addenda to Special Order 105.12 13. Memorandum from Acting Chief of Psychiatry: Individuals Taking High Risk Medications Who Refuse Laboratory Tests, January 7, 2011 14. NSH aggregated data regarding adverse drug reactions (June to

Section F: Specific Therapeutic and Rehabilitation Services

		<p>November 2010)</p> <ol style="list-style-type: none"> 15. Last twelve ADRs for this reporting period 16. ADR aggregate reports for the current period 17. Five Drug Utilization Evaluations (DUEs) completed by NSH during this review period 18. NSH aggregated data regarding medication variances (December to May 2009/2010) 19. MVR aggregate report for the current period 20. Last ten MVRs for this reporting period 21. NSH Nightly (NOC) Audit - old and new versions 22. Interdisciplinary Note from Incident Management database for DLT 23. Seven Intensive case Analyses (ICAs) completed during this review period 24. Pharmacy and Therapeutics Committee Minutes (June to December 2010)
<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. • Continue to provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH. <p>Findings:</p> <p>During this review period, the DMH medication guidelines were updated regarding the frequency of the first two injections of haloperidol decanoate. The facility's I-Net reflected this modification and the Assistant Medical Director communicated this update during the Department of Psychiatry meeting.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Recommendation 3, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 44%, 38% and 14%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. 2. Continue to provide an outline of all updates made to the individualized medication guidelines, including the specific changes made and the status of implementation at NSH. 3. Continue to monitor this requirement. 															
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 1008 1887 1084"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 1232 1887 1349"> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation is documented</i></td> <td>98%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</p>	Admission Psychiatric Assessment			8.	<i>Plan of care</i>	99%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation is documented</i>	98%	10.	<i>Psychopharmacology treatment plan</i>	98%
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F.1.a.iii	tailored to each individual's symptoms;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5.b</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i></td> <td>99%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.b	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i>	99%			
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F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	100%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.									

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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 228 1887 565"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>90%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>97%</td> </tr> </tbody> </table> <p data-bbox="991 609 1921 678">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	Monthly PPN			2.g	<i>Current AIMS</i>	90%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	97%
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F.1.a.vi	modified based on clinical rationales;	<table border="1" data-bbox="991 748 1887 1166"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>97%</td> </tr> </tbody> </table> <p data-bbox="991 1209 1921 1279">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	99%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	97%
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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result	<table border="1" data-bbox="991 1349 1887 1425"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose</i></td> <td>97%</td> </tr> </tbody> </table>	Monthly PPN			5.d	<i>Justify/explain the use of medications that pose</i>	97%			
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	<p>of excessive sedation; and</p>	<table border="1" data-bbox="991 191 1908 418"> <tr> <td data-bbox="991 191 1087 418"></td> <td data-bbox="1087 191 1793 418"> <p><i>elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></p> </td> <td data-bbox="1793 191 1908 418"></td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>		<p><i>elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></p>							
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<p>F.1.a.viii</p>	<p>Properly documented.</p>	<table border="1" data-bbox="991 602 1908 760"> <tr> <td data-bbox="991 602 1446 643"> <p>Admission Psychiatric Assessment</p> </td> <td data-bbox="1446 602 1793 643"> <p>8.a, 8.b and 8.c</p> </td> <td data-bbox="1793 602 1908 643"> <p>99%</p> </td> </tr> <tr> <td data-bbox="991 643 1446 716"> <p>Integrated Assessment (Psychiatry)</p> </td> <td data-bbox="1446 643 1793 716"> <p>7 and 10</p> </td> <td data-bbox="1793 643 1908 716"> <p>99%</p> </td> </tr> <tr> <td data-bbox="991 716 1446 760"> <p>Monthly PPN</p> </td> <td data-bbox="1446 716 1793 760"> <p>2.b, 2.g, 3 and 5.a-5.d</p> </td> <td data-bbox="1793 716 1908 760"> <p>98%</p> </td> </tr> </table>	<p>Admission Psychiatric Assessment</p>	<p>8.a, 8.b and 8.c</p>	<p>99%</p>	<p>Integrated Assessment (Psychiatry)</p>	<p>7 and 10</p>	<p>99%</p>	<p>Monthly PPN</p>	<p>2.b, 2.g, 3 and 5.a-5.d</p>	<p>98%</p>
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<p>F.1.b</p>	<p>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that the administration of PRN/Stat medication is based on specific indications and tailored to target symptoms consistent with the individual's diagnosis. <p>Findings:</p> <p>NSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 14% of individuals who have been hospitalized for 90 or more days during the review period (June-November 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 20% and 28% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p>									

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		<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 228 1087 380">6.</td> <td data-bbox="1087 228 1793 380"><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td data-bbox="1793 228 1887 380">99%</td> </tr> </tbody> </table> <p data-bbox="989 418 1898 488">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 565 1087 602">1.</td> <td data-bbox="1087 565 1793 602"><i>Safe administration of PRN medication.</i></td> <td data-bbox="1793 565 1887 602">99%</td> </tr> <tr> <td data-bbox="989 602 1087 716">3.</td> <td data-bbox="1087 602 1793 716"><i>Documentation of individual prior to PRN medication administration, which includes circumstances/behavior requiring medication.</i></td> <td data-bbox="1793 602 1887 716">99%</td> </tr> <tr> <td data-bbox="989 716 1087 792">5.</td> <td data-bbox="1087 716 1793 792"><i>Documentation of individual's response to PRN medication within one hour of administration.</i></td> <td data-bbox="1793 716 1887 792">99%</td> </tr> </tbody> </table> <p data-bbox="989 831 1898 901">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1"> <thead> <tr> <th colspan="3">Nursing Services Stat</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 977 1087 1015">2.</td> <td data-bbox="1087 977 1793 1015"><i>Safe administration of Stat medication.</i></td> <td data-bbox="1793 977 1887 1015">99%</td> </tr> <tr> <td data-bbox="989 1015 1087 1128">4.</td> <td data-bbox="1087 1015 1793 1128"><i>Documentation of individual prior to STAT medication administration, which includes circumstances/behavior requiring medication.</i></td> <td data-bbox="1793 1015 1887 1128">99%</td> </tr> <tr> <td data-bbox="989 1128 1087 1205">6.</td> <td data-bbox="1087 1128 1793 1205"><i>Documentation of individual's response to STAT medication within one hour of administration.</i></td> <td data-bbox="1793 1128 1887 1205">99%</td> </tr> </tbody> </table> <p data-bbox="989 1243 1898 1313">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 1352 1192 1425">Other findings: Same as in D.1.f.</p>	Monthly PPN			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	99%	Nursing Services PRN			1.	<i>Safe administration of PRN medication.</i>	99%	3.	<i>Documentation of individual prior to PRN medication administration, which includes circumstances/behavior requiring medication.</i>	99%	5.	<i>Documentation of individual's response to PRN medication within one hour of administration.</i>	99%	Nursing Services Stat			2.	<i>Safe administration of Stat medication.</i>	99%	4.	<i>Documentation of individual prior to STAT medication administration, which includes circumstances/behavior requiring medication.</i>	99%	6.	<i>Documentation of individual's response to STAT medication within one hour of administration.</i>	99%
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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Improve documentation of the individual's response to the administration of PRN/Stat medications. 															
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure accuracy of the polypharmacy database. <p>Findings: NSH used the standardized DMH Monthly PPN Audit Form to assess compliance (June-November 2010). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 1008 1890 1312"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines (%S = 10%)</i></td> <td>99%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics (%S = 10%)</i></td> <td>100%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy (%S = 8%)</i></td> <td>91%</td> </tr> </tbody> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	PPN - Revised			5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>		5.d.i.	<i>Benzodiazepines (%S = 10%)</i>	99%	5.d.ii.	<i>Anticholinergics (%S = 10%)</i>	100%	5.d.iii.	<i>Polypharmacy (%S = 8%)</i>	91%
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		<p>Additionally, NSH reported the following comparative data:</p> <table border="1"> <thead> <tr> <th data-bbox="991 303 1045 378"></th> <th data-bbox="1045 303 1610 378">Indicators</th> <th data-bbox="1610 303 1753 378">Previous period</th> <th data-bbox="1753 303 1896 378">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 378 1045 456">1.</td> <td data-bbox="1045 378 1610 456"><i>Total number of individuals receiving benzodiazepines</i></td> <td data-bbox="1610 378 1753 456">101</td> <td data-bbox="1753 378 1896 456">112</td> </tr> <tr> <td data-bbox="991 456 1045 566">2.</td> <td data-bbox="1045 456 1610 566"><i>Total number of individuals receiving benzodiazepines and have dx of substance abuse: (a) any substance</i></td> <td data-bbox="1610 456 1753 566">52</td> <td data-bbox="1753 456 1896 566">60</td> </tr> <tr> <td data-bbox="991 566 1045 716">3.</td> <td data-bbox="1045 566 1610 716"><i>Total number receiving benzodiazepines and have cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td data-bbox="1610 566 1753 716">15</td> <td data-bbox="1753 566 1896 716">19</td> </tr> <tr> <td data-bbox="991 716 1045 751">4.</td> <td data-bbox="1045 716 1610 751"><i>Total number receiving anticholinergics</i></td> <td data-bbox="1610 716 1753 751">52</td> <td data-bbox="1753 716 1896 751">64</td> </tr> <tr> <td data-bbox="991 751 1045 901">5.</td> <td data-bbox="1045 751 1610 901"><i>Total number receiving anticholinergics and have dx of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td data-bbox="1610 751 1753 901">8</td> <td data-bbox="1753 751 1896 901">9</td> </tr> <tr> <td data-bbox="991 901 1045 979">6.</td> <td data-bbox="1045 901 1610 979"><i>Total number with intra-class polypharmacy</i></td> <td data-bbox="1610 901 1753 979">326</td> <td data-bbox="1753 901 1896 979">333</td> </tr> <tr> <td data-bbox="991 979 1045 1053">7.</td> <td data-bbox="1045 979 1610 1053"><i>Total number with inter-class polypharmacy</i></td> <td data-bbox="1610 979 1753 1053">130</td> <td data-bbox="1753 979 1896 1053">137</td> </tr> </tbody> </table> <p>The data showed that the facility has maintained adequate practice regarding the number of individuals receiving the above-mentioned treatment interventions.</p> <p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders 		Indicators	Previous period	Current period	1.	<i>Total number of individuals receiving benzodiazepines</i>	101	112	2.	<i>Total number of individuals receiving benzodiazepines and have dx of substance abuse: (a) any substance</i>	52	60	3.	<i>Total number receiving benzodiazepines and have cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	15	19	4.	<i>Total number receiving anticholinergics</i>	52	64	5.	<i>Total number receiving anticholinergics and have dx of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	8	9	6.	<i>Total number with intra-class polypharmacy</i>	326	333	7.	<i>Total number with inter-class polypharmacy</i>	130	137
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		<p>and/or cognitive disorders;</p> <ol style="list-style-type: none"> 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following outlines these reviews (the diagnosis is listed only if it signifies a high-risk condition):</p> <p><u>Benzodiazepine use</u></p> <table border="1" data-bbox="991 634 1883 1136"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>ALF</td> <td>Clonazepam</td> <td>Alcohol Dependence</td> </tr> <tr> <td>CMS</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>CRH</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>CSB</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>DLH</td> <td>Lorazepam</td> <td>Other Substance Abuse, including Inhalants</td> </tr> <tr> <td>JND</td> <td>Clonazepam</td> <td>Alcohol Dependence</td> </tr> <tr> <td>JTC</td> <td>Lorazepam-being tapered</td> <td>Alcohol Dependence and Amphetamine Dependence</td> </tr> <tr> <td>RLH</td> <td>Lorazepam</td> <td>Moderate Mental Retardation</td> </tr> <tr> <td>SLH</td> <td>Lorazepam</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>WCF</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> </tbody> </table> <p>This review found substantial compliance in eight charts (ALF, CMS, CRH, CSB, DLH, JND, JTC and SLH) and partial compliance in two (RLH and WCF).</p> <p><u>Anticholinergic use for individuals suffering from cognitive impairments</u> (only two individual were identified):</p>	Individual	Medication(s)	Diagnosis	ALF	Clonazepam	Alcohol Dependence	CMS	Clonazepam	Polysubstance Dependence	CRH	Lorazepam	Polysubstance Dependence	CSB	Clonazepam	Polysubstance Dependence	DLH	Lorazepam	Other Substance Abuse, including Inhalants	JND	Clonazepam	Alcohol Dependence	JTC	Lorazepam-being tapered	Alcohol Dependence and Amphetamine Dependence	RLH	Lorazepam	Moderate Mental Retardation	SLH	Lorazepam	Borderline Intellectual Functioning	WCF	Lorazepam	Polysubstance Dependence
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		ERM	Quetiapine, chlorpromazine, clonazepam and trazodone	
		JCC	Clozapine, haloperidol, topiramate and citalopram	
		JCR	Clozapine, risperidone consta, lithium, risperidone, ziprasidone (discontinued) and sertraline	
		JHC	Clozapine, clonazepam, haloperidol, divalproex and zolpidem	
		RSS	Divalproex, sertraline, quetiapine, lithium, trazodone, zolpidem and lorazepam	Polysubstance Dependence
		SHL	Quetiapine, haloperidol, mirtazapine, lamotrigine and lithium	
<p>This review found substantial compliance in seven charts (AS, BAH, ERM, JCC, JCR, JHC and SHL) and partial compliance in two (CMK and RSS).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Assess current methods used for tapering off benzodiazepines to minimize likelihood of withdrawal syndromes. 3. Provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following: <ol style="list-style-type: none"> a. Benzodiazepines for 60 days or more; b. Benzodiazepines and have any diagnosis of substance use disorder; c. Benzodiazepines and have any diagnosis of cognitive impairment; d. Anticholinergics for 60 days or more; e. Anticholinergics and have any diagnosis of cognitive impairments 				

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		<p>and/or tardive dyskinesia and/or are age 65 or above; f. Intra-class polypharmacy; and g. Inter-class polypharmacy.</p>			
<p>F.1.d</p>	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that individuals who repeatedly refuse laboratory testing and are receiving high-risk medications are provided behavioral interventions (based on functional assessments) to address their maladaptive behavior. <p>Findings: Using the DMH Monthly PPN Auditing Form, NSH assessed its compliance based on an average sample of 14% of individuals hospitalized for 90 days or more during the review period (June-November 2010):</p> <table border="1" data-bbox="991 857 1906 1008"> <tr> <td data-bbox="991 857 1129 1008">5.d.v</td> <td data-bbox="1129 857 1808 1008"><i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i></td> <td data-bbox="1808 857 1906 1008">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p>	5.d.v	<i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i>	95%
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Individual	Medication(s)	Diagnosis
AB-1	Risperidone	Hyperprolactinemia
AB-2	Clozapine	Hyperlipidemia, Diabetes Mellitus and Obesity.
BAH	Olanzapine and iloperidone	Diabetes Mellitus
CCS	Risperidone	Diabetes Mellitus and Hypertension
DM	Quetiapine	Diabetes Mellitus and Obesity.
DRZ	Risperidone	Diabetes Mellitus and Obesity
JFL	Olanzapine	Diabetes Mellitus, Obesity and Hypertension
JSR	Risperidone	None documented
KVV	Olanzapine	Hyperlipidemia, Diabetes Mellitus and Hypertension
RAB	Olanzapine	Hyperlipidemia, Diabetes Mellitus, Obesity and Hypertension
TB	Clozapine	Diabetes Mellitus and Dyslipidemia
TDL	Quetiapine	Diabetes Mellitus and Hypertension

This review found general evidence of substantial compliance with this requirement. However, the following process deficiencies were identified:

1. The psychiatric progress notes did not include or address a diagnosis of hyperlipidemia for an individual (DRZ) who received high-risk treatment with risperidone and suffered from this condition (as per laboratory results). The risk/benefit analysis of this individual was in error because of an assessment that the individual did not suffer from side effects of treatment.
2. The weekly psychiatric progress notes did not address the status of diabetes control as measured by HgbA1C in one individual who received high-risk treatment with olanzapine and suffered from

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		<p>diabetes mellitus (JFL). However, the psychiatrist addressed this issue when the individual was subsequently assessed for inter-unit transfer.</p> <ol style="list-style-type: none"> 3. The WRP did not update the diagnosis for one individual whose diagnosis of diabetes mellitus was discontinued per the Physician and Surgeon (BAH). This individual received high-risk treatment with olanzapine. The psychiatric progress notes did not include a diagnosis of hyperlipidemia although the individual received treatment for this condition. However, there was evidence of appropriate psychiatric management in that high-risk treatment was eventually discontinued in favor of low-risk medication (aripiprazole). 4. There was no evidence of a behavioral assessment/guidelines/plan to address an individual's repeated refusal of laboratory testing that was needed to monitor metabolic status. The individual (CCS) received high-risk treatment (with risperidone) and was considered for another high-risk treatment (with clozapine) for clinical indications. <p>During this review period, NSH established an Interdisciplinary Refusals Work Group to address issues related to patient refusal of laboratory testing in the context of high-risk medication use. In this context, the Acting Chief of Psychiatry drafted guidelines for the interim handling of patient refusal of laboratory tests and the Medical Director developed a Refusal Behavioral Consultation form for WRPTs to request additional behavioral interventions utilizing functional assessments as appropriate. In January 2011, the Medical Director reviewed the work of the Interdisciplinary Refusals Workgroup including refusal rates, circumstances in which to request behavioral consultation and the Refusal Log maintained by nursing staff on each unit.</p> <p>Compliance: Substantial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Implement current plans to address refusal by some individuals receiving high risk treatments of necessary laboratory testing to monitor the status of these individuals. 3. Ensure that current procedure regarding use of clozapine ensures adequate frequency of checking vital signs. 															
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Ensure accuracy of self-monitoring in this area. • Correct process deficiencies outlined by this monitor [in this cell in the previous report]. <p>Findings:</p> <p>Using the DMH Movement Disorders Auditing Form, NSH assessed its compliance based on average samples ranging from 14% to 44% of individuals relevant to each indicator during the review period (June-November 2010):</p> <table border="1" data-bbox="991 971 1887 1416"> <tr> <td data-bbox="991 971 1087 1045">1.</td> <td data-bbox="1087 971 1793 1045"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 971 1887 1045">100%</td> </tr> <tr> <td data-bbox="991 1045 1087 1157">2.</td> <td data-bbox="1087 1045 1793 1157"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1045 1887 1157">90%</td> </tr> <tr> <td data-bbox="991 1157 1087 1269">3.</td> <td data-bbox="1087 1157 1793 1269"><i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 1157 1887 1269">93%</td> </tr> <tr> <td data-bbox="991 1269 1087 1349">4.</td> <td data-bbox="1087 1269 1793 1349"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 1269 1887 1349">99%</td> </tr> <tr> <td data-bbox="991 1349 1087 1416">5.</td> <td data-bbox="1087 1349 1793 1416"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with</i></td> <td data-bbox="1793 1349 1887 1416">No data</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	90%	3.	<i>Monitoring of the individual is conducted every three months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	93%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	99%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with</i>	No data
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	<i>complicated movement disorders.</i>														
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		<p>mentoring to staff psychiatrists regarding appropriate pharmacological management and aspects of the care of these individuals.</p> <ol style="list-style-type: none"> 5. The Medical Director revised the administrative directive regarding TD to reflect changes in the TRC process and expectations regarding documentation of the AIMS assessment on the new hard stock form. 6. As reported in D.1.d, a Tardive Dyskinesia CME program was provided on December 17, 2010. <p>This monitor reviewed the charts of six individuals (KC, LSB, MBD, MLD, RL and TLP) who were diagnosed with TD per the facility's database. The review found the following:</p> <ol style="list-style-type: none"> 1. There was evidence of improved evaluations by the Neurology Movement Disorders clinic that were completed in recent months (e.g KC, MBD and TLP). 2. The facility improved the filing and tracking of AIMS testing results in most of the charts that utilized the new hard stock form. 3. The quarterly AIMS were completed in the charts of KC, LSB, MBD and RL. 4. The WRP included appropriate learning-based objectives in the charts of KC and LSB. 5. There was evidence of improved clinical outcomes as a result of the use of safe antipsychotic treatment (with clozapine) for an individual (TLP). <p>The review found the following process deficiencies:</p> <ol style="list-style-type: none"> 1. AIMS tests were not completed on a quarterly basis as required by the facility's policy in the charts of MLD and TLP. 2. The WRP of MLD did not include objectives/interventions to address TD. 3. The treating psychiatrist did not address an apparent significant
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		<p>increase in the severity of movement disorders in the chart of RL.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent implementation of corrective measures regarding this requirement.
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ol style="list-style-type: none"> 1. Increase reporting of ADRs and implement corrective actions to address underreporting. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). <p>Findings: The following summarizes the facility's data for this review period ad data comparisons with the previous period:</p>

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	Previous period	Current period
Total ADRs	292	302
Classification of Probability of ADRs		
Doubtful	0	4
Possible	134	199
Probable	147	96
Definite	11	3
Classification of Severity of ADRS		
Mild	155	174
Moderate	127	120
Severe	10	8

The facility conducted intensive case analysis of all eight severe ADRs. The following is an outline of all severe ADRs during this review period:

1. Clozapine-induced blood dyscrasia;
2. Severe lethargy secondary to morphine sulfate;
3. Fever and unresponsiveness while receiving a combination regimen including clozapine and haloperidol (neuroleptic malignant syndrome was ruled out);
4. Near syncopal episode secondary to risperidone and bethanechol;
5. Same as in #4;
6. Hypotension and unresponsiveness secondary to carbidopa/levodopa;
7. Fall secondary to multiple agents including the addition of metolazone;
8. Rhabdomyolysis secondary to multiple agents including quetiapine, doxepin, ibuprofen, diphenhydramine and naproxen.

None of the above-mentioned reactions reportedly resulted in permanent harm to the individuals. The ICAs used appropriate methodology and the recommendations for systemic corrective/educational actions were

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		<p>generally adequate.</p> <p>Other findings: During this review period, NSH implemented the following corrective actions to improve reporting of ADRs:</p> <ol style="list-style-type: none"> 1. The Assistant Medical Director mentored the new P&T Committee Chair regarding to the role of the Committee in ADR and the ICA of reactions. 2. The facility improved the process of review of all transfers to outside medical centers to identify possible cases of severe ADRs and the need for ICA of these cases. 3. In August 2010, the ADR form was updated on the facility's I-NET. In September 2010, ADR forms were distributed to all units as part of their stock unit forms. 4. The Medical Director revised the Administrative Directive on ADRs to include a review of the process for tracking ADRs hospital-wide. 5. As mentioned in D.1.d.ii, the Medical Director provided three CME presentations to medical staff regarding the ADR process and the presentations were well-attended. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current efforts to improve reporting of ADRs. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious
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		<p>reactions;</p> <p>d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and</p> <p>e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p>
<p>F.1.g</p>	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: During this review period, NSH conducted the following DUEs:</p> <ol style="list-style-type: none"> 1. Use of phenytoin in individuals with seizure disorders (monitoring for side effects and feasibility of safer alternatives); 2. Monitoring requirements and clinical effectiveness of leuprolide acetate in treatment of males with a history of a sexual offense(s); 3. Monitoring the use, efficacy, and safety of donepezil; 4. Indications for use of topiramate and monitoring for metabolic complications; 5. Use of quetiapine in individuals with metabolic syndrome; and 6. Use of anticholinergics greater than 60 days. <p>The DUEs used appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to provide data on DUEs during the review period, including topic/methodology, findings, recommendations and actions taken.</p>																		
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Present data to address the following:</p> <ul style="list-style-type: none"> a) Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b) Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c) Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d) Number of critical breakdown points by outcome; e) Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f) Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g) Outline of ICAs, including description of variance, recommendations and actions taken. <p>Findings: NSH reported the following data regarding MVRs:</p> <table border="1" data-bbox="1003 1154 1612 1421"> <thead> <tr> <th>Number of Medication Variances</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>Prescribing</td> <td>112</td> <td>182</td> </tr> <tr> <td>Transcribing</td> <td>72</td> <td>30</td> </tr> <tr> <td>Ordering/Procurement</td> <td>8</td> <td>3</td> </tr> <tr> <td>Dispensing</td> <td>16</td> <td>7</td> </tr> <tr> <td>Administration</td> <td>189</td> <td>127</td> </tr> </tbody> </table>	Number of Medication Variances	Previous Period	Current Period	Prescribing	112	182	Transcribing	72	30	Ordering/Procurement	8	3	Dispensing	16	7	Administration	189	127
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Section F: Specific Therapeutic and Rehabilitation Services

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		<p>During this review period, the facility improved accuracy of data presentation. None of the MVRs reached threshold for an ICA. However, reviews by this monitor found evidence of one individual (DLT) who suffered withdrawal seizures as a result of a medication variance</p>																																																												

		<p>that led to abrupt withdrawal of the administration of clonazepam (not prescribed). This event was not reported as a medication variance.</p> <p>Recommendation 2, July 2010: Provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p>Findings: During this review period, NH conducted adequate review and analysis of its MVRs. The analysis included the following:</p> <ol style="list-style-type: none"> 1. Assessment of factors contributing to positive trends of decreases in administration, transcribing, documentation and dispensing variances compared to the last review period; 2. Corrective actions to address a trend of increase in prescription variances; and 3. Assessment of factors contributing to the outcome of variances based on the severity scale. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present data to address the following: <ol style="list-style-type: none"> a) Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b) Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c) Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d) Number of critical breakdown points by outcome;
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		<p>e) Clinical information regarding each variance (category E or above) and the outcome to the individual involved;</p> <p>f) Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and</p> <p>g) Outline of ICAs, including description of variance, recommendations and actions taken.</p> <p>2. Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Same as in F.1.a through F.1.h. • Continue to assess outcome data as outlined [in this cell in the previous report] and provide a summary of corrective actions, as indicated. <p>Findings:</p> <p>Same as in F.1.a through F.1.h. In addition, the facility presented data regarding outcomes of its clinical services. The data addressed the rate per 1000 days of the following indicators:</p> <ol style="list-style-type: none"> 1. Any aggression to self resulting in major injury (decrease); 2. Any peer-to-peer aggression resulting in major injury (increase); 3. Any aggression to staff resulting in major injury (increase); 4. Individuals having alleged abuse/neglect/exploitation (decrease); 5. Individuals having confirmed abuse/neglect exploitation (increase); 6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons (decrease); 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons (decrease); 8. Unique count of individuals in restraint (some increase); 9. Unique count of restraint events (decrease);

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		<p>10. Unique count of individuals in seclusion (some decrease);</p> <p>11. Unique count of seclusion events (decrease);</p> <p>12. Individuals on benzodiazepines who are diagnosed with substance use (decrease);</p> <p>13. Individuals on benzodiazepines diagnosed with cognitive disorder (decrease);</p> <p>14. Elderly on anticholinergic medications (age >65) (decrease);</p> <p>15. Individuals diagnosed with cognitive disorder on anticholinergics (decrease);</p> <p>16. Individuals diagnosed with TD prescribed anticholinergics (some increase);</p> <p>17. Count of severe ADRs (decrease); and</p> <p>18. Count of severe medication variances (no change at zero).</p> <p>In addition (see C.2.o), the facility presented data regarding substance use services as outlined in C.2.o.</p> <p>These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see Section I.2).</p> <p>Compliance:</p> <p>A rating of substantial compliance is justified regarding the tracking of trends as required in this cell. However, tracking is only one aspect of quality management/performance as required in Section I of the EP (please refer to this section for overall assessment of quality management/performance improvement).</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Continue to provide above outcome data for the review period.
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in F.1.a through F.1.h.</p>
F.1.k	<p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in F.1.a through F.1.h.</p>

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

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		<p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p> <p>Current recommendation: Same as in F.1.c.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as F.1.e.</p>

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

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F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	This requirement applies exclusively to Metropolitan State Hospital.
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Section F: Specific Therapeutic and Rehabilitation Services

2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p> <p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. The following individual: RD 2. Alex Kettner, PsyD, PBS Team Leader 3. Alice Rivera, RN, SL 4. Blea Caernare, RN 5. Carmen Caruso, Clinical Administrator 6. Elsa Nunez, PT 7. Gary Silgan 8. Josh Slater, PsyD, Mall Director 9. Katie Cooper, PsyD, Mall Program Director 10. Kristen Perkins, PhD, Psychologist 11. Marco Barragan, RT, Acting Assistant Chief of CPS 12. Mary Lake, US T2, Program II 13. Patricia Spivey, PsyD, DCAT Leader 14. Patricia White, PhD, Psychologist, PBS Team Leader 15. Richard Lesch, PhD, Senior Psychologists 16. Sophie Tramel, PT, By Choice staff 17. T.C. Hulsey, Mall Coordinator 18. Tony Rabin, PhD, Acting Chief of Psychology 19. Virginia Torres, PT, By Choice Assistant Coordinator 20. Wendy Hatcher, PsyD, PBS Team Leader <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 34 individuals: AA, ALW, AN, AS, ASD, BN, CS, DC, DJE, DLT, DMB, DPA, FM, GR, JDG, JH, JM, KC, LB, LC, MC, MMG, MMP, MO, MP, NH, RED, RH, RW, SHL, TF, TM, VER and ZP 2. PSSC/ETRC attendance sheets 3. PSSC meeting notes 4. Structural assessments completed during this review period 5. Functional assessments completed during this review period

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		<ol style="list-style-type: none"> 6. Behavioral guidelines implemented during this review period 7. PBS plans implemented during this review period 8. Outcome data of behavioral intervention plans 9. Treatment integrity data of behavioral intervention plans 10. List of individuals needing Neuropsychological assessment and services 11. Verification of substance abuse recovery provider competency 12. List showing missed/cancelled medical appointments 13. Psychosocial enrichment activity list 14. List of exercise groups 15. "The Mall Messenger", NSH's Mall Newsletter 16. Completed By Choice satisfaction surveys 17. PBS and DCAT Staff Development Training Roster <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. PSR Mall Group: Substance Recovery, Enhancing Motivation, Pre-contemplation 2. PSR Mall Group: Substance Recovery, Pre-Contemplation and Contemplation 3. PSR Mall Group: Impulse Control 4. PSR Mall Group: Wellness and Recovery Orientation 5. By Choice Mall store 6. WRPC (Program 3, unit T14) for review of RR 7. WRPC (Program 3, unit T14) for review of RW 8. WRPC (Program 3, unit T15) for review of AS 9. WRPC (Program 4, unit A8) for review of AN 10. PSSC/ETRC Meeting
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p>

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	<p>specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Findings: NSH has three PBS teams and one DCAT. However, two of the PBS teams are missing Psychiatric Technicians. The facility is working to fill the vacancies.</p> <p>Recommendation 2, July 2010: Continue to train all PBS team members to competency.</p> <p>Findings: Documentation review found that PBS and DCAT members had received training on a variety of topics (e.g. medication review, personality disorders and DBT, ETRC/PSSC preparation, data collection procedures, conducting functional assessments, writing PBS plans, conducting fidelity checks, Motivational Interviewing, techniques for interviewing individuals, etc.) between June 1, 2010 and November 30, 2010 of this review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p>
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The table below showing the number of direct care staff at NSH (N), the number of direct care staff trained (cumulative across months) for each month of this review period (n), and the percent staff trained (%C) is a</p>

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		<p>summary of the facility's data:</p> <table border="1" data-bbox="991 264 1906 496"> <thead> <tr> <th colspan="8">Staff Training</th> </tr> <tr> <th></th> <th>June</th> <th>July</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>17</td> <td>-</td> <td>-</td> <td>-</td> <td>76</td> <td>-</td> <td></td> </tr> <tr> <td>N</td> <td>17</td> <td>-</td> <td>-</td> <td>-</td> <td>76</td> <td>-</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>-</td> <td>-</td> <td>-</td> <td>100</td> <td>-</td> <td></td> </tr> <tr> <td>% C</td> <td>100%</td> <td>-%</td> <td>-%</td> <td>-%</td> <td>100%</td> <td>-%</td> <td>%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Staff Training									June	July	Aug	Sept	Oct	Nov	Mean	N	17	-	-	-	76	-		N	17	-	-	-	76	-		%S	100	-	-	-	100	-		% C	100%	-%	-%	-%	100%	-%	%
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F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Monitoring-By Choice Form, NSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month of this review period (June through November 2010):</p> <table border="1" data-bbox="991 1162 1890 1240"> <tr> <td>2.</td> <td><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of least 90% since the previous review period.</p> <p>A review of the records of 17 individuals found that 11 of the WRPs</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	94%																																													
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		<p>reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (ALW, ASD, CS, DJE, DLT, DPA, JDG, JM, KC, MMP and RH). In the remaining six WRPs, (DMB, JH, MMG, RED, RW and VER) the By Choice point allocation was not properly documented or was not updated (in many cases, the documentation was duplicated across WRPs). Fifteen WRPs contained documentation that the individual was a participant in his/her By Choice point allocation (ALW, ASD, CS, DJE, DLT, DPA, JDG, JH, JM, KC, MMG, MMP, RH, RW and VER); the remaining two did not (DMB and RED).</p> <p>This monitor observed three WRPCs (AN, AS, and RW). Two of the WRPTs (AN and AS) engaged the individuals in the By Choice point allocation process, and one (RW) did not.</p> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, NSH assessed its compliance based on a mean sample of 21% of the Level of Care staff:</p> <table border="1" data-bbox="991 894 1871 1421"> <tr> <td>1.</td> <td><i>Staff understands the goal of the By Choice system</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Staff can state the current point cycle</i></td> <td>84%</td> </tr> <tr> <td>3.</td> <td><i>Staff can state the procedure for assigning participation points on an individual's point card.</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i></td> <td>91%</td> </tr> <tr> <td>7.</td> <td><i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i></td> <td>90%</td> </tr> </table>	1.	<i>Staff understands the goal of the By Choice system</i>	99%	2.	<i>Staff can state the current point cycle</i>	84%	3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	92%	4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	98%	5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	99%	6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	91%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	90%
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		8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	93%
		9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	95%
		10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	99%
		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items except item 2, which was 93% in the previous review period.</p> <p>Other findings: Using the Fidelity of Implementation by Individuals Form, NSH also assessed fidelity of By Choice implementation based on a mean sample of 21% of individuals in the facility:</p>		
		1.	<i>The individual understands the goal of the By Choice system.</i>	96%
		2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	89%
		3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	99%
		4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	98%
		5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	88%
		6.	<i>Individual can indicate how many points he or she may earn each day.</i>	97%
		7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	89%
		8.	<i>Individual can correctly state the procedure for</i>	87%

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			<i>reallocating their By Choice points.</i>		
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	97%	
<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% since the previous review period for items 1, 3, 4, 6 and 9 and mixed changes in compliance for the remaining items:</p>					
				Previous period	Current period
Mean compliance rate					
		2.		91%	89%
		5.		83%	88%
		7.		94%	89%
		8.		92%	87%
<p>Using the By Choice Monitoring Form: Satisfaction Check, NSH surveyed a mean sample of 20% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>					
				Previous period	Current period
		1.	<i>By Choice motivates me to participate in treatment</i>	90%	94%
		2.	<i>The point system motivates me to improve my behavior</i>	84%	90%
		3.	<i>The point system motivates me to learn new skills</i>	78%	89%
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	73%	85%
		5.	<i>My WRPT discusses By Choice with me</i>	78%	87%

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			<i>during my WRPC</i>		
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	76%	88%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	84%	90%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	78%	89%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	84%	90%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	78%	89%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	88%	92%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	83%	91%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	80%	89%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	80%	88%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	89%	94%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, NSH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p>			
		1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	100%	
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%	

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		<table border="1"> <tr> <td>3.</td> <td><i>The incentive store is well stocked with appropriate items from the incentive list.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The incentive store has an inventory control system.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>The incentive store has a system to track and remove outdated food items.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>There is a By Choice Manual located in the incentive store.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>The incentive store staff has completed incentive store training.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>There is an Alert List in the incentive store for staff reference.</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>There is an Alert List in the incentive store for use by store staff.</i></td> <td>100%</td> </tr> </table>	3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	100%	4.	<i>The incentive store has an inventory control system.</i>	100%	5.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	6.	<i>There is a By Choice Manual located in the incentive store.</i>	100%	7.	<i>The incentive store staff has completed incentive store training.</i>	100%	8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%	9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%	10.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%	11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%	
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		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% since the previous review period for all items.</p> <p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), NSH assessed fidelity of implementation based on average samples of 21% of the Level of Care Staff, 21% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p> <table border="1"> <tr> <td>Level of Care Staff</td> <td>94%</td> </tr> <tr> <td>Individuals</td> <td>93%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>100%</td> </tr> </table>	Level of Care Staff	94%	Individuals	93%	By Choice Program Staff	100%																						
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The Psychology Department now has a new Acting Chief of Psychology. The Acting Chief of Psychology confirmed that he has the clinical and administrative authority for the PBS Teams and the By Choice incentive program. According to the Acting Chief of Psychology, he has decided to act as the PSSC Chair. He conducts weekly meetings with PBS team leaders and monthly meetings with all PBS and DCAT members, and meets at least twice a month with the By Choice store managers and data auditors.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1"> <tr> <td data-bbox="989 524 1087 638">1.</td> <td data-bbox="1087 524 1793 638"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1793 524 1892 638">100%</td> </tr> <tr> <td data-bbox="989 638 1087 711">2.</td> <td data-bbox="1087 638 1793 711"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 638 1892 711">100%</td> </tr> <tr> <td data-bbox="989 711 1087 784">3.</td> <td data-bbox="1087 711 1793 784"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1793 711 1892 784">100%</td> </tr> <tr> <td data-bbox="989 784 1087 898">4.</td> <td data-bbox="1087 784 1793 898"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1793 784 1892 898">100%</td> </tr> <tr> <td data-bbox="989 898 1087 1011">5.</td> <td data-bbox="1087 898 1793 1011"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 898 1892 1011">100%</td> </tr> <tr> <td data-bbox="989 1011 1087 1084">6.</td> <td data-bbox="1087 1011 1793 1084"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 1011 1892 1084">100%</td> </tr> <tr> <td data-bbox="989 1084 1087 1157">7.</td> <td data-bbox="1087 1084 1793 1157"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1793 1084 1892 1157">100%</td> </tr> <tr> <td data-bbox="989 1157 1087 1271">8.</td> <td data-bbox="1087 1157 1793 1271"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1157 1892 1271">100%</td> </tr> <tr> <td data-bbox="989 1271 1087 1312">9.</td> <td data-bbox="1087 1271 1793 1312"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 1271 1892 1312">100%</td> </tr> <tr> <td data-bbox="989 1312 1087 1424">10.</td> <td data-bbox="1087 1312 1793 1424"><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often</i></td> <td data-bbox="1793 1312 1892 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often</i>	100%
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11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i>	100%						
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p data-bbox="993 756 1890 789">Current findings on previous recommendation:</p> <p data-bbox="993 829 1890 898">Recommendation, July 2010: Continue to monitor this requirement.</p> <p data-bbox="993 938 1890 1117">Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="993 1157 1890 1235"> <tr> <td data-bbox="993 1157 1087 1235">5</td> <td data-bbox="1087 1157 1793 1235"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1793 1157 1890 1235">100%</td> </tr> </table> <p data-bbox="993 1276 1890 1344">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 1385 1890 1417">A review of 16 PBS plans (AA, BN, DC, FM, GR, JM, LC, MO, MMP, MP,</p>	5	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%			
5	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%						

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		<p>NH, RH, RW, SHL, TF and ZP) found that the hypotheses in all 16 were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="991 857 1887 971"> <tr> <td data-bbox="991 857 1087 971">5</td> <td data-bbox="1087 857 1793 971"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 857 1887 971">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 12 PBS plans (AA, BN, DC, FM, GR, JM, LC, MO, MP, NH, SHL and TF) found that all 12 had documented previous behavioral interventions and their effects, where applicable.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			

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<p>F.2.c.iv</p>	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans and behavior guidelines during the review months (June through November 2010):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">17.</td> <td data-bbox="1087 597 1793 711"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1793 597 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 12 PBS plans (AA, BN, DC, FM, GR, JM, LC, MO, MP, NH, SHL and TF) found that all 12 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>The quality of the plans reviewed ranged from adequate to weak in their technical and clinical adequacy. A number of areas could have been better in many plans. The following are some of the findings from the reviews:</p> <ul style="list-style-type: none"> • Clarify data disagreement from multiple sources (for example, when staff information varies from direct observation and screening instruments). • Ensure that interventions are included under "prevention/intervention strategies" and not procedural aspects (e.g. prevention strategies for 	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

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		<p>LC).</p> <ul style="list-style-type: none">• Under prevention section, use the setting events, antecedents, and establishing operation factors identified during the assessment. In many cases, this section is generic (for example, staff will meet with individual) and identified setting events and antecedents are left out.• Write hypothesis and functions in behavioral terms so that one can observe and measure when the behavior(s) occur. Statements such as "bolster self-esteem when he is embarrassed," or "to assert his importance among peers" (e.g. BS) is not helpful to observe, manipulate, or measure.• Write hypothesis fully (what, why, for what, when, with who etc.). Stating "anxiety relief" is insufficient (e.g. MP). How is this information useful to make the behavior inefficient, ineffective, or irrelevant? What can be removed/manipulated in this situation? It will be more useful if the cause for the anxiety and the behavior following is stated.• Many of the plans do not state the replacement behaviors, and/or collect data on these behaviors. Ensure that incompatible, alternate, and positive behaviors are targeted, taught/trained, and data collected and presented. In the absence of replacement behaviors, the individual has no choice to but to use the current behavior (considered maladaptive by others) to satisfy his/her needs.• Emphasize data collection on precursors to target behaviors. If you look hard enough and analyze the data fully, almost all individuals will display some form of precursor behavior prior to a full display of the target behavior. It is very difficult to de-escalate, speak to, teach, or redirect when the individual is fully engaged in the challenging behavior.• Draw graphs that are relevant and meaningful and fully analyze the data trend. There is no reason to graph all the psychotropic medications the individual is on unless they all are known to have an influence on the target behavior. Graphs showing psychotropic medication are not useful without the overlay of the target
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		<p>behaviors.</p> <ul style="list-style-type: none"> • It appears that quantitative baseline data and outcome data are not compiled for behavior guidelines. Ensure that quantitative baseline data and outcome data are collected, analyzed and reported for all behavior guidelines. How is one to know if a behavior is improving or when to modify interventions in the absence of quantitative data? <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of individuals with new or revised PBS plans or behavior guidelines during the review months (June through November 2010), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of 12 individuals (AA, BN, DC, FM, GR, JM, LC, MO, MP, NH, SHL and TF) found that NSH had conducted fidelity checks on all 12 PBS plans and PBS-driven behavior guidelines. It appears that in most cases, treatment integrity is limited to staff responsible for implementing the plans answering questions on the knowledge base of the interventions. It is essential that treatment integrity also includes performance evaluation of the staff. In an interview with this monitor, staff responsible for implementing AW's behavioral intervention plan was unable to state the elements of the plan, even though the staff had</p>

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		<p>received training on the plan.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																																																																																																
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</p> <table border="1" data-bbox="991 784 1906 1320"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th>2010</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>4</td> <td>4</td> <td>5</td> <td>9</td> <td>11</td> <td>13</td> <td>8</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Seclusion</td> <td>1</td> <td>3</td> <td>3</td> <td>2</td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>1:1</td> <td>20</td> <td>22</td> <td>20</td> <td>26</td> <td>32</td> <td>24</td> <td>24</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Aggression to peers</td> <td>4</td> <td>4</td> <td>2</td> <td>4</td> <td>3</td> <td>2</td> <td>3</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Aggression to staff</td> <td>6</td> <td>8</td> <td>9</td> <td>10</td> <td>9</td> <td>14</td> <td>9</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Aggression to self</td> <td>4</td> <td>5</td> <td>2</td> <td>7</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>This monitor's findings from review of NSH's behavioral triggers data on</p>	DMH Psychology Services Monitoring Form								2010	Jun	Jul	Aug	Sep	Oct	Nov	Mean	Restraint	4	4	5	9	11	13	8	%C	100%	100%	100%	100%	100%	100%	100%	Seclusion	1	3	3	2	2	2	2	%C	100%	100%	100%	100%	100%	100%	100%	1:1	20	22	20	26	32	24	24	%C	100%	100%	100%	100%	100%	100%	100%	Aggression to peers	4	4	2	4	3	2	3	%C	100%	100%	100%	100%	100%	100%	100%	Aggression to staff	6	8	9	10	9	14	9	%C	100%	100%	100%	100%	100%	100%	100%	Aggression to self	4	5	2	7	1	2	3	%C	100%	100%	100%	100%	100%	100%	100%
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		<p>aggression to self and others between June and November 2010 is in agreement with NSH's data given in the table above. However, not all individuals had been assessed for behavioral interventions. In a number of cases, the decision to not move forward with a behavioral assessment was made at the PSSC/ETRC meeting under the assumption that the individual's behavioral issues stemmed from his/her mental illness (e.g. DPA). Staff should keep in mind that individuals with mental illness could have bimodal functions of both non-social and learned functions for their challenging behaviors. A proper assessment incorporating mental illness signs and symptoms as part of the functional analysis assessment would clarify the functions. Furthermore, brief behavioral assessments for mental illness (non-social) related behaviors should be conducted to identify environmental/setting events, staff interaction/management styles, and establishing operations that could amplify the individual's mental status and lead to an escalation of the challenging behaviors (e.g. in the case of RT, staff report indicated that RT's behavior improved when RT was transferred to another unit; in all likelihood, RT's behaviors were maintained by some setting event in the previous unit). Under such circumstances, staff education/training and setting event modifications can help keep the behavior rates at the baseline levels.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (June through November 2010), and reported a</p>

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		<p>mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 12 behavioral intervention plans (AA, BN, DC, FM, GR, JM, LC, MO, MP, NH, SHL and TF) found progress notes from psychologists and/or psychiatrists indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="991 1079 1887 1192"> <tr> <td data-bbox="991 1079 1087 1192">19.</td> <td data-bbox="1087 1079 1793 1192"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1793 1079 1887 1192">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals with behavioral intervention plans (CS, DJE, DLT, MMP, NH, RH, RW, SHL and ZP) found that all nine</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%			

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		<p>of the WRPs in the charts had discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="991 857 1887 935"> <tr> <td data-bbox="991 857 1087 935">24.</td> <td data-bbox="1087 857 1793 935"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 857 1887 935">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals with behavioral intervention plans (CS, DJE, DLT, MMP, NH, RH, RW, SHL and ZP) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP.</p> <p>Documentation reviews (structural and functional assessments) and staff interview found that staff is unsure as to the adequacy of assessment sufficient to develop a behavioral intervention plan. In addition, it is their understanding that all assessment tools should be used for all</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			

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		<p>referrals. Thus, staff spend inordinate amounts of time conducting assessments and documentation reviews, leaving little time to be on the unit to support unit staff in implementing plans and making direct observations. The purpose of assessment is to obtain sufficient data to form a hypothesis to develop an intervention, thus assessments and written documents do not have to be exhaustive. Rather, they should be comprehensive and adequate. Assessments should stop when the necessary and sufficient information (using valid methods/measures/assessments) is obtained to ask incisive questions, formulate precise hypotheses, and to design clinically sound interventions that are technically and clinically adequate. However, one should guard against skipping on methods and procedures necessary to obtain all necessary information.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of behavior guidelines developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="993 1192 1887 1305"> <tr> <td data-bbox="993 1192 1087 1305">20.</td> <td data-bbox="1087 1192 1793 1305"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1793 1192 1887 1305">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%
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		<p>Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (June through November 2010):</p> <table border="1" data-bbox="991 375 1887 451"> <tr> <td data-bbox="991 375 1087 451">21.</td> <td data-bbox="1087 375 1793 451"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1793 375 1887 451">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 12 behavioral intervention plans (AA, BN, DC, FM, GR, JM, LC, MO, MP, NH, SHL and TF) found that all 12 plans included data on staff training, post-test, and fidelity checks. However, the primary staff training and fidelity checks are by means of evaluating the staff knowledge and understanding of the behavioral plan. Treatment fidelity is the mediator between an effective plan and outcome data. The current method of collecting fidelity data by having staff answer questions (knowledge scores) on protocols is insufficient. Elements in implementing behavioral intervention plans cannot be fully assessed through verbal report alone, but have to be observed to ensure that all elements are implemented as designed (e.g., timing of interventions, tone of voice, posture and non-verbal behaviors, etc.). PBS staff can utilize a number of strategies to obtain performance information, including having direct care "peer staff" collect fidelity data, having staff answer questions and demonstrate following the implementation of the intervention to an episode, and conducting role-play during training to obtain demonstration scores. Staff interviewed by this monitor on a plan for AW was unable to satisfactorily state the individual's plan, and this staff had received training on the plan.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%			

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F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: According to the Acting Chief of Psychology, it is the facility's intent to ensure that PBS team members are primarily responsible for the provision of behavioral interventions. However, it appears that the facility might have to utilize PBS staff members in other areas temporarily, given the current situation of needing additional staff support due to recent events. According to the Acting Chief of Psychology, these additional tasks will not interfere with the PBS team members' regular PBS duties.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: See F.2.a.ii.</p> <p>Findings: See F.2.a.ii.</p> <p>Current recommendations: See F.2.a.ii.</p>
F.2.d	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	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p>

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	<p>technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Findings: NSH has one Developmental and Cognitive Abilities (DCAT) team. The DCAT members participate in PBS staff development training. They also conduct behavioral assessments and write behavioral intervention plans, and their work is well-organized and -presented (e.g. DCAT had assessed and developed and implemented behavioral interventions for the following individuals: GA, JC, DE, SG, NH, JH, RH, VH, LJ, MJ, CK, JM, MP, SP, ZP, DP, MR, TR, BS, DS, and MT). According to the Acting Chief of Psychology, DCAT members conduct assessments for diagnostic clarification, cognitive assessments for Regional Center Services, and facilitate Mall groups (three DCAT groups a week for individuals with MR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the 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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The PSSC continues to support the facility by addressing the needs of PBS/DCAT team members and unit staff in dealing with behavior challenges of individuals in the facility. Documentation review (PSSC meeting minutes between July 2010 and January 2011) found that meetings had been conducted regularly and attendance at these meetings was high.</p>

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	<p>heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>This monitor attended a PSSC/ETRC meeting during this tour (on January 25, 2011, at 3PM). The meeting was well-attended. A number of cases were reviewed (e.g., LB, MC and TM). In general, the medical aspects of each case were presented and reviewed, followed by the psychological aspects of the case. It is recommended that where possible, the chart of the individual whose case is to be reviewed should be brought to the meeting. In a number of cases, staff did not remember some aspect of the case, and such information might be useful to make an informed decision. In addition, it will be extremely beneficial if the WRP and data in graphic form is projected on the screen/wall for staff/teams/discipline representatives to read and review for a better understanding of the case and enhanced ability to ask insightful questions based on data trend.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																		
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its compliance based on a 100% sample of referrals received each month during the review period (June through November 2010):</p> <table border="1" data-bbox="991 1300 1881 1401"> <thead> <tr> <th></th> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a.</td> <td><i>Number of neuro-psychological</i></td> <td>8</td> <td>5</td> <td>4</td> <td>9</td> <td>7</td> <td>4</td> <td>6</td> </tr> </tbody> </table>			Jun	Jul	Aug	Sep	Oct	Nov	Mean	18.a.	<i>Number of neuro-psychological</i>	8	5	4	9	7	4	6
		Jun	Jul	Aug	Sep	Oct	Nov	Mean												
18.a.	<i>Number of neuro-psychological</i>	8	5	4	9	7	4	6												

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		<table border="1" data-bbox="993 191 1881 464"> <tr> <td data-bbox="993 191 1077 293"></td> <td data-bbox="1077 191 1325 293"><i>assessments due for completion in the review month</i></td> <td data-bbox="1325 191 1402 293"></td> <td data-bbox="1402 191 1480 293"></td> <td data-bbox="1480 191 1558 293"></td> <td data-bbox="1558 191 1635 293"></td> <td data-bbox="1635 191 1713 293"></td> <td data-bbox="1713 191 1791 293"></td> <td data-bbox="1791 191 1881 293"></td> </tr> <tr> <td data-bbox="993 293 1077 362">18.a. ii</td> <td data-bbox="1077 293 1325 362"><i>Of those in 18.a.i, number completed</i></td> <td data-bbox="1325 293 1402 362">8</td> <td data-bbox="1402 293 1480 362">4</td> <td data-bbox="1480 293 1558 362">5</td> <td data-bbox="1558 293 1635 362">9</td> <td data-bbox="1635 293 1713 362">5</td> <td data-bbox="1713 293 1791 362">2</td> <td data-bbox="1791 293 1881 362">6</td> </tr> <tr> <td data-bbox="993 362 1077 464">18.a. iii</td> <td data-bbox="1077 362 1713 464"><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6" data-bbox="1713 362 1881 464">26</td> </tr> </table> <p data-bbox="993 505 1881 683">As the table above shows, Neuropsychological assessments were completed by the Neuropsychology Service within a mean of 26 days, which is within the required timeframe of 30 days. Neuropsychologists at the facility provide Mall services in the Cognitive Remediation and other Mall groups.</p> <p data-bbox="993 727 1140 792">Compliance: Substantial.</p> <p data-bbox="993 836 1457 901">Current recommendation: Continue to monitor this requirement.</p>		<i>assessments due for completion in the review month</i>								18.a. ii	<i>Of those in 18.a.i, number completed</i>	8	4	5	9	5	2	6	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>	26					
	<i>assessments due for completion in the review month</i>																											
18.a. ii	<i>Of those in 18.a.i, number completed</i>	8	4	5	9	5	2	6																				
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>	26																										
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p data-bbox="993 951 1577 984">Current findings on previous recommendation:</p> <p data-bbox="993 1024 1362 1089">Recommendation, July 2010: Continue current practice.</p> <p data-bbox="993 1133 1892 1279">Findings: Psychologists at NSH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p data-bbox="993 1320 1140 1385">Compliance: Substantial.</p>																										

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		Current recommendation: Continue current practice.
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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Diana Megary, Supervising RN, Utilization Review 2. Khanh Nguyen, Family Nurse Practitioner, Certified 3. Kym Skaife, RN, ACNS 4. Michael Sanders, RN, Nurse Administrator 5. Michelle Patterson, RN, ACNS 6. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Nursing Services Monitoring PRN Audit summary data, June-November 2010 2. NSH Nursing Services Monitoring Stat Audit summary data, June-November 2010 3. NSH Nursing Staff Familiarity Monitoring Audit summary data, June-November 2010 4. NSH Medical Transfer Audit summary data, June-November 2010 5. NSH Nursing Services Audit summary data, June-November 2010 6. NSH Medication Administration Monitoring Audit summary data, June-November 2010 7. DMH Nursing Services Monitoring-Bed Bound Audit summary data, June-November 2010 8. 50 Medication Variance forms for the review period 9. NSH's training rosters 10. Medication Observation form from Facility Nurse observer 11. Medical records for the following 45 individuals: AR, ATA, BM, BVQ, CC, CH, CL, CR, DAN, DC, DT, DWD, EJJ, EQ, ES, FM, FS, GH, HJV, JA, JC, JD, JLP, JLR, JND, JS, JSL, JTM, KB, KEP, KGO, LHG, LJ, LM, MO, NH, RCW, RLE, RR, RT, RTW, RW, TJM, TR and WML

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit T6) for quarterly review of YL 2. WRPC (Program II, unit T1) for monthly review of RA 3. WRPC (Program IV, unit A4) for monthly review of HV 4. Shift report on Unit T6 5. Medication administration on Unit A4
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p>Compliance: Substantial.</p>
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH also assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90%</p>

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		<p>from the previous review period.</p> <p>A review of 241 PRN and Stat orders (170 PRN and 71 Stat) for 33 individuals (ATA, BM, BVQ, CC, CH, CL, CR, DAN, DC, DT, DWD, EJF, FM, GH, JA, JLR, JND, JSL, KB, KEP, KGO, LHG, LJ, LM, LP, RCW, RLE, RR, RT, RTW, RW, TJM and WML) found that all included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all appropriate notes.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 1044 1887 1192"> <tr> <td data-bbox="991 1044 1087 1192">3.</td> <td data-bbox="1087 1044 1793 1192"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 1044 1887 1192">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 170 incidents of PRN medications for 13 individuals (BVQ, CH, CR, DC, DT, EJF, GH, JA, JND, KGO, LJ, RT and RTW) found</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%			

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		<p>adequate documentation in the IDNs of the circumstances requiring the PRN in 168 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH also assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2010):</p> <table border="1" data-bbox="993 488 1892 638"> <tr> <td data-bbox="993 488 1087 638">4.</td> <td data-bbox="1087 488 1793 638"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 488 1892 638">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 71 incidents of Stat medications for 22 individuals (ATA, BM, BVQ, CC, CL, DAN, DWD, FM, JLP, JLR, JSL, KB, KEP, LHG, LM, RCW, RLE, RR, RT, RW, TJM and WML) found adequate documentation in the IDNs of the circumstances requiring the Stat in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (June-November 2010):</p>			

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		<table border="1" data-bbox="993 228 1887 342"> <tr> <td data-bbox="993 228 1087 342">5.</td> <td data-bbox="1087 228 1793 342"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 228 1887 342">99%</td> </tr> </table> <p data-bbox="993 386 1919 451">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 495 1919 634">A review of 170 incidents of PRN medications for 13 individuals (BVQ, CH, CR, DC, DT, EJF, GH, JA, JND, KGO, LJ, RT and RTW) found a timely comprehensive assessment in the IDNs of the individual's response in 168 incidents.</p> <p data-bbox="993 678 1919 818">Using the DMH Nursing Services Monitoring Stat Audit, NSH also assessed its compliance based on a 28% mean sample of Stat medications administered each month during the review period (June-November 2010):</p> <table border="1" data-bbox="993 862 1887 976"> <tr> <td data-bbox="993 862 1087 976">6.</td> <td data-bbox="1087 862 1793 976"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 862 1887 976">99%</td> </tr> </table> <p data-bbox="993 1019 1919 1084">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 1128 1919 1268">A review of 71 incidents of Stat medications for 22 individuals (ATA, BM, BVQ, CC, CL, DAN, DWD, FM, JLP, JLR, JSL, KB, KEP, LHG, LM, RCW, RLE, RR, RT, RW, TJM and WML) found a timely comprehensive assessment in the IDNs of the individual's response in 70 incidents.</p> <p data-bbox="993 1312 1919 1377">Current recommendation: Continue to monitor this requirement.</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	99%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%						
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	99%						

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F.3.b	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: A review of 50 MVRs found that NSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.I for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.3.d	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and</p>	<p>Current findings on previous recommendation:</p>

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	<p>interventions for that individual.</p>	<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, NSH assessed its compliance based on an average sample of 19% of the nursing staff:</p> <table border="1" data-bbox="993 488 1887 638"> <tr> <td data-bbox="993 488 1087 638">8.</td> <td data-bbox="1087 488 1793 638"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 488 1887 638">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In the three WRPCs observed, all team members were familiar with the individual and his/her WRP goals and interventions. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	99%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	99%			
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions,</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, July 2010:</p> <ul style="list-style-type: none"> • Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. • Audit this requirement by first reading the "story" regarding the 			

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	<p>and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>change of status, which may begin days prior to the hospitalization or ER visit to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool.</p> <ul style="list-style-type: none"> • Collaborate with the facility's Nurse Practitioners to teach and mentor to build and improve nursing competency regarding changes in status. <p>Findings: To improve legibility, NSH initiating typing the nursing assessments in September 2010. Also, the Utilization Review Nurse who audits this area reported that she increased the focus of the audits to address the quality of the nursing documentation regarding changes in status. In addition, the Program HSSs are now monitoring all individuals with changes in status to ensure that assessments are appropriately documented.</p> <p>Although NSH's progress report indicated that there was an increase in oversight and evaluation of the medical transfers, information provided by Nursing indicated that this was happening inconsistently. In addition, this monitor's review found that the current strategies implemented to address and increase compliance with this requirement had not yielded significant outcomes (see specifics below).</p> <p>Recommendation 4, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, NSH assessed its compliance based on a 95% sample of individuals transferred to community hospitals each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 1338 1887 1408"> <tr> <td data-bbox="991 1338 1087 1408">1.</td> <td data-bbox="1087 1338 1793 1408"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i></td> <td data-bbox="1793 1338 1887 1408">91%</td> </tr> </table>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i>	91%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i>	91%			

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		<table border="1"> <tr> <td data-bbox="989 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>notification of the physician.</i></td> <td data-bbox="1793 190 1894 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">7.</td> <td data-bbox="1087 228 1793 342"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 228 1894 342">93%</td> </tr> </table>		<i>notification of the physician.</i>		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	93%
	<i>notification of the physician.</i>							
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	93%						
<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals who were transferred to a community hospital/emergency room (AR, CR, EQ, FS, GH, JC, JD, JS, JTM, MO, NH and TR) found that there continued to be a number of critical problematic issues with the nursing documentation for all the reviewed individuals. Examples of problematic issues included:</p> <p><u>Change in Status</u></p> <ul style="list-style-type: none"> ▪ Nurses not recognizing the symptoms of changes in status. ▪ Some Change of Status forms illegible and not indicating when the individual was actually transferred to community hospital/emergency room. <p><u>Nursing Assessments</u></p> <ul style="list-style-type: none"> ▪ No nursing assessment for an individual displaying cognitive changes who was hospitalized the same day for seizures. ▪ Incomplete assessments of an individual having seizure activity. ▪ No nursing assessment documented in response to notes from nursing and physical therapy indicating changes in an individual's behaviors, mood, and cognition. ▪ No nursing assessment conducted prior to moving an individual who was hit by a peer and was unable to get up from the floor due to extreme leg pain. The individual was moved, rather than immobilized, in an attempt to transfer him to a wheelchair while his foot was rotated outward with noted bulging at the hip. ▪ No nursing assessment conducted for symptoms of confusion, 								

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		<p>delusional statements, and struggles to stand up.</p> <ul style="list-style-type: none"> ▪ No nursing assessments found addressing circulation and skin temperatures for a fractured limb. ▪ Incomplete assessment for an individual with a temperature of 101.0F. ▪ No nursing assessments documented for ongoing and increasing complaints of pain. ▪ No assessments of bowel sounds and palpation of the abdomen found when PRNs given for episodes of constipation. ▪ Lack of follow up assessments for symptoms of constipation. ▪ No documentation found indicating assessment of lung sounds for an individual with a temperature of 103.0F and coughing up yellowish phlegm. ▪ After a hospitalization for bilateral pneumonia, no documentation found of routine assessments of lung sounds. ▪ Lack of a complete nursing assessment upon return to the facility addressing the symptoms that precipitated the hospitalization or ER visit. <p><u>Documentation</u></p> <ul style="list-style-type: none"> ▪ Lack of documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline. ▪ The lack of neurological checks and mental status documented for individuals with a significant change in cognition. ▪ Significant gaps in documentation after individuals were identified as experiencing a change in status. ▪ Lack of adequate documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room. ▪ No documentation found regarding an assault an individual sustained. ▪ Change of status form indicated that neuro checks and lungs sounds conducted, however, no results of assessments documented.
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		<ul style="list-style-type: none"> ▪ Inadequate documentation in WRP regarding summaries of hospitalizations and outcome of injuries. ▪ No consistent summary documented of treatments provided at the community hospital or ER. ▪ A number of Nurses' weekly progress notes basically identical. ▪ Some Change of Status Forms report information regarding the individual's status from previous days that was not found in the progress notes. ▪ Illegible progress notes and signatures and titles. ▪ Duplication and discrepancies between the documentation in progress notes and the Change of Status form. ▪ A significant number of progress notes were missing and took several days during the review to locate. <p><u>Timeliness of Notification/Transfer</u></p> <ul style="list-style-type: none"> ▪ Physicians not being timely notified of initial changes in status. ▪ Two-hour delay noted in transferring an individual to the hospital. ▪ Difficult to determine the actual time individuals are sent to the community hospital/ER from progress notes and change of status forms. <p>These findings do not comport with NSH data. The auditor for this area reported that she was reviewing the documentation a few days prior to the transfer to the hospital; however, in many of the cases reviewed by this monitor, the individuals were experiencing changes in status two to three weeks prior to the date they were sent to the hospital/ER but were not adequately assessed or followed. These critical deficits indicate that the facility need to do significant work to ensure that individuals are provided timely and appropriate nursing assessments and interventions, and to ultimately attain substantial compliance with this requirement. In addition, the auditing process for this area should be reviewed to determine why significant discrepancies continue to exist between the facility's data and the reviewer's findings, resulting in an</p>
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		<p>erroneous conclusion that this required clinical area is progressing appropriately.</p> <p>Using the DMH Nursing Services Audit, NSH assessed its compliance based on a 40% sample of Change of Shift Reports observed during in the review months (June-November 2010):</p> <table border="1" data-bbox="993 451 1887 565"> <tr> <td data-bbox="993 451 1087 565">10.</td> <td data-bbox="1087 451 1793 565"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 451 1887 565">94%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit T6 found that it provided appropriate and concise clinical information in alignment with the individual's Axis diagnoses. The Unit's Shift Lead effortlessly presented a focused report that included a concise summary of each individual's mental health symptoms related to their diagnoses, indicating if their status was progressing, maintaining, or worsening, and strategies for staff to use when assessing and interacting with the individuals. In addition, updates were reported regarding changes in medication regimes, results of laboratory work, and the status of medical issues. And last but not least, this was all done within the allotted timeframes for a shift report.</p> <p>The facility should consider videotaping this particular Shift Lead when conducting shift report in order to assist other units as well as other facilities that are struggling with what type of clinical content to include in shift reports and how to align it with the diagnoses of the individuals on the unit.</p> <p>Compliance: Partial, due to significant problematic issues found related to changes in</p>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	94%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	94%			

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		<p>status.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review auditing process regarding nursing documentation for changes in status to ensure that it is accurately capturing and identifying issues addressing the appropriateness of the nursing assessments and the quality of the nursing documentation. 2. Continue training focused on mentoring and improve nursing competency regarding assessments and documentation addressing changes in status. 3. Consider videotaping the shift report on unit T6 using the RN Shift Lead in order to assist other units as well as other facilities that are struggling with what type of clinical content to include in shift reports and how to align it with the diagnoses of the individuals on the unit. 4. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 98%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>This monitor observed medication administration on Unit A4, which was the same unit on which medication administration was observed during the last review. Some of the same problematic issues were again seen. Overall, the medication nurse demonstrated good interaction with the individuals but needed to consistently let the individuals know that she was giving them their medications and what medications they were receiving. She did provide some teaching, however it was minimal. In addition, privacy was not provided until the facility nurse who was also observing the medication administration pass initiated use of the privacy screens. Also, the medication nurse did not check the treatment plan/dining plan to ensure that the individuals who were receiving medication via tubes were in the correct position while getting their medications. In addition, the medication nurse did not initiate an assessment including lung sounds for an individual who was receiving her medications that had very audible "wet" respirations until prompted to do so by the reviewer. Since the nurse did have a stethoscope with her or in the medication cart, this indicated that the respiratory status of individuals at risk for aspiration is not being adequately assessed. In addition, not all MARs had the picture of the individual for identification. Although the facility nurse observing this medication administration pass provided appropriate feedback and correction to the nurse administering the medications, the safety issues while administering medications that were seen from the last review continued to be seen during this review. The facility needs to ensure that individuals with compromised health issues are safely administered medications and that specific positioning and instructions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that individuals with compromised health issues are safely administered medications and that specific positioning and instructions are followed consistently.2. Continue to monitor this requirement.
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<p>F.3.f.ii</p>	<p>education is provided to individuals during medication administration;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 96%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>F.3.f.iii</p>	<p>nursing staff are following the appropriate medication administration protocol; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 99%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, NSH assessed its compliance based on an average sample of 20% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 97%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>NSH was able to produce MVRs for the blanks that were found and reported on the MTRs and Narcotic Logs during the review period. The facility continues to evaluate strategies to ensure that medication nurses have the necessary time to appropriately administer medications and interact with the individuals during medication administration. Nursing recently submitted a proposal to the Quality Council for the addition of a medication assistant and is working on trying to not have float nurses pass medication. Although promising ideas, staffing issues present barriers to these interventions.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.g	<p>Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement in the event this issue arises.</p>

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		<p>Findings: Using the DMH Nursing Services Monitoring-Bed Bound Audit, NSH assessed its compliance based on a 100% sample (two individuals) who were bed-bound during the review period and reported a mean compliance rate of 100%. There were no comparative data from the previous review period since the facility had no bed-bound individuals at that time.</p> <p>A review of the records for two individuals (ES and HJV) who were temporarily bed-bound during the review period found that the physicians' orders and WRPs included clinical justification for bed-bound status.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH training rosters indicated that 363 out of 367 staff attended and passed the required training. The remaining staff are currently scheduled to complete the training.</p>

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		<p>Current recommendation: Continue current practice.</p>
F.3.h.ii	<p>the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.3.h.ii.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.iii	<p>positive behavior support principles.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.3.h.ii.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.3.h.ii.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Beverly Lynn, Acting Senior Rehabilitation Therapist 2. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 3. Jennie Gilmore, Acting Senior Rehabilitation Therapist 4. Jennifer Deterville, Acting Senior Rehabilitation Therapist 5. Phyllis Moore, Acting Senior Rehabilitation Therapist 6. Susan Jette, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 12. F.4 audit data for June through November 2010 13. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 14. Records of the following 18 individuals participating in or assigned to observed PSR Mall groups: BGD, DJB, DJS, EAA, JJB, KGO, KRL, LLM, LMD, MH, RJC, RWO, SAC, SM, SRB, TAW, TM and YR 15. List of individuals who received direct physical therapy services from June through November 2010 16. List of individuals who received direct speech therapy services from June through November 2010 17. List of individuals who received direct occupational therapy services from June through November 2010 18. Records of the following 17 individuals who received direct physical, occupational, or speech therapy services from June through November 2010: BMS, CC, CEF, DHB, DO, GFS, JRC, LDJ, LJA, LSB, MPB, NJ, NJ, QE, REP, RKG and SV 19. List of individuals with a 24-Hour Rehabilitation Support Plan 20. Records of the following four individuals with 24-Hour Rehabilitation Support Plans: JW, KMM, RG and WZ 21. Records for the following two individuals at high risk for falls: BB and

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		<p>EAH</p> <p>22. Records for the following three individuals who had three or more falls in 30 days or a fall with a major injury during the review period: FKL, KAJ and RLH</p> <p>23. Records for the following two individuals at high risk for impaired skin integrity: DER and JHW</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Reality Orientation PSR Mall group 2. Symptom Management through Drama PSR Mall group 3. Coping Skills through Music PSR Mall group 4. WRAP PSR Mall group 5. Solonics PSR Mall group 6. Self Esteem PSR Mall group 7. Mindfulness Strategies PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Substantial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: During the maintenance period, work to improve integration of information pertaining to direct OT, PT, and SLP treatment services into the treatment plan and Present Status section of the WRP.</p> <p>Findings: The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during the week of September 6-10:</p>

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		<table border="1" data-bbox="989 228 1587 383"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>122</td> <td>85</td> </tr> <tr> <td>OT</td> <td>20</td> <td>13</td> </tr> <tr> <td>SLP</td> <td>30</td> <td>29</td> </tr> </tbody> </table> <p>The facility reported that the most common reason for the discrepancy between scheduled and provided hours is individuals (27 individuals refused), followed by "no show" with no reason reported (11), illness (3), and schedule conflict (2).</p> <p>Other findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 14% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period June through November 2010, and reported a mean compliance rate of 98%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals receiving direct occupational, speech, or physical therapy treatment to assess compliance with F.4.a.i criteria found all records in substantial compliance.</p> <p>In terms of individualized outcomes, record review found that 14 out of 16 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes (progress for one individual could not be determined and this individual had a service objective).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Scheduled	Provided	PT	122	85	OT	20	13	SLP	30	29
	Scheduled	Provided												
PT	122	85												
OT	20	13												
SLP	30	29												

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F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: During the maintenance period, continue to assess and attempt to identify individuals who may be in need of individualized physical and occupational therapy programs implemented by nursing staff.</p> <p>Findings: During the review period, three individuals were identified for whom INPOP programs were developed. However, plan implementation and follow-up occurred after the close of the current review period and therefore the plans were not reviewed for this report cycle.</p> <p>Compliance: Unable to determine.</p> <p>Current recommendation: Continue to monitor this requirement.</p>											
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to enhance current practice.</p> <p>Findings: The facility reported the following training in areas including the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence:</p> <table border="1" data-bbox="989 1263 1873 1422"> <thead> <tr> <th>Training Type</th> <th>Date(s)</th> <th>Training Subject</th> <th># Trained</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Adaptive Equipment</td> <td>8/3/10</td> <td>Safest PO and adaptive cup use</td> <td>1</td> </tr> <tr> <td>8/26/10</td> <td>Flow control adapted</td> <td>3</td> </tr> </tbody> </table>	Training Type	Date(s)	Training Subject	# Trained	Adaptive Equipment	8/3/10	Safest PO and adaptive cup use	1	8/26/10	Flow control adapted	3
Training Type	Date(s)	Training Subject	# Trained										
Adaptive Equipment	8/3/10	Safest PO and adaptive cup use	1										
	8/26/10	Flow control adapted	3										

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			cup usage	
		9/2/10	Safety equipment/ Adaptive cup	4
	24 Hour Support Plan training	6/17/10	24-Hour Support Plan r/t wheelchair mobility and helmet	1
		8/10	24-Hour Support Plan	1
		9/2/10	24-Hour Support Plan	1
		9/9/10	24-Hour Support Plan	1
		9/10/10	24-Hour Support Plan r/t aphasia	4
		10/14/10	24-Hour Support Plan r/t diet modifications	2
		Positioning/M obility	8/18/10	Transfer training and cognition
	8/18/10		Wheelchair use and care	5
	9/14/10		Wheelchair use and care	1
	9/15/10		Wheelchair use and care	1
	10/8/10		Wheelchair use and care, transferring	2
	10/28/10		Walker use and care	1
	11/22/10		Left hand positioning	13
	Promote Individuals' Independence	8/23/10	Pragmatic/ cognitive program	2
		8/27/10	Communication board	6
		9/8/10	Soft helmet use	1
		10/4/10	Memory journal/schedule use	25
		10/22/10	Helmet use	1

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		<table border="1" data-bbox="989 190 1873 344"> <tr> <td data-bbox="989 190 1192 266">Exercise programs</td> <td data-bbox="1192 190 1392 266">9/16/10</td> <td data-bbox="1392 190 1705 266">Range of motion exercises</td> <td data-bbox="1705 190 1873 266">1</td> </tr> <tr> <td data-bbox="989 266 1192 305"></td> <td data-bbox="1192 266 1392 305">11/18/10</td> <td data-bbox="1392 266 1705 305">Exercise program</td> <td data-bbox="1705 266 1873 305">1</td> </tr> <tr> <td data-bbox="989 305 1192 344"></td> <td data-bbox="1192 305 1392 344">11/23/10</td> <td data-bbox="1392 305 1705 344">INPOP</td> <td data-bbox="1705 305 1873 344">3</td> </tr> </table> <p data-bbox="989 386 1138 451">Compliance: Substantial.</p> <p data-bbox="989 496 1455 561">Current recommendation: Continue to monitor this requirement.</p>	Exercise programs	9/16/10	Range of motion exercises	1		11/18/10	Exercise program	1		11/23/10	INPOP	3
Exercise programs	9/16/10	Range of motion exercises	1											
	11/18/10	Exercise program	1											
	11/23/10	INPOP	3											
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p data-bbox="989 610 1577 643">Current findings on previous recommendation:</p> <p data-bbox="989 683 1388 716">Recommendation 1, July 2010: During the maintenance period, ensure that 24-hour plans contain adequate detail to inform staff of supports and techniques necessary to promote maximum function and safety.</p> <p data-bbox="989 870 1104 902">Findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period June through November 2010, and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 1162 1902 1308">A review of records of four individuals with 24-hour support plans to assess compliance with F.4.c criteria found all records in substantial compliance. An improvement was noted in the quality and detail of reviewed plans in contrast to the plans reviewed during the previous tour.</p> <p data-bbox="989 1349 1759 1414">Recommendation 2, July 2010: During the maintenance period, work to improve integration of</p>												

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		<p>information pertaining to RT PSR Mall group services into the treatment plan, progress notes, and Present Status section of the WRP.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 13% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period June through November 2010, and reported a mean compliance rate of 99%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 14 records in substantial compliance (BGD, DJB, DJS, EAA, JJB, KGO, KRL, LLM, MH, RJC, SM, SRB, TM and YR), and four records in partial compliance (LMD, RWO, SAC and TAW).</p> <p>In terms of individualized outcomes, record review found that 13 out of 16 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes; progress could not be determined based on available documentation for two individuals.</p> <p>Observation of five PSR Mall groups, interview with provider for one group not observed due to cancellation, and review of lesson plan for a group in which an individual objected to observation found that in all of these groups, a lesson plan was in use and all groups appeared to provide activities that were in line with the individuals' assessed needs. During the maintenance period, the facility should focus on making lesson plans more specific, detailed and instructive to group providers.</p>
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		<p>Information on scheduled versus provided PSR Mall hours was not provided; this information is contained in Section C.2.</p> <p>Other findings: A review of the records of two individuals who were at high risk for falls found evidence that Physical Therapy focused assessment was ordered and completed for one individual (BB) for whom it was clinically indicated, and there was documentation that this individual received physical therapy direct treatment to address underlying mobility-related fall risk factors, as well as a 24-hour support plan. The record of one individual (EAH) contained no evidence of fall risk or rationale, so it was not possible to determine whether this individual required a POST assessment or services. Record reviews of two individuals who had three or more falls in 30 days found that one individual (RLH) was referred for physical therapy assessment but refused, and one individual (FKL) was referred for physical therapy direct treatment for gait training and balance exercises following MRMC review. Record review for an individual (KAJ) who had a fall resulting in major injury found no documentation of incident or potential cause, and thus it was not possible to determine whether a referral to POST was clinically indicated.</p> <p>Records for two individuals at high risk for impaired skin integrity were reviewed, but no documentation of reason for risk was found in the WRP for one individual (DER) and it was not possible to determine whether a PT or OT assessment was clinically indicated to address potential decubitus risk, and one individual (JHW) did not appear to require POST assessment or services related to risk.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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<p>F.4.d</p>	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to improve and enhance current practice.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period June through November 2010:</p> <table border="1" data-bbox="989 597 1885 976"> <tr> <td>e.</td> <td><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td>100%</td> </tr> <tr> <td>f.</td> <td><i>The individual was provided with the equipment as per the doctor's order</i></td> <td>100%</td> </tr> <tr> <td>g.</td> <td><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td>100%</td> </tr> <tr> <td>h.</td> <td><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td>100%</td> </tr> <tr> <td>i.</td> <td><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td>N/A</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period for all items.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	N/A
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g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	N/A															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Deena Rosen, Assistant Director of Dietetics 2. Emiko Taki, Clinical Dietitian 3. Heidi Vogelsang, Clinical Dietitian 4. Jessica Tuttle, Clinical Dietitian 5. Kathryn Ballatore, Clinical Dietitian 6. Kumiko Kato, Clinical Dietitian 7. Laufey Gunnarsdottir, Clinical Dietitian 8. Linderpal Dhillon, Clinical Dietitian 9. Lynn Wurzel, Clinical Dietitian 10. Lynne Fredricksen, Assistant Director of Dietetics 11. Noriko Takenawa, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from June through November 2010 for each assessment type 2. Records of the following 46 individuals with types a-j.ii assessments from June through November 2010: AJT, AR, BH, CB, CC, CDC, CF, CW, DP, DS, FP, GT, HLA, JCC, JD, JEL, JLA, JLL, JLM, JO, JT, JW, KB, KC, KDC, KJ, KR, KS, LDW, MC, MM, MO, PS, RC, RKG, RKH, RM, RRJ, RS, SL, SMC, SMH, SV, TLB, TT and VC 3. Meal Accuracy Report audit data from June through November 2010 4. Nutrition Care Monitoring Tool audit data for June through November 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals at risk for choking and aspiration 6. Record for the following two individuals at risk for choking or aspiration: JRC and WM 7. Records for the following individual with an incident of aspiration

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		<p>pneumonia during the review period: CEF</p> <ol style="list-style-type: none"> 8. List of individuals with a new diabetes diagnosis during the review period 9. Records for the following three individuals with a new diabetes diagnosis of diabetes during the review period: DJ, KUR and VMM 10. List of individuals at risk for metabolic syndrome 11. Records for the following three individuals at high risk for metabolic syndrome: HRS, MER and RS 12. Enteral Feeding Review Committee July meeting minutes 13. Records for the following individuals receiving enteral nutrition: CEF, JH, JW and NJ 						
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 41% of Nutrition Assessments (all types) due each month from June through November 2010 (total of 684 out of 1652):</p> <table border="1" data-bbox="989 1044 1885 1193"> <tr> <td>7.</td> <td><i>Nutrition education is documented.</i></td> <td>100%</td> </tr> <tr> <td>8</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 46 individuals to assess compliance with documentation of provision of Nutrition Education Training and of</p>	7.	<i>Nutrition education is documented.</i>	100%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%
7.	<i>Nutrition education is documented.</i>	100%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%						

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		<p>response to Medical Nutrition Training found all records in substantial compliance.</p> <p>Other findings: The Metabolic Syndrome Committee has continued to meet quarterly to review cases of individuals with this diagnosis; two RDs have membership on the committee and are participating in case reviews of individuals with BMI over 40. Currently, dietitians are trending BMI and assessing whether recommended supports have been effective, as well as comparing to see if the metabolic syndrome diagnosis is listed in the NCA. The committee is not yet trending and analyzing data gathered during quarterly reviews to inform practice and enhance performance improvement.</p> <p>A review of records for three individuals at high risk for metabolic syndrome and for three individuals with a new diagnosis of diabetes found that all six records had evidence of a nutrition assessment that addressed risk factors, appropriate contributing factors, and clinical recommendations, with reassessment administered in accordance with assigned acuity level.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with WRP integration based on an average sample of 41% of Nutrition Assessments (all types) due each month from June through November 2010 (684 out of 1652):</p> <table border="1" data-bbox="989 414 1885 602"> <tr> <td data-bbox="989 414 1087 488">19.</td> <td data-bbox="1087 414 1766 488"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1766 414 1885 488">100%</td> </tr> <tr> <td data-bbox="989 488 1087 602">20.</td> <td data-bbox="1087 488 1766 602"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1766 488 1885 602">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 33 individuals with completed Nutrition Care Assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	100%	20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	100%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	100%						
20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	100%						
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to enhance current practice.</p> <p>Findings: One new incident of aspiration pneumonia was reported during the review</p>						

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		<p>period, though the reporting system does not appear to be designed to easily query new cases of aspiration pneumonia, or determine cases of choking incidents.</p> <p>Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>Other findings: A review of the record of one individual with an incident of aspiration pneumonia, one individual at high risk for choking, and one individual at high risk for aspiration found that all three had an assessment by a speech therapist with subsequent recommendations for and provision of direct speech therapy treatment to address underlying risk factors and improve swallowing and eating skills and performance components. In addition, two of three individuals had an individualized 24-hour support plan to promote optimal safety due to identified risk.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The facility reported that three out of three dietitians who required training were trained to competency on issues related to aspiration and dysphagia. In addition, the following trainings were provided to nurses by</p>

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		<p>POST staff:</p> <table border="1" data-bbox="989 264 1776 570"> <thead> <tr> <th>Date(s)</th> <th>Training Subject</th> <th># Trained</th> </tr> </thead> <tbody> <tr> <td>6/15/10</td> <td>Dysphagia and safest PO intake</td> <td>2</td> </tr> <tr> <td>7/20/10</td> <td>Strictly NPO training</td> <td>3</td> </tr> <tr> <td>7/14/10</td> <td>NPO vs PO training</td> <td>5</td> </tr> <tr> <td>10/14/10</td> <td>Diet modifications 24 Hour Support Plan</td> <td>2</td> </tr> <tr> <td>11/1/10</td> <td>Swallowing Difficulties Screening form</td> <td>11</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Date(s)	Training Subject	# Trained	6/15/10	Dysphagia and safest PO intake	2	7/20/10	Strictly NPO training	3	7/14/10	NPO vs PO training	5	10/14/10	Diet modifications 24 Hour Support Plan	2	11/1/10	Swallowing Difficulties Screening form	11
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11/1/10	Swallowing Difficulties Screening form	11																		
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: During the maintenance period, ensure that findings and recommendations from the Enteral Feeding Review Committee are communicated to the treatment team and integrated into the WRP.</p> <p>Findings: A review of the records of four individuals receiving enteral nutrition found evidence in all four WRPs that enteral supports were individualized. A review of Enteral Feeding Review Committee meeting minutes found that all four individuals were reviewed by the committee to discuss justification of enteral nutrition and/or possible return to oral intake; improved integration of recommendations into the Present Status section of the WRP was noted. Three individuals were receiving PO trials for return to oral intake, one individual had trials attempted but discontinued</p>																		

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		<p>due to safety issues, and one individual was determined to not be appropriate for oral trials due to the degenerative nature of his condition.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	As of the tour conducted in July 2010, NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	

7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Abishai Rumano, MD, Chief Physician and Surgeon 2. David Perts, MD, Physician and Surgeon 3. Dennis Hawley, MD, Physician and Surgeon 4. Emmanuel Cepe, MD, Physician and Surgeon 5. Hong-Shen Yeh, MD, Physician and Surgeon 6. James Young, MD, Acting Assistant Medical Director 7. Jaskaran Momi, MD, Physician and Surgeon 8. Joseph Ritsick, MD, Physician and Surgeon 9. Manveen Sekhon, MD, Physician and Surgeon 10. Rajeev Sachdev, MD, Physician and Surgeon 11. Rodolfo Pineda, MD, Physician and Surgeon 12. Shahid Rehman, MD, Staff Neurologist 13. William Kocsis, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 13 individuals who were transferred to an outside medical facility during this reporting period: AR, CR, FS, GH, JC, JD, JM, JS, MC, MO, NH, QE, and TR 2. Physician's Quarterly Progress note for the following 17 individuals: AB, BM, CD, CTJ, DL, FM, GS, GTE, II, JLM, JR, KC, KH, RC, RR, RWO, and YJL 3. Reference for Assessment and Notification (RAN) on the following conditions: <ul style="list-style-type: none"> • Abdominal Pain • Altered Mental Status • Cardiovascular • Gastrointestinal Bleed • Infection • Respiratory

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		<ul style="list-style-type: none"> • Seizure <ol style="list-style-type: none"> 4. List of all individuals admitted to external hospitals during the review period 5. Template of Medicine-Surgery Quality Performance Profile 6. Summary of systemic changes made after case involving individual MO 7. Summary of findings from Medical Emergency Response (MERS) Drills and Events during the review period. 8. NSH Medical-Surgical Progress Note Auditing summary data (June to November 2010) 9. NSH Integration of Medical Conditions into the WRP Auditing summary data (June to November 2010) 10. NSH Medical Transfer Auditing summary data (June to November 2010) 11. NSH Audit of Timeliness of Consultations & Referrals to off-site Medical Consultants/Services (June to November 2010) 12. NSH revised Seizure Management Guidelines 13. NSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: <ul style="list-style-type: none"> • Diabetes Mellitus • Dyslipidemia • Obesity • Hypertension • Bowel Dysfunction • Aspiration Pneumonia • Falls • Seizure Disorder • Unexpected Mortalities
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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Provide a summary of any changes in current medical policies, procedures,</p>

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	<p>generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>ADs or protocols/guidelines during this review period.</p> <p>Findings: NSH revised its Seizure Practice Guidelines to address the risks of treatment with older generation anticonvulsant medications. The facility reported that most individuals who had received long-term treatment with older agents were transitioned to newer agents, per neurology consultations, and that only two of these individuals experienced a breakthrough seizure during this process. As mentioned in F.1.g, a DUE on the use of the older agent phenytoin was completed during this review period. This DUE found that individuals were monitored appropriately during treatment, including testing for serum levels and liver functions but that newer agents may be better tolerated due to fewer adverse effects and equal therapeutic efficacy.</p> <p>Recommendation 2, July 2010: Develop and implement corrective actions to address any process deficiencies identified by this monitor in this cell.</p> <p>Findings: As mentioned in F.1.e, NSH hired a new full-time staff neurologist during this review period in an effort to improve care for individuals with movement and seizure disorders. In addition, the facility hired an internist with subspecialty qualifications in nephrology to provide both general medical care and subspecialty consultations for individuals with difficult-to-manage problems including hypertension and polydipsia.</p> <p>NSH conducted an investigation of a finding by this monitor during the last review regarding a delay in reporting the result of a Stat order (for serum amylase and lipase). The facility found that serum amylase was reported in a timely manner and that the delay in the reporting of serum lipase (by one day) was due to current procedure of sending out the sample. No corrective action was deemed necessary.</p>
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Other findings:

This monitor reviewed the charts of 13 individuals who were transferred to an outside medical facility during this reporting period on 15 occasions. The monitor also interviewed the physicians and surgeons who involved in the care of these individuals prior to, during and following the transfers. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

Individual	Date/time of MD evaluation	Reason for transfer
1	6/13/10	Bowel Obstruction
2	7/12/10	Pneumonia
3	7/12/10	Head Injury
4	7/13/10	Fracture Hip
3	7/25/10	Unresponsiveness (R/O CVA)
2	7/31/10	Recurrent Pneumonia
5	8/3/10	Hypotension
6	8/19/10	Hyponatremia
7	8/25/10	Fever R/O Sepsis
8	9/1/10	Seizure
9	9/19/10	Lethargy
10	9/23/10	Abdominal pain
11	10/19/10	Altered Level of Consciousness
12	11/3/10	Seizure
13	11/29/10	Seizure

The review found general evidence of adequate and timely medical care and significant progress in the neurological management of individuals with seizure disorders. However, the following process deficiencies were identified. These deficiencies must be corrected during next reporting

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		<p>period in order to maintain substantial compliance with this requirement.</p> <ol style="list-style-type: none"> 1. The nursing assessment of an individual who was found unresponsive (7/12/10) was inadequate. This individual was later diagnosed with a cerebrovascular event (subdural hematoma) secondary to a head injury that he reportedly suffered during an assault by a peer. 2. There was evidence of inadequate nursing follow-up on reports by a physical therapist of a significant change in an individual's condition. 3. There was no evidence that neurological checks were implemented for an individual upon return transfer from outside hospitalization with a diagnosis of a new cerebrovascular event (7/22/10). The individual was transferred back to the outside hospital on 7/25/10 after being found unresponsive. There was no documentation of a medical assessment/examination of this individual upon the outside transfer. 4. The treating Physician and Surgeon presented inaccurate information regarding the status of phenytoin level in an individual who reportedly suffered recurrent seizure activity. However, there was evidence of appropriate management of this individual by the facility's staff neurologist. 5. There was evidence of unacceptable delay in medical attention to an individual who suffered a fall resulting in a hip fracture. The individual was subsequently transferred to an outside hospital and received needed care with no complications. The chief of the medical service assessed this matter to be a systemic issue related to staffing level shortage during off-hours and corrective action was in process. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure proper implementation of a procedure of timely neurological checks for individuals following head injury.
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		<ol style="list-style-type: none"> 2. Ensure proper implementation by nursing staff of current nursing procedures regarding assessments of changes in the physical status of individuals including, but not limited to, alteration of mental status. 3. Address the issue of inadequate staff coverage during off-hours as mentioned in finding #5 above. 4. Continue to provide summary of any changes in current medical policies, procedures, ADs or protocols/guidelines during this review period. 									
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.									
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, NSH assessed its compliance based on an average sample of 14% of all individuals with at least one diagnosis on Axis III during the review period (June-November 2010):</p> <table border="1"> <tr> <td>1.</td> <td><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td>100%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	100%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</i>	100%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	100%
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		<p>4. <i>If applicable, the primary care 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. (This question applies only to individuals who have been seen by an on-call physician during the interval period and the on-call physician wrote an order for the primary care physician to evaluate the individual.)</i></p>	<p>100%</p>
		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: Reviewing the most recent Physician's Quarterly Progress note for 17 individuals residing in different units (AB, BM, CD, CTJ, DL, FM, GS, GTE, II, JLM, JR, KC, KH, RC, RR, RWO and YJL), this monitor found that the facility has maintained substantial compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	
<p>F.7.b.ii</p>	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Auditing Form, NSH assessed its</p>	

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	<p>and medical care;</p>	<p>compliance based on an average sample of 100% of medical transfers during the review period (June-November 2010):</p> <table border="1" data-bbox="991 305 1885 1198"> <tr> <td data-bbox="991 305 1087 415">1.</td> <td data-bbox="1087 305 1793 415"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 305 1885 415">91%</td> </tr> <tr> <td data-bbox="991 415 1087 565">2.</td> <td data-bbox="1087 415 1793 565"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 415 1885 565">99%</td> </tr> <tr> <td data-bbox="991 565 1087 643">3.</td> <td data-bbox="1087 565 1793 643"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 565 1885 643">85%</td> </tr> <tr> <td data-bbox="991 643 1087 792">4.</td> <td data-bbox="1087 643 1793 792"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1793 643 1885 792">99%</td> </tr> <tr> <td data-bbox="991 792 1087 941">5.</td> <td data-bbox="1087 792 1793 941"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1793 792 1885 941">98%</td> </tr> <tr> <td data-bbox="991 941 1087 1091">6.</td> <td data-bbox="1087 941 1793 1091"><i>Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></td> <td data-bbox="1793 941 1885 1091">100%</td> </tr> <tr> <td data-bbox="991 1091 1087 1198">7.</td> <td data-bbox="1087 1091 1793 1198"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 1091 1885 1198">93%</td> </tr> </table> <p data-bbox="991 1243 1917 1386">Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 2 and 4-6. The compliance rates for items 3 and 7 were 84% and 89% respectively in the previous period.</p>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	91%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	99%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	85%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	99%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	98%	6.	<i>Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	100%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	93%
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		<p>NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 17% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (June-November 2010). The following is a summary of the data:</p> <table border="1" data-bbox="991 414 1885 792"> <tr> <td data-bbox="991 414 1087 488">1.</td> <td data-bbox="1087 414 1793 488"><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td data-bbox="1793 414 1885 488">99%</td> </tr> <tr> <td data-bbox="991 488 1087 563">2.</td> <td data-bbox="1087 488 1793 563"><i>The WRP includes each medical condition listed on the Medical Conditions form</i></td> <td data-bbox="1793 488 1885 563">100%</td> </tr> <tr> <td data-bbox="991 563 1087 638">3.</td> <td data-bbox="1087 563 1793 638"><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td data-bbox="1793 563 1885 638">100%</td> </tr> <tr> <td data-bbox="991 638 1087 712">4.</td> <td data-bbox="1087 638 1793 712"><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td data-bbox="1793 638 1885 712">100%</td> </tr> <tr> <td data-bbox="991 712 1087 792">5.</td> <td data-bbox="1087 712 1793 792"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1793 712 1885 792">99%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>The facility did not present data regarding individuals who have refused medical treatment or laboratory tests during this review period.</p> <p>Recommendation 2, July 2010: Provide information on reviews by the Chief Physician and Surgeon of the appropriateness of referrals or outside consultations during the review period.</p> <p>Findings: Based on a review of 15% of the referrals for external consultations, the facility reported that the average time to appointment was 15 days or sooner as dictated by the clinical indication and that 100% of the referrals were assessed to be appropriate.</p>	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	99%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	100%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	100%	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	100%	5.	<i>There are appropriate intervention(s) for each objective</i>	99%
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		<p>Recommendation 3, July 2010: Provide information based on the DMH medical emergency response indicators (actual emergencies and drills). Specify the nature of each issue identified for performance improvement.</p> <p>Findings: During this review period, six code blue emergency response events and 113 practice drills reportedly occurred at NSH.</p> <p>The facility reportedly reviewed the code blue events and identified failure to document the rate of flow of oxygen as a concern in one of these events. In-service training was provided to address this issue. No performance issues were identified in the other events, including an event during which an individual expired following transfer to an outside medical facility.</p> <p>The facility's review of medical emergency drill practices identified a variety of areas for performance improvement. The following outlines these areas and the corresponding corrective actions:</p> <table border="1" data-bbox="991 967 1885 1416"> <thead> <tr> <th data-bbox="991 967 1312 1008">Area of concern</th> <th data-bbox="1312 967 1885 1008">Corrective actions</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1008 1312 1122">Cardiopulmonary resuscitation technique</td> <td data-bbox="1312 1008 1885 1122">Staff training regarding rate and number of compressions/breaths, hand location for compression and depth of compressions</td> </tr> <tr> <td data-bbox="991 1122 1312 1195">Inadequate initial assessments</td> <td data-bbox="1312 1122 1885 1195">Staff training</td> </tr> <tr> <td data-bbox="991 1195 1312 1382">Broken or misplaced equipment</td> <td data-bbox="1312 1195 1885 1382">Replacement of malfunctioning suction machine and placement in proper location, replacement of cold compresses and removal of inappropriately placed phones from crash carts</td> </tr> <tr> <td data-bbox="991 1382 1312 1416">Organization of</td> <td data-bbox="1312 1382 1885 1416">Instruction of staff and unit supervisors</td> </tr> </tbody> </table>	Area of concern	Corrective actions	Cardiopulmonary resuscitation technique	Staff training regarding rate and number of compressions/breaths, hand location for compression and depth of compressions	Inadequate initial assessments	Staff training	Broken or misplaced equipment	Replacement of malfunctioning suction machine and placement in proper location, replacement of cold compresses and removal of inappropriately placed phones from crash carts	Organization of	Instruction of staff and unit supervisors
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Organization of	Instruction of staff and unit supervisors											

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		<p>emergency response paper work</p>	
		<p>Crowd control during drills, leadership of drills and response time</p>	<p>Drills were repeated</p>
		<p>Adherence to universal precautions</p>	<p>Staff training</p>
		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement, including medical transfers, integration of medical conditions into WRPs and refusal by individuals of medical treatment/laboratory testing. 2. Provide information on reviews by the Chief Physician and Surgeon of the appropriateness of referrals or outside consultations during the review period. 3. Provide information based on the DMH medical emergency response indicators (code blue emergencies and drills). In addition, provide a summary of the performance issues that were identified in the code blue events and in practice drills and corresponding corrective actions. 	
<p>F.7.b.iii</p>	<p>define the duties and responsibilities of primary care (non-psychiatric) physicians;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH has continued its practice. The physicians' duty statements are aligned with current administrative directive, policies and procedures and</p>	

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		<p>guidelines regarding Admission Medical Assessments, Provision of Medical Care to Individuals, Transfer and Return from Outside Medical Facilities, Off-Site Referrals/Consultations, Emergency Medical Response and Seizure Management.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH has continued its practice. Review of the schedule of on-call coverage found that both a Primary Care Physician and a Psychiatrist provided after-hours coverage. However, a deficiency was found regarding the off-hours coverage during a significant change in the condition of one individual (see F.7.a).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Same as in recommendation #3 in F.7.a.
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p>Current findings on previous recommendation:</p>

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		<p>Recommendations 1 and 2, July 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide specific information regarding the facility's reviews to assess compliance with this requirement. <p>Findings: All physicians and surgeons at NSH are privileged for continuous access to the hospital records of their individuals during outside hospitalization. This monitor's reviews (see F.7.a) found that discharge summaries from outside hospitals were available in all charts that were selected for this review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia, asthma/COPD and cardiac disease. The average samples were 17% (diabetes mellitus), 16% (hypertension), 18% (dyslipidemia), 19% (COPD/asthma) and 100% (cardiac disease) of individuals diagnosed with these disorders during the review months (June-November 2010). In addition, the facility provided compliance data regarding preventive care based on a 100% sample of individuals. The following tables summarize the facility's data:</p>

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		<u>Diabetes Mellitus</u>	
1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	99%	
2.	<i>HgbA1C was ordered quarterly.</i>	99%	
3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%	
4.	<i>Blood sugar is monitored regularly.</i>	100%	
5.	<i>Urinary micro albumin is monitored annually.</i>	97%	
6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	98%	
7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	
8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	99%	
9.	<i>Blood pressure is monitored weekly.</i>	99%	
10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	100%	
11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	97%	
12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	97%	
13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	97%	
14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	96%	
15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	100%	
<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>			

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		<p><u>Hypertension</u></p> <table border="1"> <tr> <td data-bbox="989 302 1087 378">1.</td> <td data-bbox="1087 302 1793 378"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 302 1887 378">98%</td> </tr> <tr> <td data-bbox="989 378 1087 418">2.</td> <td data-bbox="1087 378 1793 418"><i>Blood pressure is monitored weekly.</i></td> <td data-bbox="1793 378 1887 418">98%</td> </tr> <tr> <td data-bbox="989 418 1087 529">3.</td> <td data-bbox="1087 418 1793 529"><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td data-bbox="1793 418 1887 529">100%</td> </tr> <tr> <td data-bbox="989 529 1087 605">4.</td> <td data-bbox="1087 529 1793 605"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1793 529 1887 605">99%</td> </tr> <tr> <td data-bbox="989 605 1087 646">5.</td> <td data-bbox="1087 605 1793 646"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 605 1887 646">93%</td> </tr> <tr> <td data-bbox="989 646 1087 722">6.</td> <td data-bbox="1087 646 1793 722"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1793 646 1887 722">100%</td> </tr> <tr> <td data-bbox="989 722 1087 799">7.</td> <td data-bbox="1087 722 1793 799"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1793 722 1887 799">99%</td> </tr> <tr> <td data-bbox="989 799 1087 940">8.</td> <td data-bbox="1087 799 1793 940"><i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i></td> <td data-bbox="1793 799 1887 940">100%</td> </tr> <tr> <td data-bbox="989 940 1087 980">9.</td> <td data-bbox="1087 940 1793 980"><i>An exercise program has been initiated.</i></td> <td data-bbox="1793 940 1887 980">100%</td> </tr> <tr> <td data-bbox="989 980 1087 1057">10.</td> <td data-bbox="1087 980 1793 1057"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1793 980 1887 1057">N/A</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Dyslipidemia</u></p> <table border="1"> <tr> <td data-bbox="989 1279 1087 1356">1.</td> <td data-bbox="1087 1279 1793 1356"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 1279 1887 1356">98%</td> </tr> <tr> <td data-bbox="989 1356 1087 1388">2.</td> <td data-bbox="1087 1356 1793 1388"><i>A lipid panel was ordered at least quarterly.</i></td> <td data-bbox="1793 1356 1887 1388">99%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	98%	2.	<i>Blood pressure is monitored weekly.</i>	98%	3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	100%	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	99%	5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	93%	6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	100%	7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	99%	8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	100%	9.	<i>An exercise program has been initiated.</i>	100%	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	N/A	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	98%	2.	<i>A lipid panel was ordered at least quarterly.</i>	99%
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		3.	<i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i>	100%
		4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%
		5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	100%
		6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	90%
		7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%
		8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	99%
		9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	100%
		10.	<i>An exercise program has been initiated.</i>	100%
		11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	100%
<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Asthma/COPD</u></p>				
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
		2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	97%
		3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	100%
		4.	<i>If the individual is currently a smoker, a smoking</i>	N/A

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			<i>cessation program has been discussed and included in the WRP.</i>	
5.			<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	89%
6.			<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	99%
7.			<i>The individual has been assessed for a flu vaccination.</i>	100%
8.			<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	98%
<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items except for item 5, for which compliance was 90% in the previous period.</p> <p><u>Cardiac Disease</u></p> <p>The facility used the NSH standardized tool regarding the management of Cardiac Disease assess compliance with this requirement, based on a 100% sample of individuals with a diagnosis of cardiac disease during the review period:</p>				
1.			<i>Did the patient receive CAD symptom and activity assessment?</i>	97%
2.			<i>Did the patient receive at least one lipid profile in last year?</i>	99%
3.			<i>Did the patient receive lipid-lowering therapy for anyone with LDL > 100?</i>	98%
4.			<i>Does the patient have a LDL-C level <130mg/dl?</i>	94%
5.			<i>Does the patient have a LDL-C <100mg/dl?</i>	91%
6.			<i>Was antiplatelet therapy prescribed?</i>	99%
7.			<i>Was beta blocker prescribed after MI or contraindication documented?</i>	100%
8.			<i>Was ACE inhibitor (or ARB) prescribed?</i>	100%

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		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Preventive Care</u></p> <p>The facility used the NSH standardized tool regarding preventive care to assess compliance with this requirement, based on a 100% sample of individuals receiving an annual medical history and physical exam during the review period:</p> <table border="1" data-bbox="991 561 1892 1416"> <tr> <td data-bbox="991 561 1087 857">1.</td> <td data-bbox="1087 561 1793 857"><i>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?</i></td> <td data-bbox="1793 561 1892 857">N/A</td> </tr> <tr> <td data-bbox="991 857 1087 1117">2.</td> <td data-bbox="1087 857 1793 1117"><i>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 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?</i></td> <td data-bbox="1793 857 1892 1117">96%</td> </tr> <tr> <td data-bbox="991 1117 1087 1268">3.</td> <td data-bbox="1087 1117 1793 1268"><i>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?</i></td> <td data-bbox="1793 1117 1892 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1382">4.</td> <td data-bbox="1087 1268 1793 1382"><i>If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?</i></td> <td data-bbox="1793 1268 1892 1382">100%</td> </tr> <tr> <td data-bbox="991 1382 1087 1416">5.</td> <td data-bbox="1087 1382 1793 1416"><i>If the individual is a women age 50 or older or has a</i></td> <td data-bbox="1793 1382 1892 1416">100%</td> </tr> </table>	1.	<i>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?</i>	N/A	2.	<i>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 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?</i>	96%	3.	<i>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?</i>	100%	4.	<i>If the individual is 65 or older, has a pneumococcal vaccine by ordered in the previous two years as documented on the Preventive Care Tracking Form?</i>	100%	5.	<i>If the individual is a women age 50 or older or has a</i>	100%
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			<i>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?</i>	
		6.	<i>If the individual is age 50 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?</i>	100%
		7.	<i>If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?</i>	100%
		8.	<i>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?</i>	100%
		9.	<i>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?</i>	100%
		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items except item 2, which was 85% in the previous period.</p> <p>Compliance: Substantial.</p>		

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.7.d	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Provide data regarding the status of implementation of the current process of physician performance profile and utilization of the data in the processes of reappointment and repriviliging.</p> <p>Findings: NSH reported that nine physicians and surgeons were reprivilinged during this review period using the indicators that were outlined in previous reports. This represents 100% of all physicians and surgeons who were scheduled for repriviliging.</p> <p>Recommendation 2, July 2010: Continue to update practice guidelines guided by current literature and relevant clinical experience. Provide summary information regarding these updates, if any.</p> <p>Findings: As mentioned earlier, the facility updated its practice guideline regarding seizure management. All other practice guidelines were reportedly reviewed and no significant changes were indicated.</p> <p>Recommendation 3, July 2010: Provide specific information regarding any educational/corrective actions based on peer review data analysis (practitioner and group patterns/trends).</p>

		<p>Findings: The facility reported that one practitioner fell below group standards (regarding Quarterly Reassessments < 80%). The practitioner was reportedly counseled and is now meeting the standard.</p> <p>Recommendation 4, July 2010: Provide data regarding clinical and process outcomes of medical care and data analysis of significant trends/patterns.</p> <p>Findings: NSH provided data on process and clinical outcome data based on indicators that were developed during the December 2009 meeting between the chiefs of medical services and this monitor. The following is a summary outline of the data:</p> <ul style="list-style-type: none"> ❖ Process outcomes tracked: <ul style="list-style-type: none"> ➤ Number of individuals newly diagnosed with diabetes mellitus ➤ Number of new diagnoses of diabetes mellitus in individuals receiving new generation antipsychotics ➤ Number/percentage of individuals whose BMI is tracked monthly ➤ Number of individuals receiving Clozaril ➤ Number of individuals with three or more falls in 30 days ➤ Total number of falls ➤ Individuals with cognitive disorders on old generation anticonvulsants ➤ Review process for unexpected mortalities ❖ Clinical outcomes tracked: <ul style="list-style-type: none"> ➤ Average HA1c value for all individuals with diabetes mellitus ➤ Average HA1c value for all individuals with diabetes mellitus receiving new generation antipsychotics ➤ Percentage of individuals with dyslipidemia with LDL <130 ➤ Percentage of individuals with dyslipidemia with LDL <100 ➤ Number/percentage of individuals with BMI >25
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		<ul style="list-style-type: none"> ➤ Percentage of individuals with hypertension with blood pressure < 140/90 ➤ Percentage of individuals with diabetes mellitus and blood pressure <130/80 ➤ Number of individuals hospitalized for bowel dysfunction ➤ Individuals with falls with major injury ➤ Number of individuals diagnosed with aspiration pneumonia ➤ Number of individuals with refractory seizures ➤ Number of individuals with status epilepticus ➤ Unexpected mortalities <p>Other findings: The outcome data, including comparisons with the last review period, demonstrated that NSH has, in general, maintained positive outcomes in medical services.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding the status of implementation of the current process of physician performance profile and utilization of the data in the processes of reappointment and reprivileging. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. Provide summary information regarding these updates, if any. 3. Provide specific information regarding any educational/corrective actions based on peer review data analysis (practitioner and group patterns/trends). 4. Provide data regarding clinical and process outcomes of medical care and data analysis of significant trends/patterns.
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Gordon Wells, PHN I 2. Maj Yazidi, RN, PHN I 3. Michelle Patterson, RN, ACNS 4. Robert Kolker, RN, PHN II 5. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH IC Admission PPD summary data, June-November 2010 2. NSH IC Annual PPD Audit summary data, June-November 2010 3. NSH IC Hepatitis C Audit summary data, June-November 2010 4. NSH IC HIV Positive Audit summary data, June-November 2010 5. NSH IC Immunization Audit summary data, June-November 2010 6. NSH IC Immunization Refusal Audit summary data, June-November 2010 7. NSH IC MRSA Audit summary data, June-November 2010 8. NSH IC Positive PPD Audit summary data, June-November 2010 9. NSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, June-November 2010 10. NSH IC Sexually Transmitted Disease (STD) Audit summary data, June-November 2010 11. Quarterly Infection control Committee Meeting minutes 12. Medical records for the following 89 individuals: AB, ADL, AGB, AL, ALT, AMB, AR, ATT, AV, BAP, BJC, BRT, CCR, CCS, CEN, CHB, CYW, DAG, DIB, DRH, DTP, EB, EP, FDB, FEB, GF, GHH, GN, GSC, HV, JA, JAG, JDH, JEC, JEE, JJL, JLA, JLM, JWM, KY, LAL, LJM, LLE, LO, LUM, LY, MCG, MDB, MDC, MG, MGK, MHH, MHJ, MID, MLS, MM, MP, NKP, ORP, PFC, PLD, PR, RA, RAE, RAS, REB, REG, REH, RJC, RJT, RLE, RLH, RLK, RRB, RRG, RWM, SJW, SK, SRB, SRK, TCK, TDY, TE, TMC, TW, VB, WJB, WLM and WMM

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F.8.a	Each State hospital shall establish an effective infection control program that:	Compliance: Substantial.															
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, NSH assessed its compliance based on an average sample of 65% of individuals admitted to the hospital with a negative PPD in the review months (June-November 2010):</p> <table border="1" data-bbox="991 748 1887 1125"> <tr> <td data-bbox="991 748 1087 823">1.</td> <td data-bbox="1087 748 1793 823"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 748 1887 823">100%</td> </tr> <tr> <td data-bbox="991 823 1087 898">2.</td> <td data-bbox="1087 823 1793 898"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 823 1887 898">100%</td> </tr> <tr> <td data-bbox="991 898 1087 972">3.</td> <td data-bbox="1087 898 1793 972"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1793 898 1887 972">100%</td> </tr> <tr> <td data-bbox="991 972 1087 1047">4.</td> <td data-bbox="1087 972 1793 1047"><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1793 972 1887 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1122">5.</td> <td data-bbox="1087 1047 1793 1122"><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1047 1887 1122">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 19 individuals admitted during the review period (ALT, AR, CCS, EB, JLA, JLM, LJM, MDB, MLS, MP, PLD, REB, RJC, RJT, SJW, SK, TCK, TMC and WLM) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, NSH assessed its compliance based on an average sample of 40% of individuals needing an annual PPD during the review months (June-November 2010):</p> <table border="1" data-bbox="991 894 1887 1195"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1793 971"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 894 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">2.</td> <td data-bbox="1087 971 1793 1047"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 971 1887 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1123">3.</td> <td data-bbox="1087 1047 1793 1123"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 1047 1887 1123">100%</td> </tr> <tr> <td data-bbox="991 1123 1087 1195">4.</td> <td data-bbox="1087 1123 1793 1195"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1123 1887 1195">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
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4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%												

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals requiring an annual PPD during the review period (AL, AR, AV, BJC, CYW, EP, JEE, J JL, KY, LY, MID, MM, NKP, RA, RLH, RLK, RWM, TE, TW and VB) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, NSH assessed its compliance based on an average sample of 96% of individuals admitted to the hospital in the review months (June-November 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 967 1890 1421"> <tr> <td data-bbox="991 967 1087 1081">1.</td> <td data-bbox="1087 967 1793 1081"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 967 1890 1081">100%</td> </tr> <tr> <td data-bbox="991 1081 1087 1195">2.</td> <td data-bbox="1087 1081 1793 1195"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1081 1890 1195">100%</td> </tr> <tr> <td data-bbox="991 1195 1087 1308">3.</td> <td data-bbox="1087 1195 1793 1308"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 1195 1890 1308">100%</td> </tr> <tr> <td data-bbox="991 1308 1087 1382">4.</td> <td data-bbox="1087 1308 1793 1382"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1308 1890 1382">100%</td> </tr> <tr> <td data-bbox="991 1382 1087 1421">5.</td> <td data-bbox="1087 1382 1793 1421"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 1382 1890 1421">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%															
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%															
3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%															
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%															
5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%															

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		<table border="1"> <tr> <td data-bbox="987 194 1087 267">6.</td> <td data-bbox="1087 194 1795 267"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1795 194 1890 267">100%</td> </tr> <tr> <td data-bbox="987 267 1087 381">7.</td> <td data-bbox="1087 267 1795 381"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1795 267 1890 381">90%</td> </tr> </table>	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	90%	
6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%							
7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	90%							
		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 15 individuals who were admitted Hepatitis C positive during the review period (ADL, AGB, CHB, DTP, GN, LO, LUM, MGK, ORP, PR, RAS, REG, SRK, TDY and WJB) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, NSH assessed its compliance based on a 100% sample (two individuals) of individuals who were positive for HIV antibody in the review months (June-November 2010):</p>							

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		1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%
		2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%
		3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%
		4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A
		5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%
		6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%
		7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%
		8.	<i>Appropriate interventions are written.</i>	100%
		<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p>		
		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>		
		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>		
		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>		

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of two individuals who were admitted during the review period with HIV (BAP and FDB) found that both were in compliance regarding clinic referrals and follow-up, and both WRPs contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u></p> <p>Using the DMH IC Immunization Audit, NSH assessed its compliance based on an average sample of 42% of individuals admitted to the hospital during the review months (June-November 2010):</p> <table border="1" data-bbox="991 711 1885 1047"> <tr> <td data-bbox="991 711 1087 784">1.</td> <td data-bbox="1087 711 1793 784"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 711 1885 784">100%</td> </tr> <tr> <td data-bbox="991 784 1087 857">2.</td> <td data-bbox="1087 784 1793 857"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 784 1885 857">100%</td> </tr> <tr> <td data-bbox="991 857 1087 930">3.</td> <td data-bbox="1087 857 1793 930"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 857 1885 930">100%</td> </tr> <tr> <td data-bbox="991 930 1087 1047">4.</td> <td data-bbox="1087 930 1793 1047"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 930 1885 1047">100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%												
2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%												
3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%												
4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%												

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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 19 individuals (ALT, AR, CCS, EB, JLA, JLM, LJM, MDB, MLS, MP, PLD, REB, RJC, RJT, SJW, SK, TCK, TMC and WLM) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, NSH assessed its compliance based on a 94% sample (21 individuals) of individuals in the hospital who refused to take their immunizations during the review months (June-November 2010):</p> <table border="1" data-bbox="991 857 1887 1344"> <tr> <td data-bbox="991 857 1087 971">1.</td> <td data-bbox="1087 857 1793 971"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1793 857 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1045">2.</td> <td data-bbox="1087 971 1793 1045"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 971 1887 1045">93%</td> </tr> <tr> <td data-bbox="991 1045 1087 1120">3.</td> <td data-bbox="1087 1045 1793 1120"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1045 1887 1120">93%</td> </tr> <tr> <td data-bbox="991 1120 1087 1230">4.</td> <td data-bbox="1087 1120 1793 1230"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1120 1887 1230">93%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">5.</td> <td data-bbox="1087 1230 1793 1344"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 1230 1887 1344">N/A</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</p>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	93%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	93%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	93%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%															
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	93%															
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	93%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	93%															
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A															

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		<p>at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 12 individuals who refused immunizations during the review period (AMB, DAG, JAG, JDH, MDC, MG, MHH, PFC, RRB, RRG, SRB and WMM) found that all WRPs contained an open Focus 6 and appropriate objectives and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, NSH assessed its compliance based on the single individual in the hospital who tested positive for MRSA during the review months (June-November 2010):</p> <table border="1" data-bbox="989 1117 1890 1414"> <tr> <td data-bbox="989 1117 1087 1227">1.</td> <td data-bbox="1087 1117 1793 1227"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 1117 1890 1227">100%</td> </tr> <tr> <td data-bbox="989 1227 1087 1338">2.</td> <td data-bbox="1087 1227 1793 1338"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 1227 1890 1338">100%</td> </tr> <tr> <td data-bbox="989 1338 1087 1414">3.</td> <td data-bbox="1087 1338 1793 1414"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 1338 1890 1414">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%									
2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%									
3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%									

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		<table border="1"> <tr> <td data-bbox="987 191 1081 267">4.</td> <td data-bbox="1081 191 1795 267"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1795 191 1890 267">100%</td> </tr> <tr> <td data-bbox="987 267 1081 381">5.</td> <td data-bbox="1081 267 1795 381"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1795 267 1890 381">100%</td> </tr> <tr> <td data-bbox="987 381 1081 422">6.</td> <td data-bbox="1081 381 1795 422"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1795 381 1890 422">100%</td> </tr> <tr> <td data-bbox="987 422 1081 495">7.</td> <td data-bbox="1081 422 1795 495"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1795 422 1890 495">100%</td> </tr> <tr> <td data-bbox="987 495 1081 568">8.</td> <td data-bbox="1081 495 1795 568"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1795 495 1890 568">100%</td> </tr> </table>	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%	<p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the record of one individual with MRSA (GF) found that the individual was placed on contact precautions; placed on the appropriate antibiotic; and the WRP contained appropriate objectives and interventions.</p> <p><u>Positive PPD</u> Using the DMH IC Positive PPD Audit, NSH assessed its compliance</p>
4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%																
5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%																
6.	<i>A Focus 6 is opened for MRSA.</i>	100%																
7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%																
8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%																

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		<p>based on an average sample of 97% of individuals in the hospital who had a positive PPD test during the review months (June-November 2010):</p> <table border="1" data-bbox="991 305 1885 867"> <tr> <td data-bbox="991 305 1087 380">1.</td> <td data-bbox="1087 305 1793 380"><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td data-bbox="1793 305 1885 380">100%</td> </tr> <tr> <td data-bbox="991 380 1087 418">2.</td> <td data-bbox="1087 380 1793 418"><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td data-bbox="1793 380 1885 418">100%</td> </tr> <tr> <td data-bbox="991 418 1087 493">3.</td> <td data-bbox="1087 418 1793 493"><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td data-bbox="1793 418 1885 493">100%</td> </tr> <tr> <td data-bbox="991 493 1087 607">4.</td> <td data-bbox="1087 493 1793 607"><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td data-bbox="1793 493 1885 607">N/A</td> </tr> <tr> <td data-bbox="991 607 1087 646">5.</td> <td data-bbox="1087 607 1793 646"><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td data-bbox="1793 607 1885 646">96%</td> </tr> <tr> <td data-bbox="991 646 1087 753">6.</td> <td data-bbox="1087 646 1793 753"><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td data-bbox="1793 646 1885 753">96%</td> </tr> <tr> <td data-bbox="991 753 1087 867">7.</td> <td data-bbox="1087 753 1793 867"><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td data-bbox="1793 753 1885 867">96%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	96%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	96%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	96%
1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%																					
2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%																					
3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%																					
4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A																					
5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	96%																					
6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	96%																					
7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	96%																					

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 10 individuals who had a positive PPD (AB, ATT, BRT, FEB, HV, JEC, LAL, MHJ, RAE and TCK) found that all individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, NSH assessed its compliance based on a 90% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (June-November 2010):</p> <table border="1" data-bbox="991 782 1887 1159"> <tr> <td data-bbox="991 782 1087 932">1.</td> <td data-bbox="1087 782 1793 932"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 782 1887 932">100%</td> </tr> <tr> <td data-bbox="991 932 1087 1008">2.</td> <td data-bbox="1087 932 1793 1008"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 932 1887 1008">89%</td> </tr> <tr> <td data-bbox="991 1008 1087 1084">3.</td> <td data-bbox="1087 1008 1793 1084"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1008 1887 1084">89%</td> </tr> <tr> <td data-bbox="991 1084 1087 1159">4.</td> <td data-bbox="1087 1084 1793 1159"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1084 1887 1159">89%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% for item 1; the compliance rates for items 2, 3 and 4 were 99% in the previous period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> NSH did not identify problematic trends.</p>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	89%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	89%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	89%
1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%												
2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	89%												
3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	89%												
4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	89%												

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None were reported by NSH.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None were reported by NSH.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the records of 11 individuals who refused admitting or annual labs/diagnostics (CCR, CEN, DIB, DRH, GHH, GSC, JWM, LLE, MCG, REH and RLE) found that all refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> Using the DMH IC Sexually Transmitted Disease (STD) Audit, NSH assessed its compliance based on a 100% sample (one individual) of individuals in the hospital who tested positive for an STD during the review months (June-November 2010):</p> <table border="1" data-bbox="991 930 1887 1421"> <tr> <td>1.</td> <td><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>An RPR is ordered during the admission process for each individual.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td>N/A</td> </tr> <tr> <td>7.</td> <td><i>Focus 6 is opened for an individual testing positive for</i></td> <td>100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%																					
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%																					
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6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A																					
7.	<i>Focus 6 is opened for an individual testing positive for</i>	100%																					

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		<table border="1"> <tr> <td></td> <td><i>an STD.</i></td> <td></td> </tr> <tr> <td>8.</td> <td><i>Appropriate objective(s) are written.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Appropriate interventions are written.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> <p>A review of the record of one individual with diagnosed STDs (JA) found that the appropriate lab work indicating a positive STD was obtained and the STD was adequately addressed in the WRP.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Continue to monitor this requirement.</p>		<i>an STD.</i>		8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%
	<i>an STD.</i>										
8.	<i>Appropriate objective(s) are written.</i>	100%									
9.	<i>Appropriate interventions are written.</i>	100%									
F.8.a.ii	assesses these data for trends;	Current findings on previous recommendation:									

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		<p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH's key indicator data from the facility accurately reflected the infection control trends from the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p>

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		<p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: Review of the minutes of NSH's meetings verified that IC data are discussed at the Infection Control Committee meetings and other discipline committee meetings and are included in the Facility's Key Indicator data.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Craig B. Story, DDS, Chief Dentist 2. Michelle Patterson, RN, ACNS 3. Ronaldo Chavez, DDS 4. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Dental Services Audit summary data, June-November 2010 2. NSH's Dental Department staffing 3. NSH's appointment log 4. NSH's Refusal Log form 5. Medical records for the following 97 individuals: AA, ABM, AGC, AIL, AJL, ALT, AMC, AS, AT, ATS, AWM, BBK, BDN, BGD, BMD, BP-1, BP-2, BTM, BVT, CAR, CDD, CEG, CFP, CFT, CLH, CRJ, CVS, CW, DAK, DB, DDK, DEC, DK, DLR, DSK, DVB, DVH, DVL, DWB, EH, ELB, EM, ET, ETP, FK, GGJ, HH, HSD, JCW, JEC, JJB, JJI, JLM, JTJ, LAG, LAL, LAZ, LDF, LH, LLB, MB, MCC, MDB, MJL, MRS, MW, NNJ, NS, PD, PDD, POL, PP, PTR, RA, RB, RCH, RES, RF, RGM, RH, RLM, RM, ROH, ROW, RWH, SJW, SL, SNR, SRA, SUG, TMG, TOT, TRO, VIC, VK, VL and WHG
<p>F.9.a</p>	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: Since the last review, no additional staff have been added to the NSH's Dental Department. The current staffing has been adequate to provide timely and appropriate dental care and treatment.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for comprehensive dental exams during the review months (June-November 2010):</p> <table border="1" data-bbox="989 933 1892 974"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 25 individuals (AJL, ALT, AMC, BP, DEC, DK, DLR, DSK, DWB, EH, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, PDD, RCH, RH, RWH, SJW, SL and SRA) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals who have been in the hospital for 90 days or less during the review period (June-November 2010):</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

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		<table border="1" data-bbox="991 228 1887 267"> <tr> <td data-bbox="991 228 1087 267">1.b</td> <td data-bbox="1087 228 1793 267"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 228 1887 267">100%</td> </tr> </table> <p data-bbox="991 310 1887 378">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 420 1887 560">A review of the records of 25 individuals (AJL, ALT, AMC, BP, DEC, DK, DLR, DSK, DWB, EH, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, PDD, RCH, RH, RWH, SJW, SL and SRA) found that all individuals were timely seen for their admission exams.</p> <p data-bbox="991 602 1887 709">Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (June-November 2010):</p> <table border="1" data-bbox="991 748 1887 824"> <tr> <td data-bbox="991 748 1087 824">1.c</td> <td data-bbox="1087 748 1793 824"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 748 1887 824">100%</td> </tr> </table> <p data-bbox="991 867 1887 935">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 977 1887 1084">A review of the records of 15 individuals (AIL, BBK, CFT, CVS, DB, DVH, ETP, FK, GGJ, MJL, POL, RGM, TRO, VL and WHG) found that all annual exams were timely completed.</p> <p data-bbox="991 1127 1887 1266">Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (June-November 2010):</p> <table border="1" data-bbox="991 1305 1887 1416"> <tr> <td data-bbox="991 1305 1087 1416">1.d</td> <td data-bbox="1087 1305 1793 1416"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 1305 1887 1416">100%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</i>	100%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%
1.b	<i>If admission examination date was 90 days or less</i>	100%									
1.c	<i>Annual date of examination was within anniversary month of admission</i>	100%									
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%									

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		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 40 individuals (AIL, AJL, ALT, AMC, BBK, BP, CFT, CVS, DB, DEC, DK, DLR, DSK, DVH, DWB, EH, ETP, FK, GGJ, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, MJL, PDD, POL, RCH, RGM, RH, RWH, SJW, SL, SRA, TRO, VL and WHG) found that all individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (June-November 2010):</p> <table border="1" data-bbox="991 743 1887 894"> <tr> <td data-bbox="991 743 1087 894">1.e</td> <td data-bbox="1087 743 1793 894"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 743 1887 894">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (ABM, AS, BGD, CW, DVB, ELB, EM, JJI, LAG, MB, MCC, NS, PTR, RB, RES, RLM, ROH, SNR, SUG and VK) found that all individuals received timely follow-up care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	Current findings on previous recommendation:			

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		<p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals scheduled for follow-up dental care during the review months (June-November 2010), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 40 individuals (AIL, AJL, ALT, AMC, BBK, BP, CFT, CVS, DB, DEC, DK, DLR, DSK, DVH, DWB, EH, ETP, FK, GGJ, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, MJL, PDD, POL, RCH, RGM, RH, RWH, SJW, SL, SRA, TRO, VL and WHG) found compliance with the documentation requirements in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (June-November 2010):</p> <table border="1" data-bbox="991 1263 1890 1380"> <tr> <td data-bbox="991 1263 1087 1380">3.a</td> <td data-bbox="1087 1263 1793 1380"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 1263 1890 1380">100%</td> </tr> </table>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	100%			

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		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 25 individuals (AJL, ALT, AMC, BP, DEC, DK, DLR, DSK, DWB, EH, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, PDD, RCH, RH, RWH, SJW, SL and SRA) found that all individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals scheduled for Level 1 restorative care during the review months (June-November 2010):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">3.c</td> <td data-bbox="1087 636 1793 711"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 20 individuals (ABM, AS, BGD, CW, DVB, ELB, EM, JJI, LAG, MB, MCC, NS, PTR, RB, RES, RLM, ROH, SNR, SUG and VK) found that all individuals received restorative care.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals who had tooth extractions</p>			

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		<p>during the review months (June-November 2010):</p> <table border="1" data-bbox="993 264 1887 526"> <tr> <td data-bbox="993 264 1087 526">4.</td> <td data-bbox="1087 264 1793 526"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></td> <td data-bbox="1793 264 1887 526">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 18 individuals (AA, AGC, ATS, BMD, BP, BTM, CAR, CDD, CEG, ET, JJB, JTJ, LLB, MRS, PP, RA, RM and TMG) found that all records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%			
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (June-November 2010), and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p>			

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		<p>A review of the records of 40 individuals (AIL, AJL, ALT, AMC, BBK, BP, CFT, CVS, DB, DEC, DK, DLR, DSK, DVH, DWB, EH, ETP, FK, GGJ, HSD, JCW, JLM, LAL, LAZ, LDF, LH, MDB, MJL, PDD, POL, RCH, RGM, RH, RWH, SJW, SL, SRA, TRO, VL and WHG) found that all records were in compliance with the documentation requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals scheduled for dental appointments during the review months (June-November 2010):</p> <table border="1" data-bbox="993 1008 1892 1045"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>70%</td> </tr> </table> <p>Comparative data indicated that the attendance for dental appointments was little changed from 72% in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 1268 1829 1421"> <thead> <tr> <th>Month/2010</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>June</td> <td>15</td> <td>10</td> <td>0</td> </tr> <tr> <td>July</td> <td>15</td> <td>7</td> <td>0</td> </tr> </tbody> </table>	6.a	<i>The individual attended the scheduled appointment</i>	70%	Month/2010	Refused to come to appt	Unit staff procedural problem	Transportation problem	June	15	10	0	July	15	7	0
6.a	<i>The individual attended the scheduled appointment</i>	70%															
Month/2010	Refused to come to appt	Unit staff procedural problem	Transportation problem														
June	15	10	0														
July	15	7	0														

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		<table border="1" data-bbox="997 191 1827 345"> <tr> <td>August</td> <td>16</td> <td>13</td> <td>0</td> </tr> <tr> <td>Sept</td> <td>17</td> <td>5</td> <td>0</td> </tr> <tr> <td>Oct</td> <td>14</td> <td>9</td> <td>0</td> </tr> <tr> <td>Nov</td> <td>15</td> <td>6</td> <td>0</td> </tr> </table> <p data-bbox="989 386 1839 488">From review of NSH's dental logs, the majority of missed dental appointments were due to refusals. See F.9.e for findings regarding dental refusals.</p> <p data-bbox="989 537 1140 597">Compliance: Substantial.</p> <p data-bbox="989 646 1457 711">Current recommendation: Continue to monitor this requirement.</p>	August	16	13	0	Sept	17	5	0	Oct	14	9	0	Nov	15	6	0
August	16	13	0															
Sept	17	5	0															
Oct	14	9	0															
Nov	15	6	0															
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p data-bbox="989 760 1591 789">Current findings on previous recommendations:</p> <p data-bbox="989 833 1390 862">Recommendation 1, July 2010: WRPTs need to ensure that WRPs addressing refusals are appropriately individualized.</p> <p data-bbox="989 980 1104 1010">Findings: The Facility provided 104 RN case managers with follow-up training regarding the quality of individualized focus, plans and interventions addressing dental refusals on October 20, 2010 through November 4, 2010. Data collected for refusals was separated by Program and distributed to the Program NCs for review. A review of systematic issues will be an ongoing agenda item at the NC meetings to focus on improvement and in increasing compliance in the area of refusals. Also, on November 23, 2010, the list of October dental refusals was sent to each Program for WRP revisions with a completion date of 12/3/10. The NCs were directed to follow up and to provide feedback to CNS. Then, the revised WRPs will be audited by CNS. In addition, the RNs are to</p>																

Section F: Specific Therapeutic and Rehabilitation Services

		<p>address progress regarding refusals in their Monthly Progress Note and in the WRP.</p> <p>Recommendation 2, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (June-November 2010), and reported a mean compliance rate of 77%. Comparative data indicated that NSH's compliance rate decreased from a compliance rate of at least 90% from the previous review period to 77%. However, the auditing of this area is now focused on the individualization of the WRPs rather than just the completion.</p> <p>A review of the records of 20 individuals (AT, AWM, BDN, BP, BVT, CFP, CLH, CRJ, DAK, DDK, DVL, HH, JEC, MW, NNJ, PD, RF, ROW, TOT and VIC) found that 12 WRPs contained an open focus with appropriate interventions addressing refusals (AT, AWM, BVT, CFP, CRJ, DAK, HH, JEC, NNJ, PD, TOT and VIC).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementing strategies addressing dental refusals. 2. Continue to monitor this requirement.
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Section G: Documentation

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

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress: NSH continues to be committed to decreasing the use the restraint and seclusion and has maintained substantial compliance with all areas of Section H.</p>
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michelle Patterson, RN, ACNS 2. Steve Athens, NC, CNS 3. Steve Weule, SRN, Risk Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Seclusion/Restraint Audit summary data, June-November 2010 2. NSH's training rosters 3. Medical records for the following 35 individuals: AB, BAS, BL, BVQ, CCB, CCP, CH, DBC, DFJ, DLT, DPA, DWD, FM, JA, JLB, JW, JWF, KB, KRD, LMK, MAM, ML, MYA, RBC, RCW, RLE, ROK, RT, SEK, SHL, TDL, TGJ, TJM, UP and YH
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: There were no incidents of prone restraint, prone containment or prone transportation found during the current review.</p> <p>Other findings: NSH continues to put significant efforts into decreasing the use of</p>

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

		<p>restraint and seclusion. The following comparison data demonstrates this:</p> <ul style="list-style-type: none"> • The number of restraint and seclusion hours decreased from 963 hours in July 2006 to 207 hours in November 2010; • The average number of restraint episodes declined from 153 per month in 2006 to 54 episodes per month in 2010; and • The average number of seclusion episodes declined from 67 per month in 2006 to 30 episodes per month in 2010. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>									
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Substantial.</p>									
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 68% mean sample of initial seclusion orders each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 1265 1892 1416"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive</i></td> <td>98%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	98%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	99%	3.	<i>Seclusion is used after a hierarchy of less-restrictive</i>	98%
1.	<i>Seclusion is used in a documented manner.</i>	98%									
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	99%									
3.	<i>Seclusion is used after a hierarchy of less-restrictive</i>	98%									

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

		<table border="1" data-bbox="991 191 1906 269"> <tr> <td data-bbox="991 191 1087 269"></td> <td data-bbox="1087 191 1793 269"><i>measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 191 1906 269"></td> </tr> </table> <p data-bbox="991 310 1906 378">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 418 1906 638">A review of 30 episodes of seclusion for 17 individuals (AB, BL, CCB, DBC, DPA, DWD, FM, KB, MAM, ML, MYA, RBC, RLE, TGJ, TJM, UP and YH) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p data-bbox="991 678 1906 784">Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 74% mean sample of initial restraint orders each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 824 1906 1052"> <tr> <td data-bbox="991 824 1087 865">1.</td> <td data-bbox="1087 824 1793 865"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 824 1906 865">99%</td> </tr> <tr> <td data-bbox="991 865 1087 938">2.</td> <td data-bbox="1087 865 1793 938"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 865 1906 938">100%</td> </tr> <tr> <td data-bbox="991 938 1087 1052">3.</td> <td data-bbox="1087 938 1793 1052"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 938 1906 1052">100%</td> </tr> </table> <p data-bbox="991 1092 1906 1161">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 1201 1906 1417">A review of 33 episodes of restraint for 18 individuals (BAS, BVQ, CCP, CH, DFJ, DLT, JA, JLB, JW, JWF, KR, LMK, RCW, ROK, RT, SEK, SHL and TDL) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p>		<i>measures has been considered in a clinically justifiable manner or exhausted.</i>		1.	<i>Restraint is used in a documented manner.</i>	99%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%
	<i>measures has been considered in a clinically justifiable manner or exhausted.</i>													
1.	<i>Restraint is used in a documented manner.</i>	99%												
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%												
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%												

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

		<p>Current recommendation: Continue to monitor this requirement.</p>									
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 68% mean sample of initial seclusion orders each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 711 1885 1230"> <tr> <td data-bbox="991 711 1087 784">4.</td> <td data-bbox="1087 711 1793 784"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 711 1885 784">99%</td> </tr> <tr> <td data-bbox="991 784 1087 1008">5.</td> <td data-bbox="1087 784 1793 1008"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1793 784 1885 1008">99%</td> </tr> <tr> <td data-bbox="991 1008 1087 1230">6.</td> <td data-bbox="1087 1008 1793 1230"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 1008 1885 1230">98%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 30 episodes of seclusion for 17 individuals (AB, BL, CCB, DBC,</p>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	99%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	99%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	98%
4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	99%									
5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	99%									
6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	98%									

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

		<p>DPA, DWD, FM, KB, MAM, ML, MYA, RBC, RLE, TGJ, TJM, UP and YH) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 29 episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 74% mean sample of initial restraint orders each month during the review period (June-November 2010):</p> <table border="1" data-bbox="991 522 1892 1047"> <tr> <td data-bbox="991 522 1094 597">4.</td> <td data-bbox="1094 522 1793 597"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 522 1892 597">98%</td> </tr> <tr> <td data-bbox="991 597 1094 821">5.</td> <td data-bbox="1094 597 1793 821"><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 597 1892 821">99%</td> </tr> <tr> <td data-bbox="991 821 1094 1047">6.</td> <td data-bbox="1094 821 1793 1047"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 821 1892 1047">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 33 episodes of restraint for 18 individuals (BAS, BVQ, CCP, CH, DFJ, DLT, JA, JLB, JW, JWF, KRD, LMK, RCW, ROK, RT, SEK, SHL and TDL) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm</p>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	98%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	99%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	98%									
5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	99%									
6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (NSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%									

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

		<p>Current recommendation: Continue to monitor this requirement.</p>
H.2.c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendations: See F.2.c.iv.</p>
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 68% mean sample of episodes of seclusion each month during the review period (June-November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 74% mean sample of episodes of restraint each month during the review period (June-November 2010), and reported a mean compliance rate of 99%. Comparative data indicated that NSH</p>

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

		<p>maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.3	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance with the one-hour requirement based on a 68% mean sample of initial seclusion orders each month during the review period (June-November 2010), and reported a mean compliance rate of 95%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 30 episodes of seclusion for 17 individuals (AB, BL, CCB, DBC, DPA, DWD, FM, KB, MAM, ML, MYA, RBC, RLE, TGJ, TJM, UP and YH) found that the RN conducted a timely assessment in 29 episodes and that the individual was timely seen by a psychiatrist in 28 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH also assessed its compliance with the one-hour requirement based on a 74% mean sample of initial restraint orders each month during the review period (June-November 2010), and reported a mean compliance rate of 95%. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p>

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

		<p>A review of 33 episodes of restraint for 18 individuals (BAS, BVQ, CCP, CH, DFJ, DLT, JA, JLB, JW, JWF, KRD, LMK, RCW, ROK, RT, SEK, SHL and TDL) found that the RN conducted a timely assessment in 32 episodes and that the individual was timely seen by a psychiatrist in 31 episodes.</p> <p>NSH's training rosters indicated that all staff that were required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: NSH continues to compare the Medication Administration Record for administered PRN/Stat medications to the PRN/Stat data entered into the WaRMSS system to validate reliability. Seclusion and restraint data are entered into incident management at the time of the incident. Incident entry into the incident management system is verified by real-time review of the incident during the incident or as soon as possible by HSS/NOD. Individual Programs review incidents in their Program for entry and accuracy. Seclusion and restraint episodes are also verified for accuracy by Standards Compliance Department reviewers, who compare the Emergency Intervention Reports with the seclusion and restraint data in WaRMSS. Any discrepancies in data are verified for</p>

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

		<p>accuracy and data is entered or adjusted as indicated. A review of PRN/Stat medications and seclusion and restraint incidents found no instances that were not included in NSH's databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 100% sample of individuals who were in seclusion more than three times in 30 days during the review period (June-November 2010), and reported a mean compliance rate of 100% with the three-day review requirement. Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals who were in seclusion more than three times in 30 days during the review period (AB, DBC, KB and TJM) found that all WRPs included documentation within three business days.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH also assessed its compliance based on a 100% sample of individuals who were in restraint more than three times in 30 days during the review period (June-November 2010), and reported a mean compliance rate of 100% with the three-day review requirement. Comparative data indicated that NSH</p>

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

		<p>maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals who were in restraint more than three times in 30 days during the review period (BAS, CH, DLT, JLB, RCW, RT and TDL) found that all WRPs included documentation within three business days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized	<p>Current findings on previous recommendation:</p>

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

	behaviors.	<p>Recommendation, July 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendations: See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the	<p>Current findings on previous recommendation:</p>

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

	administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Recommendation, July 2010: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: See F.3.h.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.8	Each State hospital shall:	<p>Compliance: Not applicable.</p>
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	There were no previous recommendations, as side rails are no longer used at NSH.
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	Current findings on previous recommendation:

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

	<p>identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Recommendation, January 2010: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendation: None required.</p>
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The sample of investigations reviewed was characterized by thoroughness and clarity. These attributes and the timeliness of the investigations are the result, in large measure, of the guidance and supervision provided by the Supervising Special Investigator. 2. The Incident Review Committee minutes reveal careful review of the investigations and the presentation of programmatic recommendations. Responsibility for the implementation of the recommendations is assigned to specific staff members and implementation status is tracked. 3. The NSH Standards Compliance Department with UC Davis researchers produced in January 2011 the document entitled, "Napa State Hospital Safety and Security Aggression Analysis." This document identifies the tools and approaches the facility has used to address aggression and violence and lists all of the factors associated with aggression suggested by staff and individuals and suggestions for addressing aggression. The document provides data and trends related to aggression during the six-month period June-December 2010 by type of aggression, location, day of the week and time, commitment status of the aggressor and diagnosis of the offender. This work has been and is being used to guide violence reduction initiatives. 4. The facility has responded to the October tragedy by implementing environmental changes to enhance the safety of both staff and individuals on the outdoor campus. The careful reintroduction of grounds privilege is underway. 5. Recently, the facility took major steps towards the development of an effective quality management system. In this venue, NSH modified the structure and functions of the quality council, improved reporting channels to facilitate the oversight system and initiated effective academic liaison with the UC at Davis to assist in the data analysis. This has resulted in recent improvement in the oversight function as

		<p>evidenced by:</p> <ol style="list-style-type: none"> a. Identification of important trends and patterns of high risk indicators, primarily aggression data; b. Review and analysis of factors that contributed to these trends/patterns, including, but not limited to, the individual's diagnosis, commitment codes, length of stay and nature and history of involvement in the legal justice system; and c. Development of data-based actions/recommendations for systemic corrective measures at a variety of levels. <p>6. As of the tour conducted in July 2010, NSH had maintained compliance with all of the requirements of Section J for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><i>Areas of need include:</i></p> <ol style="list-style-type: none"> 1. <i>Serious deficiencies exist in the operational implementation of the risk management system, as outlined in I.2.b.v. These deficiencies must be rectified to improve the safety and well-being of individuals in care. Questions arose concerning the assistance rendered by the Risk Management Committees to the WRPT. Specifically, some questioned whether the time and talent resources devoted to the meetings in a facility the size of NSH, which produces a high volume of individuals for review, were commensurate with the outcomes. The facility was advised by the Court Monitor to study the issue and make any adjustments necessary to meet the needs of the facility while ensuring that individuals who presented a high risk to themselves and/or others were afforded a review by senior clinicians and outside consultants when indicated.</i> 2. <i>NSH needs to fully implement a variety of corrective measures that were initiated or are being planned to address the problem of violence at the facility.</i> 3. <i>The current twice-weekly schedule of review of high-risk events by</i>
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Section I: Protection from Harm

		<p><i>senior leadership is insufficient. It is strongly recommended that the facility hold a daily morning executive meeting to review high-risk events that require immediate attention by facility leadership.</i></p>
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Black, Director of Standards Compliance 2. D. Hauscarriague, Senior Special Investigator 3. M. McQueeney, Acting Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Thirteen A/N/E investigations 2. Selected personnel information on 15 staff members 3. Incident and aggression data from the Safety and Security Aggression Analysis document 4. Incident Review Committee minutes 5. Notification of Rights signing for 12 individuals 6. Documents related to the deaths of 11 individuals 7. Special Investigations Unit Case Log 8. Ten HQ briefs 9. Quality Council meeting minutes
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice--identifying failure to report in investigations and taking progressive disciplinary action.</p>

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		<p>Finding: Failure to report was not a violation found in the sample of investigations.</p> <p>Other findings: The Human Resources department at the facility provided the following information regarding disciplinary actions taken in response to sustained A/N/E allegations. There were no sustained cases reviewed in which action was not taken.</p> <table border="1" data-bbox="955 526 1896 1019"> <thead> <tr> <th>Incident type</th> <th>Incident date</th> <th>HR Response</th> </tr> </thead> <tbody> <tr> <td>Neglect</td> <td>5/18/10</td> <td>Verbal Counseling of four named staff members</td> </tr> <tr> <td>Neglect and criminal charges</td> <td>6/3/10</td> <td>Dismissed</td> </tr> <tr> <td>Neglect</td> <td>7/6/10</td> <td>Counseling delivered 9/27/10</td> </tr> <tr> <td>Unapproved TSI technique</td> <td>7/22/10</td> <td>Letter of Reprimand 12/7/10</td> </tr> <tr> <td>Neglect</td> <td>9/3/10</td> <td>Action pending</td> </tr> <tr> <td>Verbal abuse</td> <td>9/15/10</td> <td>Resigned immediately</td> </tr> <tr> <td>Neglect</td> <td>9/22/10</td> <td>Salary reduction</td> </tr> <tr> <td>Failure to maintain enhanced observation</td> <td>9/22/10</td> <td>Counseling delivered 9/27/10</td> </tr> </tbody> </table> <p>Current recommendation: Continue current practice.</p>	Incident type	Incident date	HR Response	Neglect	5/18/10	Verbal Counseling of four named staff members	Neglect and criminal charges	6/3/10	Dismissed	Neglect	7/6/10	Counseling delivered 9/27/10	Unapproved TSI technique	7/22/10	Letter of Reprimand 12/7/10	Neglect	9/3/10	Action pending	Verbal abuse	9/15/10	Resigned immediately	Neglect	9/22/10	Salary reduction	Failure to maintain enhanced observation	9/22/10	Counseling delivered 9/27/10
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I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Monitor daily HSS reports and other information sources to ensure that incidents are reported.</p>																											

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	<p>neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Findings: This process continues.</p> <p>Other findings: Each of the investigation reports includes the SIR definition of the incident type under investigation.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.a.iii</p>	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Develop, as planned, a statewide policy and procedure for making decisions regarding whether and when to remove a named staff member and monitor its impartial application.</p> <p>Findings: DMH has provided the state hospitals with guidance on standard procedures for removing staff members named in A/N/E. This guidance was provided in October 2010 and hence was not available to Napa during most of the current review period.</p> <p>Other findings: All of the investigations reviewed stated whether the named staff member was reassigned. In eight of the 13 investigations reviewed, the named staff members were reassigned and in one instance the named staff member resigned before reassignment went into effect.</p> <p>Current recommendation: Follow DMH guidance on standard procedure for removing staff named in A/N/E investigations.</p>

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<p>I.1.a.iv</p>	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Include attendance at annual required training as a component of staff members' annual reviews.</p> <p>Findings: See the table below, which indicates that 13 of the 15 staff members sampled had completed A/N/E training in the last 12 months.</p> <p>Recommendation 2, July 2010: Track the implementation of training recommendations to ensure that they are carried out in a timely fashion.</p> <p>Findings: The OSI/IRMC tracking sheet states that the following training recommendations made in the investigations reviewed were implemented:</p> <ul style="list-style-type: none"> • Retraining for the staff member on the responsibility to assess an individual when placed in R/S was provided on 1/14/11 [incident date: 9/3/10]. • Staff members were retrained on accepted practice for enhanced observation on 1/6/11 [incident date: 9/22/10]. • Training was provided to staff by the Unit Supervisor on what to do when they observe fellow employees with their eyes closed when providing enhanced observation [incident date 4/23/10]. • Training on facility expectations for the use of cell phones and PDAs were provided to the relevant staff members by the Unit Supervisor [incident date: 5/27/10]. • One employee received training on employee ethics and another was provided training on documentation expectations [incident date: 7/19/10].
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Recommendation 3, July 2010:

Consider posting short written instructions for reporting incidents in each unit's nurses' station.

Findings:

This recommendation is no longer necessary as staff members are familiar with the WaRMSS incident management module.

Other findings:

As noted below, with the exception of two staff members, the remaining 13 staff members sampled had completed A/N training in the last 12 months.

Staff member*	Date of:			
	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_S	2/1/82	2/1/82	4/16/86	11/15/10
_H	10/1/95	N/A	10/1/95	9/10/09
_T	1/2/97	10/21/96	1/2/97	4/15/10
_N	3/16/98	1/14/98	3/16/98	11/1/10
_M	10/1/99	9/15/99	10/1/99	3/24/10
_E	7/23/01	2/27/01	7/23/01	7/18/08
_D	5/8/02	3/11/02	5/8/02	3/24/10
_H	1/1/03	6/12/02	1/2/03	7/15/10
_M	12/18/05	9/19/05	12/8/05	3/25/10
_O	4/17/06	4/7/06	4/17/06	12/29/10
_B	11/8/06	8/28/06	11/8/06	2/11/10
_F	3/1/07	1/10/07	3/1/07	10/21/10
_K	7/2/07	5/17/07	7/2/07	10/28/10
_O	8/16/10	6/8/10	8/16/10	8/16/10
_L	8/16/10	6/8/10	8/16/10	8/17/10

*Only last initials are provided to protect confidentiality

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		<p>Current recommendation: Continue current practices.</p>
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue to monitor attendance at annual A/N/E training.</p> <p>Findings: See the positive findings in the table in the cell above.</p> <p>Recommendation 2, July 2010: Continue to provide progressive discipline for staff members who fail to report incidents of A/N/E.</p> <p>Findings: The facility reports that it continues this practice.</p> <p>Other findings: As noted in the table above, 14 of the 15 sampled staff member had signed the mandatory reporting form by or on the date they were hired. The one exception was a staff member who hired in 1982, when perhaps such a requirement was not in force. This staff member signed the form several years later, however.</p> <p>Current recommendation: Continue current practice.</p>
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p>

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		<p>Findings: As shown below, nine of the 10 individuals sampled had been given the opportunity to sign the Notification of Rights in the last 12 months.</p> <table border="1" data-bbox="961 378 1415 914"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>MG</td> <td>7/27/09</td> </tr> <tr> <td>AH</td> <td>6/13/10</td> </tr> <tr> <td>RG</td> <td>6/17/10</td> </tr> <tr> <td>MG</td> <td>Refused 7/15/10</td> </tr> <tr> <td>LR</td> <td>7/19/10</td> </tr> <tr> <td>LW</td> <td>7/19/10</td> </tr> <tr> <td>AD</td> <td>7/29/10</td> </tr> <tr> <td>DF</td> <td>8/14/10</td> </tr> <tr> <td>CH</td> <td>10/13/10</td> </tr> <tr> <td>AB</td> <td>10/14/10</td> </tr> <tr> <td>SC</td> <td>12/13/10</td> </tr> <tr> <td>DG</td> <td>12/29/10</td> </tr> </tbody> </table> <p>Current recommendation: Continue current practice.</p>	Individual	Date of most recent signing	MG	7/27/09	AH	6/13/10	RG	6/17/10	MG	Refused 7/15/10	LR	7/19/10	LW	7/19/10	AD	7/29/10	DF	8/14/10	CH	10/13/10	AB	10/14/10	SC	12/13/10	DG	12/29/10
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Include sighting of the rights poster as part of unit environmental rounds, with the expectation that the poster will be replaced and a work order submitted for the framing.</p> <p>Findings: The rights poster was affixed to a wall in the common area on each of the</p>																										

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		<p>units toured.</p> <p>Current recommendation: Continue current practice.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: Following the homicide on October 23, the assailant was removed from the facility to jail within two hours.</p> <p>Current recommendation: Continue current practice.</p>
I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p> <p>Findings: The investigations reviewed contained no evidence of retaliation, threat of retaliation for reporting an allegation or evidence of bribery to refrain from reporting or cooperating with an investigation.</p> <p>Current recommendation: Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p>

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I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	<p>Compliance: Substantial.</p>
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of directing Performance Improvement Initiatives based on the reviews of deaths.</p> <p>Findings: The MIRC and the Internal and External reviews of deaths identified areas for improvement and posed questions. For example:</p> <ul style="list-style-type: none"> • At the time of the death of EM, three staff were on duty for 45 individuals. This raised the question as to whether this met staffing ratios. The CA responded that it met minimum standards. • Reviews of EM's death also raised questions about the timely use of the AED. • The Independent External review of the death of KS noted the need for clearer explanations for changes in medication and the need for staff to be aware of the increased risk of suicide for individuals who get bad news at court. • As a result of the reviews of the death of FS, nurse practitioners were provided training on the need to order EKGs with annual physicals. • Gurneys now have backboards as a result of the reviews of FS's death. <p>Other findings: Eleven individuals (current and former residents) died during the review period; five were unexpected deaths. An independent external review was completed for each of the unexpected deaths.</p>

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Individual/ Age	Date of death	Expected ?	Circumstance of death
FS 60	6/4/10	Unexpected	Cardiac arrest, hypertensive heart disease
CM 62	6/8/10	Expected	Right heart failure cardiomyopathy at QVMC
EL 73	7/28/10	Expected	Sepsis and streptococcus cellulitis
EM 68	8/1/10	Unexpected	Seizure Disorder of unknown etiology
FS 97	8/2/10	Expected	Aspiration pneumonia at QVMC hospital
WT 60	8/18/10	Expected	Metastatic lung cancer Cardio-respiratory arrest
GH 53	9/2/10	Expected	Advanced non-Hodgkins lymphoma
JD 73	9/3/10	Expected	Bilateral occlusive pulmonary emboli at QVMC hospital
ET 70	9/17/10	Unexpected	Cirrhosis, history of GI bleed
CV 27	10/18/10	Unexpected	Suicide by hanging post discharge at residence
KS 39	11/5/10	Unexpected	Suicide by hanging at the Alameda County jail

An autopsy was performed on the body of JD and there was an external examination performed on the body of EM.

Current recommendation:
Continue current practice of implementing performance improvement actions identified as a result of the review of deaths.

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<p>I.1.b.ii</p>	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: Investigations of events involving criminal activity are conducted by local law enforcement or by hospital police. The HPD investigations are supervised by the Chief of Police.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b.iii</p>	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The investigations reviewed state that the audiotape of the interview of the named staff member is available for review. Additionally, several of the investigations reviewed specifically note the safeguarding of other types of evidence. For example, the investigation of exploitation (5/14/10) notes that a Ziploc bag of loose-leaf tobacco and two ends from rolled marijuana cigarettes taken from the named staff member were placed in evidence locker #5. In the investigation of the allegation of sexual abuse and exploitation (6/3/10), photos of medications, hospital gloves, gauze sponges and an envelope that figured in the investigation were taken and preserved.</p> <p>Current recommendation: Continue current practice.</p>

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I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Take any measures necessary to improve the functioning of the committee.</p> <p>Findings: Please see I.1.b.iv.4.</p> <p>Other findings: The investigations reviewed followed standard procedures and protocols for the administrative investigations of A/N/E.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.1	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue efforts to complete investigations in the timeframe provided in the EP and monitor for compliance.</p> <p>Findings: Preliminary investigations are initiated by hospital police as soon as they are notified of the incident. Those concerning A/N/E are passed on to the OSI.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.2	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue working to close cases in the timeframe provided by the EP.</p>

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	<p>within 5 business days of its availability;</p>	<p>Findings: As indicated in the table below, 9 of the 13 investigations reviewed were completed within the timeframe set in the EP.</p> <table border="1" data-bbox="955 341 1858 987"> <thead> <tr> <th>Incident type</th> <th>Date reported</th> <th>Date to OSI</th> <th>Date Closed</th> </tr> </thead> <tbody> <tr> <td>Abuse and Neglect</td> <td>4/23/10</td> <td>5/3/10</td> <td>6/1/10</td> </tr> <tr> <td>Exploitation</td> <td>5/14/10</td> <td>5/18/10</td> <td>6/2/10</td> </tr> <tr> <td>Neglect</td> <td>5/18/10</td> <td>6/3/10</td> <td>6/30/10</td> </tr> <tr> <td>Physical/ Psychological Abuse</td> <td>5/28/10</td> <td>5/28/10</td> <td>7/9/10</td> </tr> <tr> <td>Physical Abuse</td> <td>6/2/10</td> <td>6/8/10</td> <td>6/17/10</td> </tr> <tr> <td>Sexual Abuse and Exploitation</td> <td>6/3/10</td> <td>6/3/10</td> <td>9/21/10</td> </tr> <tr> <td>Neglect</td> <td>7/6/10</td> <td>7/7/10</td> <td>8/16/10</td> </tr> <tr> <td>Neglect</td> <td>7/13/10</td> <td>7/14/10</td> <td>10/15/10</td> </tr> <tr> <td>Neglect</td> <td>7/19/10</td> <td></td> <td>9/9/10</td> </tr> <tr> <td>Physical Abuse</td> <td>7/22/10</td> <td>7/26/10</td> <td>9/2/10</td> </tr> <tr> <td>Physical Abuse</td> <td>9/3/10</td> <td>9/9/10</td> <td>10/15/10</td> </tr> <tr> <td>Verbal Abuse</td> <td>9/15/10</td> <td>9/30/10</td> <td>10/20/10</td> </tr> <tr> <td>Neglect</td> <td>9/22/10</td> <td>9/30/10</td> <td>11/9/10</td> </tr> </tbody> </table> <p>Other findings: The facility reports that 98% of the investigations monitored during the review period were completed within the timeframe required by the EP.</p> <p>Current recommendation: Continue current practice.</p>	Incident type	Date reported	Date to OSI	Date Closed	Abuse and Neglect	4/23/10	5/3/10	6/1/10	Exploitation	5/14/10	5/18/10	6/2/10	Neglect	5/18/10	6/3/10	6/30/10	Physical/ Psychological Abuse	5/28/10	5/28/10	7/9/10	Physical Abuse	6/2/10	6/8/10	6/17/10	Sexual Abuse and Exploitation	6/3/10	6/3/10	9/21/10	Neglect	7/6/10	7/7/10	8/16/10	Neglect	7/13/10	7/14/10	10/15/10	Neglect	7/19/10		9/9/10	Physical Abuse	7/22/10	7/26/10	9/2/10	Physical Abuse	9/3/10	9/9/10	10/15/10	Verbal Abuse	9/15/10	9/30/10	10/20/10	Neglect	9/22/10	9/30/10	11/9/10
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I.1.b. iv.3	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate,</p>	<p>Current findings on previous recommendations:</p>																																																								

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	<p>recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Recommendation 1, July 2010: Investigators, the Supervising Special Investigator, and the IRC need to recognize programmatic and systemic areas for improvement and make recommendations to address them.</p> <p>Findings: Review of the IRC minutes yield the finding that the committee has made programmatic recommendations related to the review of specific incidents and has followed progress in implementation. Examples include:</p> <ul style="list-style-type: none">• Revise AD 378 to include the use of English in the workplace—in progress;• Implement a system whereby the Chief of Police has real-time access to "Report of Transfer"—completed in December 2010; and• Implement a system wherein investigative findings are made available to the medical peer review—completed in November 2010. <p>Recommendation 2, July 2010: Ensure that allegations of misconduct that surface during the investigation of another investigation receive the attention they merit.</p> <p>Findings: This circumstance did not surface in the investigations reviewed.</p> <p>Recommendation 3, July 2010: Implement plans for live presentation annually of <i>Crossing the Line</i> training.</p> <p>Findings: The facility reported that Annual <i>Crossing the Line</i> (Anatomy of a Set-up) training curriculum has been revised as a result of trends noted in IRC. Content and scenarios reflect actual events that have been noted/trended.</p>
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		<p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of addressing policy violations as well as A/N/E in investigations as this provides a starting point for discussions by the IRC.</p> <p>Findings: With the exception of the investigation of sexual abuse and exploitation (6/3/10), the investigation reports reviewed adequately addressed each of the allegations presented. The exception did not conduct an investigation into the allegation of sexual abuse but nonetheless determined the allegation to be not substantiated. In contrast, however, the same investigation did substantiate neglect when investigators found medication in the car of the staff member which the staff member had signed out as having been administered to the individual for whom it was prescribed. Petty theft and Alteration/Modification of a Medical Record with Fraudulent Intent were also sustained.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Take measures to identify persons who may have witnessed an incident and interview them.</p> <p>Findings: The investigation reports reviewed identified witnesses and provided a summary of their interviews. For example, the investigation of the 6/2/10</p>

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		<p>allegation of physical abuse made by TB in which he alleged the named staff member punched him in the chest and challenged him to fight after asking his roommate to leave includes an interview with TB's roommate. The roommate said he did not recall ever being asked to leave his room by the named staff member and did not see TB being abused and did not hear TB complain about being abused.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: All investigation reports reviewed clearly identified the names and titles of the alleged victims and perpetrators in the introductory section of the report.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: All of the investigation reports reviewed provided the names and titles of all persons interviewed along with summaries of the interviews.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Ask additional questions when an interviewee's response is unclear and/or open to several interpretations.</p> <p>Findings: In two of the investigation reports reviewed, the investigator conducted a second interview of a person involved. Specifically, in the investigation of the 4/23/10 allegation of neglect of JM, the investigator called the named staff back for a second interview to present him with accountability sheets that he had signed for the day in question.</p> <p>A second interview of the reporting staff member was conducted in the investigation of the allegation of neglect of SB (9/22/10) to verify the position of the staff member responsible for providing 1:1 observation of the individual.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: All investigation reports reviewed included a listing of all documents reviewed. For example, the investigation of neglect of SB contains a listing of 23 documents reviewed.</p>

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		<p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3 (vii)	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of reviewing the incident history of the alleged victims and alleged perpetrators.</p> <p>Findings: All of the investigation reports reviewed provided information from the review of the incident history of the alleged perpetrator(s) and victim(s).</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3 (viii)	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Ensure that physicians and other persons interviewed as clinical experts are quoted precisely throughout the investigation.</p> <p>Findings: In two of the investigations reviewed involving medical issues, the investigator consulted with a physician in a leadership position to ascertain the seriousness of the alleged inaction. There is no indication in the investigation reports that the physicians' opinions were misquoted or misinterpreted. Specifically, a neglect investigation was opened when on 5/18/10 a barber found stitches in DC's scalp that were placed there on 12/14/09 and had not been removed. The investigation report states that the investigator consulted with the NSH Medical Director, who reportedly told the investigator that he "did not feel this situation met the required</p>

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		<p>reporting definitions of neglect." In the investigation of the alleged neglect of MO (7/13/10), who did not receive immediate medical attention for a hip fracture, the MAS Director offered the opinion that the physician "could have provided better service" but added that he did not think the physician was neglectful.</p> <p>Other findings: Several of the investigations reviewed, in addition to determinations related to the A/N/E allegations, cited staff members for violations of policy. Specifically, the named staff members in the investigations of sexual abuse and exploitation (6/3/10), physical abuse (7/22/10), verbal abuse (9/15/10) and neglect (7/13/10) were found to have violated AD 378, Employee Ethics and Conduct. Offenses included falsification of an official document, failure to follow policy on completing the count of individuals, dishonesty, and failure to follow the directions of a supervisor.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Implement the plan described [in this cell in the previous report] in which the Supervising Special Investigator will attach an addendum to any investigation in which he does not agree with the determination and has not been able to convince the investigator that he/she has failed to meet the preponderance of the evidence standard or has not addressed the risk of harm component of the abuse definition as well as the actual harm element.</p> <p>Findings: No investigations reviewed demonstrated this set of circumstances.</p>

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		<p>Recommendation 2, July 2010: Ensure that the IRC reviews every OSI investigation—with members having read the entire investigation prior to the committee's review.</p> <p>Findings: The IRC minutes indicate that the committee is providing a thorough review of the investigations and offering recommendations.</p> <p>Other findings: In the investigation of the neglect of SB (9/22/10), the reporting staff member said the named staff member (responsible for providing line-of-sight observation to SB) was seated in a chair next to SB's bedroom. Other staff confirmed that the named staff was seated next to SB's bedroom, but facing away from the closed bedroom door. When the reporting party asked where SB was, the named staff reported he was sleeping in his room. But when both staff looked, he was not there. He was found shortly thereafter in the bathroom at the other end of the hall. The named staff denied SB could have left the bedroom without her knowledge and his leaving must have occurred when the reporting party opened the door to check on SB. SB resolved the conflict when he stated he walked by the named staff and she didn't see him because she wasn't looking in his direction.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Implement the plan for documenting the Supervising Special Investigator's views when they differ from those of the investigator.</p> <p>Findings: This issue did not surface in any of the investigations reviewed.</p>

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	<p>necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Recommendation 2, July 2010: Implement plans to improve the operation of the Incident Review Committee.</p> <p>Findings: The IRC minutes reflect a close review of investigations and recommendations for improvement where necessary. Several examples include:</p> <ul style="list-style-type: none"> • In the September meeting, investigators were reminded to check with the TSI training manual or with a TSI trainer when questions arise about the use of restraint techniques. • In the July meeting, investigators were reminded to cross-check details, so as to identify and correct inconsistencies. • The June meeting sent a special note of commendation to an SI for the work done on a particular case. That same meeting also reminded investigators to interview all parties involved in an incident. <p>Current recommendation: Continue current practice.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of tracking the implementation of disciplinary actions for staff members found to have engaged in mistreatment of individuals.</p> <p>Findings: Please see I.1.a.i for review of disciplinary actions taken in response to sampled investigations.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																		
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Substantial.</p>																		
I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Present data in a form for the IRC and the QC that makes trends and patterns evident.</p> <p>Findings: The Napa Safety and Security Aggression Analysis presents analysis of aggression data in numerous charts and graphs that clearly identify trends.</p> <table border="1"> <thead> <tr> <th>Abuse type</th> <th>June-November</th> </tr> </thead> <tbody> <tr> <td>Physical</td> <td>18</td> </tr> <tr> <td>Verbal</td> <td>8</td> </tr> <tr> <td>Psychological</td> <td>2</td> </tr> <tr> <td>Sexual</td> <td>8</td> </tr> <tr> <td>Neglect</td> <td>17</td> </tr> <tr> <td>Exploitation</td> <td>0</td> </tr> <tr> <td>Other</td> <td>0</td> </tr> <tr> <td>Total</td> <td>53</td> </tr> </tbody> </table> <p>Current recommendation: Continue the presentation of data in a form that makes trends apparent.</p>	Abuse type	June-November	Physical	18	Verbal	8	Psychological	2	Sexual	8	Neglect	17	Exploitation	0	Other	0	Total	53
Abuse type	June-November																			
Physical	18																			
Verbal	8																			
Psychological	2																			
Sexual	8																			
Neglect	17																			
Exploitation	0																			
Other	0																			
Total	53																			

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I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Provide information on staff members named in multiple incidents, focusing on possible patterns.</p> <p>Findings: No data related to this recommendation was presented. However, the incident history of staff members named in allegations of A/N/E is presented in the investigation reports.</p> <p>Current recommendation: Provide on a periodic basis a listing of staff members who have been named in A/N/E that includes sufficient information to discern any patterns.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue to provide the IRC and QC with deeper analysis of data showing patterns and trends as an aid to facility leadership in formulating corrective actions.</p> <p>Findings: Review of behavioral trigger data for the six-month period June- November 2010 indicated that a small number of individuals are responsible for a sizeable number of aggressive incidents. Specifically, six individuals triggered in three or more months for both two aggressive acts in seven days <u>and</u> four acts in 30 days as shown below. Eight other individuals triggered in two months for each category. This suggests that responses to curb the incidents of aggression were not successful with these individuals.</p>

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		<table border="1" data-bbox="955 227 1648 535"> <thead> <tr> <th>Individual</th> <th>2 in 7: # months triggered</th> <th>4 in 30: # months triggered</th> </tr> </thead> <tbody> <tr> <td>JC</td> <td>5</td> <td>5</td> </tr> <tr> <td>FM</td> <td>5</td> <td>6</td> </tr> <tr> <td>RW</td> <td>5</td> <td>5</td> </tr> <tr> <td>GB</td> <td>4</td> <td>4</td> </tr> <tr> <td>VC</td> <td>3</td> <td>3</td> </tr> <tr> <td>CK</td> <td>3</td> <td>3</td> </tr> </tbody> </table> <p data-bbox="955 576 1923 901">The facility's analysis of individuals who frequently engaged in aggressive acts during the period July-December 2010 found that 28 individuals had 20 or more aggressive assaults, totaling 861 assaults or 27% of the total number of assaults in the review period. The 28 individuals represent 4.28% of all individuals who engaged in assaultive behaviors. Thus, 4% of the individuals who assaulted accounted for over a quarter of all assaults. Sixteen (16) of the 28 individuals (57%) were on A units (LPS), while 11, or 30%, were on STA units. One individual was associated with both an A unit and an STA unit during the time period.</p> <p data-bbox="955 950 1923 1047">Sixteen (16) individuals were responsible for 35 assaults on staff resulting in major injuries during an unspecified time period, according to facility data reported in January 2011.</p> <p data-bbox="955 1096 1923 1242">Aggressive acts to self during the period April 2009-September 2010 peaked in May 2010 with approximately 10 acts, then contracted in August 10 with four acts and increased again in September, with approximately nine acts of aggression toward self.</p> <p data-bbox="955 1282 1923 1421">Recommendation 2, July 2010: The QC should document its response to information showing that a limited number of individuals are displaying serious behaviors that endanger themselves and others.</p>	Individual	2 in 7: # months triggered	4 in 30: # months triggered	JC	5	5	FM	5	6	RW	5	5	GB	4	4	VC	3	3	CK	3	3
Individual	2 in 7: # months triggered	4 in 30: # months triggered																					
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VC	3	3																					
CK	3	3																					

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		<p>Findings: The January 18, 2011 QC minutes report the QC's review of 18-month aggression data and aggression research. The minutes also note the QC's review of efforts to enhance DBT training and measures by Programs to reduce victimization.</p> <p>Current recommendation: Continue the production and analysis of useful aggression data and enact corrective measures accordingly.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The facility data reveals that Units A-7 and A-9 (LPS units) were the scene of more incidents than other units during the period June-November 2010, with approximately 200 and 180 incidents respectively. Units A-8 and Q-9 followed with approximately 125 incidents each.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The Aggression Analysis (January 2011) shows no significant difference in day of the week of incidents of aggression, except that Sunday appears to</p>

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		<p>be when the fewest aggressive incidents occurred during the period June-November 2010.</p> <p>The data shows that during the review period, aggression peaked around 3:00 and 4:00PM. A smaller peak occurred around 11:00AM. Total incidents of all types peaked at 4:00 PM, with higher numbers of other rule violations and medical/health and safety incidents as well as incidents involving aggression.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Take measures to improve the timeliness of HQ briefs.</p> <p>Findings: The review of the HQ briefs for 10 incidents occurring in October found that all of the initial briefs were completed within seven days of the incident; seven were completed within three days of the report of the incident.</p> <p>Other findings: Each investigation report attempts to identify the cause of the incident. In 11 of the 13 investigations reviewed, the cause was identified as unknown or undetermined. One investigation did not address cause. The investigation of the allegation of exploitation identified "personal financial gain" as the cause of the incident.</p> <p>The Safety and Security Aggression Analysis establishes a correlation between commitment status and types of aggression. A review of the commitment status of the 20 individuals who triggered in two or more</p>

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		<p>months during the six month review period for four aggressive acts in 30 days finds that 14 were on LPS status and three were on 1026 status (NGI). The remaining three individuals each had a different commitment status (2972, 2974 and 1370).</p> <p>Current recommendation: Continue to use aggression data to guide the allocation of resources.</p>																								
<p>I.1.d. vii</p>	<p>outcome of investigation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The Special Investigations Unit Case Log lists the outcomes below for the 2010 OSI investigations:</p> <table border="1" data-bbox="955 820 1696 1242"> <thead> <tr> <th>Incident type</th> <th>Number Investigated</th> <th>Outcome/ Determination</th> </tr> </thead> <tbody> <tr> <td>Neglect</td> <td>13</td> <td>5 Sustained 8 Not sustained</td> </tr> <tr> <td>Exploitation</td> <td>1</td> <td>1 Sustained</td> </tr> <tr> <td>Physical Abuse</td> <td>15</td> <td>15 Not Sustained</td> </tr> <tr> <td>Sexual Abuse</td> <td>4</td> <td>4 Not sustained</td> </tr> <tr> <td>Verbal Abuse</td> <td>5</td> <td>1 Sustained 4 Not sustained</td> </tr> <tr> <td>Deaths</td> <td>9</td> <td>9 Closed</td> </tr> <tr> <td>Psych. Abuse</td> <td>2</td> <td>2 Not sustained</td> </tr> </tbody> </table> <p>Current recommendation: Continue to maintain the OSI Case Log and make it available to the IRC.</p>	Incident type	Number Investigated	Outcome/ Determination	Neglect	13	5 Sustained 8 Not sustained	Exploitation	1	1 Sustained	Physical Abuse	15	15 Not Sustained	Sexual Abuse	4	4 Not sustained	Verbal Abuse	5	1 Sustained 4 Not sustained	Deaths	9	9 Closed	Psych. Abuse	2	2 Not sustained
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<p>I.1.e</p>	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Finalize as quickly as possible the DMH guidelines on the reassignment of staff named in A/N/E allegations.</p> <p>Findings: DMH has finalized its guidance document specifying procedures for the reassignment of staff named A/N/E allegations. This document was not available to the facility until late in the review period.</p> <p>Other findings: As shown in the table in I.1.a.iv, 14 of the 15 staff members sampled had cleared background checks prior to or on the date of hire.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: As planned, follow DMH guidance on procedures for reassigning staff named in A/N/E allegations.</p>
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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Abishai Rumano, MD, Chief Physician and Surgeon, Quality Council member 2. Alex Lapinske, Clinical Social Worker 3. Alice Rivera, Registered Nurse 4. Amarpreet Singh, MD, Senior Psychiatrist 5. Anish Shah, MD, Acting Medical Director, Quality Council member 6. Aparna Dixit, PsyD 7. Barbara McDermott, PhD, Research Director, Quality Council member 8. Carmen Carruso, Clinical Administrator, Quality Council member 9. Carol L. Humphreys, PhD, Unit Psychologist 10. Cathie Reichstein, Health and Safety Officer, Quality Council member 11. Chandandeep Singh Chahal, MD, Staff Psychiatrist 12. Christina Patino, Associate Social Worker 13. Cindy Black, Standard Compliance Director, Quality Council member 14. Cristian Mateescu, MD, Staff Psychiatrist 15. Cynthia M Guilford, Social Worker 16. D. Kormanik, RN, Standards Compliance 17. Debra Asaro Braun, Psych Tech, Unit Supervisor 18. Debra Mapp-McKenzie, Rehabilitation Therapist 19. Dolly Matteucci, Interim Executive Director, Quality Council Chair 20. Harry Oei, MD, Physician and Surgeon 21. James Young, MD, Acting Assistant Medical Director, Quality Council member 22. Javed Iqbal, MD, Psychiatrist 23. Jennifer Marshall, Rehabilitation Therapist 24. Jocelyn Ricafort, Registered Nurse 25. Jonathan Berry, MD, Senior Psychiatrist 26. Josefina DelaTorre, Registered Nurse 27. Kathy Mattheis, Rehabilitation Therapist

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		<p>28. Katie Cooper, PsyD, Mall Director 29. Kristen Perkins, PsyD 30. Leizel Fajardo, Registered Nurse 31. Lena Dhillon, MD, Staff Psychiatrist 32. Lilibeth Inoceeto, Registered Nurse 33. Lonna Sanders, Licensed Clinical Social Worker 34. LuAnn Whale, Art Therapist, Registered 35. Mandeep Singh, MD, Physician and Surgeon 36. Michael Feddersen, MD, Staff Psychiatrist 37. Mike McQueeney, Acting Hospital Administrator, Quality Council member 38. Mike Saunders, Nurse Administrator, Quality Council member 39. Nader Wassef, MD, Staff Psychiatrist 40. Patty Lamb, PsyD 41. PJ Thomson, Rehabilitation Therapist 42. Rebecca Bartlett, Rehabilitation Therapist 43. Renee Hutchinson, PsyD 44. Roberta Rosenberg, Social Worker 45. Roy Ramos, Registered Nurse 46. Sarah Benington, MD, Staff Psychiatrist 47. Simonetta Fosci, Clinical Social Worker 48. Steve Hubert, PhD, Senior Psychologist 49. Steve Weule, Senior Registered Nurse, Risk Manager, Quality Council member 50. Sue Cooper, Licensed Clinical Social Worker 51. Todd Thatcher, Occupational Therapist, Registered, Licensed 52. Tony Rabin, PhD, Acting Chief of Psychology Services, Quality Council member 53. Victoria Cabanela, MD, Senior Psychiatrist 54. William Gardner, PhD</p> <p><u>Reviewed:</u> 1. List of Behavioral Triggers occurring during the review period</p>
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		<ol style="list-style-type: none"> 2. List of PRN Triggers occurring during the review period 3. The charts and Risk Management System's level I, II and III response/recommendations for the following eight individuals: CS, DA, DE, DT, JB, RT, RW, and TM 4. Behavior Guidelines on the following two individuals: DT and RW 5. Summary of interventions targeted at RW assaultive behavior towards staff 6. Risk Management Membership structure 7. Mortality Review documents on individual EGM <ul style="list-style-type: none"> • Medical Death Summary 8/31/10 • Nursing Mortality Review 8/10/10 • Final Death Report - Department of Police Services Office of Special Investigations • Supplemental Final Death Report - Department of Police Services Office of Special Investigations • Mortality Interdisciplinary Review Committee (MIRC), Initial Meeting Minutes 8/18/10 • Release/Discharge/Transfer Summary 8/2/10 • Internal Quality Review of pre-terminal medical care 8/20/10 • Independent External Medical Review 9/7/10 • Coroner's Report 8/1/10 • Mortality Interdisciplinary Review Committee (MIRC), Final Meeting Minutes 9/24/110 • Addendum to Final MIRC Summary • Report to Quality Council 1/3/11 • MIRC Task Tracking Log - 8/1/10 8. Mortality Review documents on individual CV <ul style="list-style-type: none"> • Report to Quality Council 1/3/11 • Napa State Hospital Police Department Crime/Incident Report 10/28/10 • Medical Death Summary 11/2/10 • Release/Discharge/Transfer Summary 10/6/10 • Nursing Mortality Review 10/25/10
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		<ul style="list-style-type: none"> • Mortality Interdisciplinary Review Committee (MIRC), Initial Meeting Minutes 11/3/10 • Internal Death Review 11/30/10 • Certificate of Death 10/21/10 • Independent External Medical Review 11/21/10 with cover memo from DMH to Napa State Hospital • Mortality Interdisciplinary Review Committee (MIRC), Final Meeting Minutes 12/29/10 • MIRC Task Tracking Log <p>6. Mortality Review documents on individual KTS</p> <ul style="list-style-type: none"> • Napa State Hospital Police Department Crime/Incident Report 11/10/10 • Medical Death Summary 11/22/10 • Release/Discharge/Transfer Summary 10/20/10 • Nursing Mortality Review 11/5/10 • Mortality Interdisciplinary Review Committee (MIRC), Initial Meeting minutes 12/1/10 • Internal Death Review 11/23/10 • Certificate of Death 11/7/10 • Coroner Investigator's Report • Independent External Medical Review 12/10/10 with cover memo from DMH to Napa State Hospital • Mortality Interdisciplinary Review Committee (MIRC), Final Meeting Minutes 12/29/10. • MIRC Task Tracking Log <p>9. Mortality Review documents on individual ET</p> <ul style="list-style-type: none"> • Napa State Hospital Police Department Crime/Incident Report 9/17/10 • Supplemental Final Death Report - Department of Police Services Office of Special Investigations 9/14/10 • Final Death Supplemental Report - Department of Police Services Office of Special Investigations 9/30/10 • Medical Death Summary 9/24/10
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		<ul style="list-style-type: none"> • Release/Discharge/Transfer Summary 9/23/10 • Nursing Mortality Review 9/17/10 • Mortality Interdisciplinary Review Committee (MIRC), Initial Meeting Minutes 9/29/10 • Internal Quality Review of pre-terminal medical care 10/1/10 • Certificate of Death 9/28/10 • Independent External Medical Review 10/21/10 • Mortality Interdisciplinary Review Committee (MIRC), Final Meeting Minutes 11/22/10. • MIRC Task Tracking Log <p>10. Mortality Review documents on individual FS</p> <ul style="list-style-type: none"> • Napa State Hospital Police Department Incident Report 6/4/10 • Release/Discharge/Transfer Summary 6/7/10 • Medical Death Summary 6/10/10 • Primary Care Death Review 6/7/10 • Nursing Mortality Review 6/5/10 • Mortality Interdisciplinary Review Committee (MIRC), Initial Meeting Minutes 6/18/10 • Internal Death Review 6/28/10 • Certificate of Death 6/8/10 • Independent External Medical Review 7/18/10 with cover memo from DMH to Napa State Hospital • Mortality Interdisciplinary Review Committee (MIRC), Final Meeting Minutes 8/6/10 • MIRC Task Tracking Log <p>11. Quality Council documents:</p> <ul style="list-style-type: none"> • Quality Council Meeting Agendas and Minutes; 1/18/11, 12/28/10, 11/23/10, 10/6/10, 8/24/10, 8/3/10, 7/27/10, and 6/22/10. • Action Items Tracking Log • Monthly Key Indicator Report • High Risk List • Key Indicator Graphs • Reports to Quality Council: MVR, Psychotropic Medication, Medical
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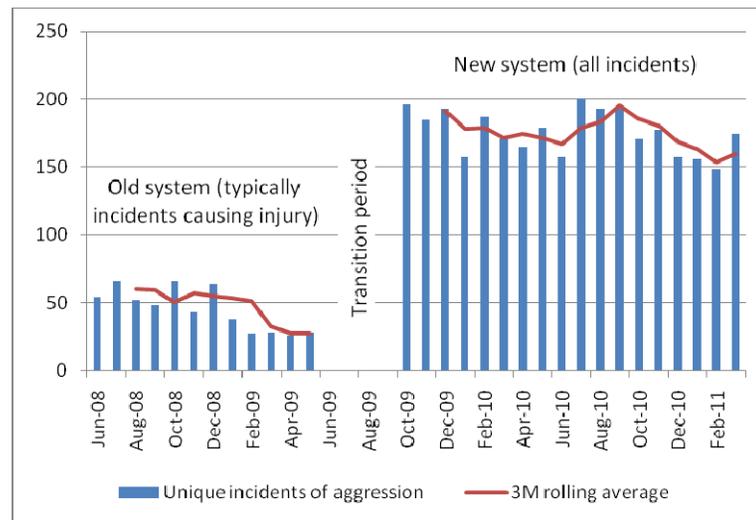
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		<p>Key Indicator, DBT Therapy, Incident Review Committee, P&T Committee, Hallway Victimization, Aggression 18 months, ECT, Polypharmacy, Key Indicator Aggression, AD 780, Grounds Access, Risk Management, Aggression to Staff, and Safety & Security; Comprehensive Tracking Sheet and Donna Gross homicide</p> <p>12. Safety and Security Aggression Analysis document 13. Minutes from ETRC/PSSC and FRC Risk Management Committees 14. Behavioral trigger and high risk lists 15. WRPs of 10 individuals on behavioral high risk lists 16. WRPs of 16 individuals on medical high risk lists 17. Aggregate high risk data by month for March-September</p> <p><u>Observed:</u> ETRC meeting</p>
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Present historical data on high risk situations in such a manner that the trend is evident.</p> <p>Findings: The implementation of the electronic WaRMSS Incident Management System has improved the facility's ability to produce data on risk-related trends such as aggression. However, it is important to note that long-term trend analysis incorporating periods of time before the full implementation of the WaRMSS module is not possible with regards to aggression. Prior to June 2009, a paper-based system was used to report incidents of</p>

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aggression, and typically only those incidents that resulted in injury to some party (a peer or staff) were reported. The WaRMSS Incident Management System significantly increased the facility's ability to track aggression and since October 2009, the facility is reporting all aggressive incidents regardless of significance, degree or injury to any party. Furthermore, the new system counts all discrete acts of aggression in a single aggressive incident. For example, an incident in which an individual pushes a peer and then swings at a responding staff member would be counted as two acts of aggression.

In the previous report, this cell contained a table suggesting that aggression increased several-fold between September 2008 and February 2010. In response to questions, the facility explained that this table combined data produced by the paper-based system (which typically captured only acts of aggression resulting in injury) and the WaRMSS system (which captures all acts of aggression). Additional data provided by the facility do not support a conclusion that aggression has increased over time:



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		<p>It is essential that data used internally (for example, by the Quality Council) and/or distributed to external recipients (such as the court monitor) be clearly labeled to indicate any changes to collection methodology or definitions. Data sets that include multiple methodologies or definitions have limited analytical utility and should be distributed and used with caution.</p> <p>Review of the High Risk List for Aggression for the review period finds that 32 of the 80 individuals on the list (40%) are from Program IV (LPS individuals). Similarly, of the seven individuals who triggered in three or more months in the six-month review period for four aggressive acts in 30 days, six resided on Program IV. Predatory aggression, which results in higher rates of injury and is most frightening to staff members, occurs almost exclusively among the forensic population, according to the Safety and Security Aggression Analysis.</p> <p>Recommendation 2, July 2010: Document the discussion of this data and the facility's response in the QC minutes.</p> <p>Findings: The January minutes indicate that the QC reviewed an in-depth analysis of the characteristics of aggression in the facility, as well as reports on procedures for restoring grounds access, the Intimidation Training initiative for staff and training for psychiatry and psychology staff on violence risk assessment and the assessment tools available. As related to the aggression data and research, the QC will "look at the full content, compare the trends and findings against desired outcomes and develop interventions as indicated" (January 18, 2011 minutes).</p> <p>Recommendation 3, July 2010: Continue efforts to reduce violence.</p>
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		<p>Findings: Please see I.2.c and the Environment section of the report for discussion of some of the facility's efforts to reduce violence.</p> <p>Other findings: The facility prepared a count of individuals in high risk categories by month for the period March-September 2010. Findings include:</p> <ul style="list-style-type: none"> • In March, 269 individuals were on the list. In September, the number had declined to 231. • Forty-one individuals were on the list for aggression to self in March; 43 individuals were on the list in September. • With increased attention to victimization, the number of individuals on that high risk list rose from 139 in March to 158 in September. • Individuals at risk of suicide numbered 14 in March and 19 in September. • June saw the highest number of individuals added to the aggression list in a single month; May saw the greatest number added for aggression to self and for suicide. March saw the greatest increase in individuals added to the victimization list. <p>Current recommendation: Continue the development and implementation of plans addressing the aggression on Program IV and the predatory aggression of individuals in the STA that is most frightening for staff.</p>
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue current plans on a local and statewide level to make behavioral/psychiatric outside consultation services available when needed.</p>

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		<p>Findings: The facility reported that it has benefited from the work of Dr. Tandy, an outside consultant from ASH, in directing the treatment of three individuals who caused harm to themselves. The consultations have resulted in enhanced staffing on the units where the individuals reside, measures were enacted to decrease/prevent staff burnout, weekly staff support meetings were held, training in behavioral guidelines and data gathering methods was provided, as was specialized training for all staff in the Programs in order to be able to rotate staff through the unit.</p> <p>Recommendation 2, July 2010: Ensure that the FRC is reviewing all individuals who reach third level review and is considering the use of outside consultants when these services are required, as evidenced by no break in the individual's dangerous behavior.</p> <p>Findings: The individuals listed below engaged in nearly uninterrupted aggressive behavior as evidenced by their behavioral trigger pattern in the period June-November as shown below. Four of the five were reviewed by the FRC.</p> <table border="1" data-bbox="953 1003 1885 1308"> <thead> <tr> <th>Individual</th> <th>4 agg. acts/ 30 days Months triggered</th> <th>2 agg. acts/ 7 days Months triggered</th> <th>FRC date</th> </tr> </thead> <tbody> <tr> <td>GB</td> <td>4 of 6 months</td> <td>4 of 6 months</td> <td>9/7/10</td> </tr> <tr> <td>JC</td> <td>5 of 6 months</td> <td>5 of 6 months</td> <td>No review</td> </tr> <tr> <td>FM</td> <td>6 of 6 months</td> <td>5 of 6 months</td> <td>11/2/10</td> </tr> <tr> <td>RW</td> <td>5 of 6 months</td> <td>5 of 6 months</td> <td>9/7& 9/17/10</td> </tr> <tr> <td>ZP</td> <td>4 of 6 months</td> <td>3of 6 months</td> <td>9/7/10</td> </tr> </tbody> </table> <p>Recommendation 3, July 2010: Continue addressing trigger behaviors in WRPs.</p>	Individual	4 agg. acts/ 30 days Months triggered	2 agg. acts/ 7 days Months triggered	FRC date	GB	4 of 6 months	4 of 6 months	9/7/10	JC	5 of 6 months	5 of 6 months	No review	FM	6 of 6 months	5 of 6 months	11/2/10	RW	5 of 6 months	5 of 6 months	9/7& 9/17/10	ZP	4 of 6 months	3of 6 months	9/7/10
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ZP	4 of 6 months	3of 6 months	9/7/10																							

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		<p>Findings: The WRPs of 10 individuals sampled addressed behaviors that reached trigger levels as evidenced in I.2.b.ii.</p> <p>Other findings: As shown below, the number of individuals frequently engaging in acts of aggression increased in the current review period, while the seriousness of the injuries to peers decreased.</p> <table border="1" data-bbox="955 560 1843 1091"> <thead> <tr> <th></th> <th>December 2009-May 2010</th> <th>June-November 2010</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>33</td> <td>21</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>68</td> <td>68</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>33</td> <td>28</td> </tr> <tr> <td>Individuals with two or more aggressive acts in 7 days</td> <td>149</td> <td>163</td> </tr> <tr> <td>Individuals with four or more aggressive acts in 30 days</td> <td>75</td> <td>89</td> </tr> <tr> <td>Homicide threats</td> <td>0</td> <td>4</td> </tr> <tr> <td>Suicide attempts/threats</td> <td>67</td> <td>42</td> </tr> </tbody> </table> <p>The facility reported that DMH is considering a master contract for outside consultation on psychiatric issues.</p> <p>Current recommendation: Continue implementation of plans to make outside consultations and specialized training available.</p>		December 2009-May 2010	June-November 2010	Peer-to-peer aggression resulting in major injury	33	21	Aggression to staff resulting in major injury	68	68	Aggression to self resulting in major injury	33	28	Individuals with two or more aggressive acts in 7 days	149	163	Individuals with four or more aggressive acts in 30 days	75	89	Homicide threats	0	4	Suicide attempts/threats	67	42
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<p>I.2.a. iii</p>	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Present sufficient historical data on high risk situations such that trends and patterns are evident.</p> <p>Findings: As cited in I.2.a.i, the Safety and Security Aggression Analysis provides data and analysis that covers an 18-month period beginning in June 2009 through to the present.</p> <p>Other findings: Review of several data sets identifying individuals who engaged in aggressive acts towards others during the report period revealed the following:</p> <ul style="list-style-type: none"> • Twenty individuals triggered in two or more months for four aggressive acts in 30 days. • Twenty-six individuals triggered in two or more months for two aggressive acts in 7 days. • As noted in I.1.d.iii, six individuals triggered in three or more months for both two aggressive acts in 7 days <u>and</u> four in 30 days. • Four individuals who engaged in two aggressive acts in 7 days in two or more months were also responsible for aggressive acts that resulted in serious injury. • Two individuals who engaged in four aggressive acts in 30 days in two or more months were also responsible for aggressive acts that resulted in serious injury. <p>Current recommendation: Continue to identify those individuals whose multiple and serious acts of aggression indicate a need for further consultation and treatment recommendations.</p>
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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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Same as in I.2.b.ii.</p> <p>Findings: As shown in the table below, the recommendations of the RM committees were incorporated into the WRPs of the individuals reviewed. However, while the RM committee minutes and WRPs of these individuals cite by trigger code (e.g., 1.2) each trigger, there was no discussion or documentation that indicated that the committee recognized the seriousness of the pattern of aggression exhibited by these individuals.</p> <table border="1" data-bbox="955 896 1885 1416"> <thead> <tr> <th data-bbox="955 896 1066 971">Individual</th> <th data-bbox="1073 896 1339 971">Trigger/Dates</th> <th data-bbox="1346 896 1612 971">RM Committee Recommendation</th> <th data-bbox="1619 896 1885 971">WRP Implementation or Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 971 1066 1122">JC</td> <td data-bbox="1073 971 1339 1122">4 agg acts in 30 days (triggered in June, July, August and September)</td> <td data-bbox="1346 971 1612 1122">ETRC 9/14/10. Consider the use of a specific medication.</td> <td data-bbox="1619 971 1885 1122">Yes WRP 10/13/10</td> </tr> <tr> <td data-bbox="955 1122 1066 1344">FM</td> <td data-bbox="1073 1122 1339 1344">4 agg acts in 30 days (triggered in June, July, August, September, October and November)</td> <td data-bbox="1346 1122 1612 1344">ETRC 8/3/10. Adjust a specific medication. FRC 11/2/10. Adjust medications.</td> <td data-bbox="1619 1122 1885 1344">Yes WRP 1/20/11</td> </tr> <tr> <td data-bbox="955 1344 1066 1416">ZP</td> <td data-bbox="1073 1344 1339 1416">4 agg acts in 30 days (triggered in</td> <td data-bbox="1346 1344 1612 1416">FRC 9/7/10. Clarify Axis I dx. Review</td> <td data-bbox="1619 1344 1885 1416">Yes WRP</td> </tr> </tbody> </table>			Individual	Trigger/Dates	RM Committee Recommendation	WRP Implementation or Response	JC	4 agg acts in 30 days (triggered in June, July, August and September)	ETRC 9/14/10. Consider the use of a specific medication.	Yes WRP 10/13/10	FM	4 agg acts in 30 days (triggered in June, July, August, September, October and November)	ETRC 8/3/10. Adjust a specific medication. FRC 11/2/10. Adjust medications.	Yes WRP 1/20/11	ZP	4 agg acts in 30 days (triggered in	FRC 9/7/10. Clarify Axis I dx. Review	Yes WRP
Individual	Trigger/Dates	RM Committee Recommendation	WRP Implementation or Response																	
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			June, July, August, September)	neuropsych assessment.	1/26/11
		CK	4 agg acts in 30 days (triggered in September, October, November)	ETRC 10/19/10. No new recommendations. Continue a specific medication. FRC 11/30/10. DCAT and PBS involved. Motivate for discharge through conservator. Consider vocational referral.	Yes WRP 1/20/11
		RW	4 agg acts in 30 days (triggered in June, July, August, September, October)	FRC 9/7/10. Review psychopharmacology intervention with Sr. Psychiatrist. Expedite external consult. Recommend DBT unit at another hospital. ETRC 9/17/10. Refer to FRC. FRC reviewed case again on 9/17/10. Meet with HPO to discuss legal issues re: ongoing incidents of staff assaults.	Yes WRP 11/8/10 and 1/24/11 No f/u available

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		<p>Other findings: In the review period June-November, the ETRC/PSSC met weekly and reviewed 105 unique individuals; 15 of these individuals were reviewed at two meetings and three were reviewed at three meetings. Of the 105 individuals, 15 were subsequently reviewed by FRC, as they met the criteria for a higher level review. In total, FRC reviewed 17 individuals during the review period.</p> <p>Current recommendation: It may be helpful for a WRPT member to summarize the significant trigger history of the individual so that this information can inform the work of the RM committee.</p>												
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue current practice of WRPTs addressing the recommendations made by risk management committees.</p> <p>Findings: Review of the WRPs of ten individual on behavior high risk lists finds that the behavior was addressed in each of the WRPs.</p> <table border="1" data-bbox="953 1044 1860 1416"> <thead> <tr> <th>Individual</th> <th>High risk behavior</th> <th>WRP address</th> </tr> </thead> <tbody> <tr> <td>GR</td> <td>Aggression to self</td> <td>WRP 1/26/11 Focus 3.3 self harm Focus 3.4 property destruction leading to self harm Noted in risk factors</td> </tr> <tr> <td>JC</td> <td>Aggression</td> <td>WRP 10/13/10 Focus 3.1. and noted in risk factors</td> </tr> <tr> <td>FM</td> <td>Aggression</td> <td>WRP 10/13 Focus 3.1 and noted in</td> </tr> </tbody> </table>	Individual	High risk behavior	WRP address	GR	Aggression to self	WRP 1/26/11 Focus 3.3 self harm Focus 3.4 property destruction leading to self harm Noted in risk factors	JC	Aggression	WRP 10/13/10 Focus 3.1. and noted in risk factors	FM	Aggression	WRP 10/13 Focus 3.1 and noted in
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		<table border="1" data-bbox="953 190 1860 683"> <tr> <td></td> <td></td> <td>risk factors. WRP 1/20/11 Focus 3.1.</td> </tr> <tr> <td>ZP</td> <td>Aggression</td> <td>WRP 1/26/11 Focus 3.2 and noted in risk factors.</td> </tr> <tr> <td>KP</td> <td>Aggression to self</td> <td>WRP 1/30/11 Focus 3.1</td> </tr> <tr> <td>RB</td> <td>Aggression to self</td> <td>WRP 8/24/10 Focus 3.1.</td> </tr> <tr> <td>AS</td> <td>Aggression to self</td> <td>WRP 8/24/10 Focus 3.3</td> </tr> <tr> <td>ES</td> <td>Aggression</td> <td>WRP 1/29/11 Focus 3.1 and noted in risk factors.</td> </tr> <tr> <td>CS</td> <td>Aggression</td> <td>WRP 1/10/11 Focus 3.1 and noted in risk factors.</td> </tr> <tr> <td>AS</td> <td>Aggression</td> <td>WRP 1/4/11 Focus 3.1 and noted in risk factors.</td> </tr> </table> <p data-bbox="953 727 1860 829">Recommendation 2, July 2010: Continue efforts to improve the quality of care and treatment at the facility.</p> <p data-bbox="953 873 1860 976">Findings: Please see I.2.c for actions presented by the Interim Executive Director to improve care and treatment.</p> <p data-bbox="953 1019 1860 1089">Current recommendation: Continue current practice and monitoring.</p>			risk factors. WRP 1/20/11 Focus 3.1.	ZP	Aggression	WRP 1/26/11 Focus 3.2 and noted in risk factors.	KP	Aggression to self	WRP 1/30/11 Focus 3.1	RB	Aggression to self	WRP 8/24/10 Focus 3.1.	AS	Aggression to self	WRP 8/24/10 Focus 3.3	ES	Aggression	WRP 1/29/11 Focus 3.1 and noted in risk factors.	CS	Aggression	WRP 1/10/11 Focus 3.1 and noted in risk factors.	AS	Aggression	WRP 1/4/11 Focus 3.1 and noted in risk factors.
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I.2.b. iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p data-bbox="953 1133 1860 1166">Current findings on previous recommendation:</p> <p data-bbox="953 1209 1860 1312">Recommendation, July 2010: Continue current practice of WRPTs addressing the recommendations made by risk management committees.</p> <p data-bbox="953 1356 1860 1414">Findings: Please see findings in I.2.b.i and I.2.b.v.</p>																								

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		<p>Other findings: During the ETRC meeting observed, it was apparent that it would be helpful if the chairperson or his/her designee reviewed, at the close of the discussion, the recommendations that had been approved. This would facilitate the complete and accurate recording of the meeting. It is important to note that the meeting observed was chaired by a staff member who had taken on this responsibility in the absence of the regular chairpersons.</p> <p>Current recommendation: Summarize RM committee recommendations at the close of the discussion to ensure they are recorded clearly and correctly.</p>						
<p>I.2.b. iv</p>	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice of WRPTs addressing continuing behaviors/conditions that warrant high risk status for the individuals for whom they provide care.</p> <p>Findings: As shown below in the review of medical triggers for 16 individuals, two individuals were reviewed by the MRMC. The WRPs of 13 of the 16 individuals had an open focus addressing the problem. For two individuals, the medical high risk was not identified in their WRP and there were no treatment objectives and interventions directed at the problem. Follow-up of recommendations for assessments or direct service was evident for the 11 individuals for which these recommendations were made.</p> <table border="1" data-bbox="953 1300 1871 1411"> <thead> <tr> <th>Indiv.</th> <th>Issue</th> <th>WRP documentation</th> </tr> </thead> <tbody> <tr> <td>KAJ</td> <td>Met trigger 7.1 for fall with major</td> <td>Most recent WRP dated 11/22/10 discussed November fall incident</td> </tr> </tbody> </table>	Indiv.	Issue	WRP documentation	KAJ	Met trigger 7.1 for fall with major	Most recent WRP dated 11/22/10 discussed November fall incident
Indiv.	Issue	WRP documentation						
KAJ	Met trigger 7.1 for fall with major	Most recent WRP dated 11/22/10 discussed November fall incident						

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			injury	resulting in hospitalization; no open focus of treatment for falls noted.
		FKL	Met trigger 7.2 for 3 or more falls in 30 days	Reviewed in MRMC, with recommendations for follow-up neuro consultation and review of past participation in physical therapy as well as report of trigger documented in WRP. Focus 6.35 open to address learning about fall risk; referral made to physical therapy and gait training and balance exercises added to direct therapy interventions.
		RLH	Met trigger 7.2 for 3 or more falls in 30 days	Reviewed in MRMC and PRC, with recommendations for follow-up neuro consultation, medication change, helmet use and referral to POST services as well as report of trigger documented in WRP. Focus 6.24 open to address safety measures to prevent falling; referral made to physical therapy for evaluation due to fall risk but individual refused.
		CEF	Aspiration pneumonia diagnosis	Individual hospitalized from 9/1/10 with aspiration pneumonia and 10/1/10 following an incident of apparent aspiration. PEG tube placed, and speech therapy evaluation performed on 10/26/10, with direct treatment for therapeutic modalities, exercises, and trials for return to safe oral intake initiated 10/28/10.
		VMM	New diagnosis of diabetes	The WRP dated 12/23/10 listed diabetes diagnosis, but not listed as an Axis III diagnosis. Focus 6.1 objective

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			and intervention in place for diabetes. Dietitian assessment dated 12/06/10 addressed diabetes and made appropriate recommendations (e.g., ADA diet, objective for weight loss). Following most recent nutrition assessment, acuity level changes to NST II as diabetes reported to be under good control with diet and medication.
		DJ	New diagnosis of diabetes The WRP dated 11/09/10 listed diabetes as Axis III diagnosis; Focus 6.2 for diabetes and 6.3 for metabolic syndrome opened 11/03/10, with nursing objectives and interventions related to naming health risks and strategies to manage weight. Dietitian assessment dated 12/14/10 addressed abnormal labs, and provided health education about importance of compliance with recommended interventions. NST level III assigned due to diabetes being uncontrolled.
		KUR	New diagnosis of diabetes The WRP dated 9/20/10 listed diabetes as Axis III diagnosis; Focus 6.2 for diabetes open with nursing objectives and interventions related to reporting hyper- and hypoglycemia symptoms. Most recent dietitian assessment dated 10/20/10 addressed diabetes and underlying factors and made recommendations for therapeutic interventions and follow up on possible inaccurate lab (A1C). This lab follow up

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			not documented in WRPC dated 1/20/11. NST level III assigned due to diabetes being uncontrolled.
		RS	At high risk for metabolic syndrome Dietitian assessment 11/10/10 addressed recommendations for contributing factors of obesity and hyperlipidemia. High risk identified in the present status of the most recent WRP dated 1/14/11; open foci 6.17 for obesity and 6.6 for hyperlipidemia.
		HRS	At high risk for metabolic syndrome High risk not identified in the present status of the most recent WRP dated 12/28/10, open foci 6.1-6.3 are open for hypertension, dyslipidemia, and obesity. Dietitian assessment 12/13/10 addressed recommendations for contributing factors of obesity and hyperlipidemia; dietitian education regarding weight loss not listed in WRP as an intervention, although RN education was listed. Individual followed quarterly by dietitian as an NST III.
		MER	At high risk for metabolic syndrome High risk for metabolic syndrome cited in the present status of the most recent WRP dated 12/27/10. Open foci 6.13 for diabetes and 6.2 for elevated lipids. Objective 6.13.2 and intervention recommended in Nutrition assessment dated 12/10/10 addressed teaching individual how to plan daily meals in line with ADA recommendations prior to transitioning to the community; very individualized and occupation based

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			objective.
		JHW	At high risk for impaired skin integrity High risk identified in the present status of the most recent WRP dated 12/17/10; focus 6.4 open with objective and intervention to address incontinence related to skin integrity risk. POST assessment not clinically indicated.
		DER	At high risk for impaired skin integrity High risk not identified in the present status of the most recent WRP dated 1/3/11; no open focus related to risk for impaired skin integrity or contributing factors, though 6.3 is open for acne.
		WM	At high risk for choking High risk identified in the present status of the most recent WRP dated 12/12/10, with 6.12 objective and intervention in place to address risk. Speech therapy assessment completed 7/21/10 for evaluation of eating and swallowing, and direct speech therapy initiated for therapeutic trials and compensatory strategies. In addition, individual has 24 hour support plan that addresses mealtime safety.
		JRC	At high risk for aspiration High risk identified in the present status of the most recent WRP dated 12/29/10; focus 6.21 objectives and interventions in place by nursing staff and speech therapist to address aspiration risk. In addition, a CIPRTA assessment that included SLP assessment of swallowing and intake was performed on 7/1/10. The individual was subsequently enrolled in direct speech

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				therapy treatment to address underlying aspiration risk factors, as well as a 24 hour support plan.
		EAH	At high risk for falls	High risk not identified in the present status of the most recent WRP dated 1/25/11, or in WRP dated 11/24/10. Last fall risk assessment dated 3/4/10 indicated low risk, and no fall triggers listed in the WRP.
		BB	At high risk for falls	High risk identified in the present status of the most recent WRP dated 12/28/10; focus 6.3 objective and interventions in place to address fall risk. In addition, individual received a physical therapy assessment dated 8/16/10 following identification of high risk, and received physical therapy direct treatment to address underlying mobility related fall risk factors, as well as a 24-hour support plan.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p>Current recommendation: Continue current practice in addressing medical high risk conditions in WRPs.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Ensure that individuals who meet the criteria are reviewed by the FRC and that referrals to outside and DMH consultants are considered when necessary.</p>		

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		<p>Findings: See I.2.a.ii.</p> <p>Other findings: A review of the charts of three individuals who were reviewed in 12 RM committee meetings found both evidence that recommendations were implemented and evidence that other recommendations were not implemented in a timely manner and that committees did not have current information about the implementation status of previous recommendations.</p> <table border="1" data-bbox="961 561 1866 1421"> <thead> <tr> <th data-bbox="961 561 1119 638">Individual</th> <th data-bbox="1119 561 1312 638">RM Committee</th> <th data-bbox="1312 561 1631 638">Recommendation</th> <th data-bbox="1631 561 1866 638">WRPT Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="961 638 1119 748">FM</td> <td data-bbox="1119 638 1312 748">ETRC/PSSC 6/5/10</td> <td data-bbox="1312 638 1631 748">Revise PBS plan Get medication blood levels</td> <td data-bbox="1631 638 1866 748">Completed Completed</td> </tr> <tr> <td data-bbox="961 748 1119 824"></td> <td data-bbox="1119 748 1312 824">PRC 6/17/10</td> <td data-bbox="1312 748 1631 824">Add physical exercise to WRP</td> <td data-bbox="1631 748 1866 824">Completed</td> </tr> <tr> <td data-bbox="961 824 1119 901"></td> <td data-bbox="1119 824 1312 901">PRC 7/29/10</td> <td data-bbox="1312 824 1631 901">Get TRC consult</td> <td data-bbox="1631 824 1866 901">Requested 8/9/10</td> </tr> <tr> <td data-bbox="961 901 1119 1011">ZP</td> <td data-bbox="1119 901 1312 1011">PRC 8/12/10</td> <td data-bbox="1312 901 1631 1011">Address victimization in appropriate focus and update risk profile.</td> <td data-bbox="1631 901 1866 1011">PRC 9/2/10- Focus 3.2addresses aggression and victimization</td> </tr> <tr> <td data-bbox="961 1011 1119 1088"></td> <td data-bbox="1119 1011 1312 1088">ETRC 8/23/10</td> <td data-bbox="1312 1011 1631 1088">Concur with PRC to add victimization</td> <td data-bbox="1631 1011 1866 1088"></td> </tr> <tr> <td data-bbox="961 1088 1119 1421">CK</td> <td data-bbox="1119 1088 1312 1421">PSSC 9/14/10</td> <td data-bbox="1312 1088 1631 1421">Refer for ECT consult.</td> <td data-bbox="1631 1088 1866 1421">FRC 11/30/10- Team will continue to pursue ECT if they can get a consult which is difficult due to hospital resources.</td> </tr> </tbody> </table>	Individual	RM Committee	Recommendation	WRPT Response	FM	ETRC/PSSC 6/5/10	Revise PBS plan Get medication blood levels	Completed Completed		PRC 6/17/10	Add physical exercise to WRP	Completed		PRC 7/29/10	Get TRC consult	Requested 8/9/10	ZP	PRC 8/12/10	Address victimization in appropriate focus and update risk profile.	PRC 9/2/10- Focus 3.2addresses aggression and victimization		ETRC 8/23/10	Concur with PRC to add victimization		CK	PSSC 9/14/10	Refer for ECT consult.	FRC 11/30/10- Team will continue to pursue ECT if they can get a consult which is difficult due to hospital resources.
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				Work with PBS.	PSSC 10/19/10- PBS review completed
	ETRC 9/14/10	Increase a specific medication	Completed		PRC 10/14/10
Get medication blood levels Get TRC consult	PRC 11/10/10 If not already done, get TRC consult	<p>This monitor and his experts interviewed members of the WRPTs who provided care to eight individuals (CS, DA, DE, DT, JB, RT, RW, and TM) who met a variety of high risk triggers/thresholds including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions (seclusion/restraints). These interviews included reviews of the charts of these individuals. The main purpose of this review was to assess the current system of implementation of the DMH Risk Management policy/procedure. Based on these reviews and interviews, this monitor found serious deficiencies in the operational implementation of this system, primarily in the key areas of:</p>			
<ol style="list-style-type: none"> 1. Prioritization of triggers in a manner that increases the efficiency of the system to address high risk individuals; 2. Timely and adequate reviews by the treating psychiatrists of individuals who reached triggers/thresholds that did not involve the use of seclusion/restraints; 3. Timely and adequate reviews by the team psychologists of the technical and clinical efficacy of the behavioral guidelines/plans; 4. Meaningful clinically relevant reviews and recommendations by the Program Review Committee (PRC), the Enhanced Trigger Review Committee and the Facility Review Committee (FRC); and 5. Utilization of external consultations for individuals who exceeded the 					

		<p>facility's capacity to meet their needs.</p> <p>In conversation, some staff raised the question of whether the time and resources spent on RM committees yielded commensurate levels of assistance to WRPTs and desired outcomes. The facility was advised by the Court Monitor to investigate the concerns and take whatever measures were necessary to modify the RM committee structure to meet the facility's needs, while remaining faithful to the objective of providing a hierarchical clinical review structure for those individuals who present high risk to themselves and others.</p> <p>This monitor found that the facility did not have a daily morning executive meeting to review high risk events that require immediate attention by facility leadership. The current schedule of twice weekly meetings was insufficient to ensure timely reviews.</p> <p>This monitor reviewed the facility's Mortality Review documents related to five unexpected mortalities including two individuals who committed suicide in the community following their discharge from the facility. This review found that the facility's reviews were generally adequate, including recommendations for systemic corrective actions as appropriate. However, from a performance improvement standpoint, one mortality review did not identify a significant area that required corrective action related to the provision of adequate family assessment prior to the discharge of an individual who was admitted to the facility for a brief duration.</p> <p>Current recommendation:</p> <ol style="list-style-type: none">1. Study the functioning of the RM committees and take whatever actions are indicated to modify it to address the needs of the facility and of the individuals in care whose conditions as indicated by high risk status and patterns of behavior or medical condition require review by senior clinicians and outside consultants.
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		<p>2. Improve oversight of high-risk situations at the daily morning executive meetings.</p>
<p>I.2.c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue implementing plans for advancing the quality of life at NSH.</p> <p>Findings: The Quality Council has implemented a number of changes to broaden and deepen its review of incident/aggression data with the objective of identifying and implementing measures to enhance the safety of staff and individuals. The changes listed below were discussed in a meeting with the members of the Quality Council, Dr. McDermott, Research Director, members of the HOM team, DOJ and DMH attorneys, and the Court Monitor. The Napa Executive Director led the discussion.</p> <ul style="list-style-type: none"> • The QC will review a broader range of issues. It will review and analyze data beyond incidents and key indicators and across programs. • A standardized format has been developed to assist staff in preparing a presentation bringing issues forward to the QC. • The membership of the QC has been expanded to include Dr. McDermott, Dr. Tony Rabin, Acting Chief of Psychology and Cathy Reichstein, the Health and Safety Officer. • The QC review of the Medical Key Indicators will be led by Dr. Rumano. <p>Dr. McDermott's research group and the facility's Standards Compliance Department have completed the report to the Statewide Violence Reduction Taskforce. This data indicates, in part:</p> <ul style="list-style-type: none"> • The population of NSH is composed of individuals with 1026 commitments [NGRI] (48%), 1370 commitments [not competent to

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		<p>stand trial] (22%) and LPS status individuals (15%). (The remaining 15% have a variety of other commitment types.)</p> <ul style="list-style-type: none">• In comparing 2005 and 2010, the facility is now treating many more individuals with a 1026 commitment and the crimes with which these individuals have been charged are more serious and more violent.• Research shows that violence perpetrated by individuals with a 1026 commitment tends to be planned and predatory and result in graver injuries. The aggression is largely directed at peers. These individuals need a highly structured environment with video surveillance and the presence of hospital police. In the Secure Treatment Area, 17% of the violence is predatory.• Individuals with a 1370 commitment tend to engage in impulsive aggression, especially within the first 90 days of admission. This group accounts for the highest volume of injuries to staff within the first 90 days of admission. Staff members need to identify the stressors that lead to an individual's aggression. DBT and PBS plans are suggested treatment modalities. In the Secure Treatment Area, 65% of the violence is impulsive.• Individuals on LPS status engaged in psychotic aggression, especially within the first 90 days of admission. Staff members need to identify psychotic symptoms, such as suspicion and fear. <p>The Executive Director identified measures taken in response to this research and the October 23 tragedy, noting that additional measures are under consideration. The following is an outline of the main areas addressed in these measures:</p> <ul style="list-style-type: none">• Initiation of a research project with the University of California at Davis (UCD), including recommendations for pharmacological management of individuals with violent behavior;• Identification of individuals who are potentially inappropriately placed at NSH, including individuals to be considered for transfer to a more secure setting;
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		<ul style="list-style-type: none">• Staffing revisions based on review patterns/trends of aggressive acts and staff injuries on units/hallways and staff concerns related to clinical acuity;• Planning for development of a more secure/specialty and structured unit for individuals with prominent predatory and antisocial features;• Treatment models to improve skills in Dialectical Behavioral Therapy (DBT) for individuals with prominent impulsive features (facility will be starting DBT treatment in the A units (LPS) and is expanding PBS so that whole diagnostic categories of individuals are not removed from consideration);• Improved screening medication reassessments of individuals with prominent psychotic features;• Enhanced monitoring/screening measures for contraband/drug passing;• Specific actions in response to the staff mortality in October 2010, including, but not limited to the following:<ul style="list-style-type: none">○ Environmental measures: tree trimming; lighting replacements; patio wall removal; temporary observation kiosks and painting of out of bounds signage in certain areas and unit court yard safety measures;○ Personal safety measures: Use of on-ground personal alarm devices, increase in staff escort ratios, ID badge modifications, provision of shuttle services to staff (every individual will be re-evaluated to determine grounds access status and escort ratio. This process has begun and approximately 75 individuals have been evaluated);,○ Policy updates/changes: Grounds Access including oversight team and screening for (and revoking of) privileges and establishment of a new out of bounds area and a Grounds Presence team (AD 432: Restricted Areas for Individuals Served and Staff was revised and became effective December 21, 2010. It identified those areas of the campus which are out-of-bounds for staff and individuals served, locations that are out-of-bounds for individuals only, locations that are pass-
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		<p>through (no loitering) and those that are designated supervised access only).</p> <ul style="list-style-type: none">○ Service delivery changes: Medication Delivery to include hospital police escort for night deliveries, redeployment of hospital police staff to secure treatment area and modification of visiting and package center hours, modification of Mall services to include limitation of off-unit and increasing on-unit activities, changes in medication pass procedures to reduce potential for hallway violence, revision of Therapeutic Review Committee consultation process to suggest medication changes considering type of aggression and proposal for legislative change;○ Staff training programs on aggression reduction: series of trainings provided including Developing a Peaceful Treatment Milieu for all staff and Aggression Reduction for Nursing Staff and Supervisors (300) nurses were provided training by Dr. Scott of UC Davis) and planned (Gang Training Program for Hospital Police, Unit Supervisors and Program Directors, Forensic Education Lectures, Training of Program Review Committees including identification and Review of legal Commitment, Diagnosis and Type of Aggressive Acts and Training of Unit Staff on Type of Aggression). <ul style="list-style-type: none">● A risk assessment will be completed on each new admission and follow-up reviews of the types of aggression each engages in at the facility will be conducted. This will provide valuable current aggression profiles. <p>Compliance: Partial; substantial compliance is contingent on adequate implementation of above-mentioned measures.</p> <p>Current recommendation: Implement corrective actions that were initiated or planned by the</p>
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		facility's Quality Council and provide periodic updates to this monitor regarding the status of implementation.
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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Caruso, Clinical Administrator 2. C. Ochoa, Hospital Administrative Resident II 3. K. Cooper, PsyD, Mall Director 4. M. McQueeney, Acting Hospital Administrator, Assistant Hospital Administrator and former Head of Plant Operations <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRPs of 12 individuals with the problem of incontinence 2. Clinical records of eight individuals for documentation related to sexual incidents <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Four units: Q3-4, T-3, T-11, A-7 2. S complex (off-unit Mall group location)
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue to implement plans with timeframes for refurbishing and furnishing the environment to increase safety.</p> <p>Findings: The facility reported that it has continued to purchase and install nightstands that have no metal drawer gliders that can be removed and used as a weapon. Thus far, NSH has purchased 980 nightstands. Similarly, the facility has purchased 1003 wardrobes that have a safe locking mechanism and sliding doors that eliminate the suicide hazard presented by looping or wedging a ligature at the door hinge. The facility has purchased nearly 500 no-throw chairs. Wardrobes, nightstands and</p>

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		<p>heavy chairs furnished the bedrooms toured. Future plans call for the facility to replace over time existing beds with one-piece beds that have no moving parts. In addition, the facility is investigating electrical fixtures and modifications to existing fixtures to eliminate their use to light cigarettes, a fire hazard and possible electrical shock hazard.</p> <p>Mr. McQueeney pointed out the stainless steel mesh covers installed over the thermostats. The covers eliminate any gap that could be used for looping a ligature. Diverter valves in the showers have been modified or replaced so that material cannot be tied around them.</p> <p>In meeting its obligation to identify potential environmental safety hazards and work to remediate them, Plant Operations and Hospital Police teamed up after the tragedy of October 23 to modify the outdoor environment within the STA. Activities included:</p> <ul style="list-style-type: none">• Audit and Search procedures for hidden contraband were expanded;• Patio walls were removed to eliminate hiding spots;• Trees were trimmed back;• Street lighting was upgraded and additional wall-mounted lighting was installed;• Out-of-bounds areas were redefined to enhance the visibility of individuals while outdoors. <p>During the tour of the units, the common rooms were generally clean. Each unit had operating flashlights to use when making nighttime rounds. Each staff member questioned on the units toured was able to describe where the cut-down instrument is kept.</p> <p>Other tour observations include:</p> <ul style="list-style-type: none">• Q3-4 has a census of 65 men. At approximately 9:40 AM, two individuals were in an on-unit group and eight individuals were outside
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		<p>in a walking group. The majority of the remaining men were in their bedrooms either sleeping or not. Some bedrooms on this unit are singles and others have as many as five men in them.</p> <ul style="list-style-type: none"> • On Unit T-3, which is a co-ed unit for 20 individuals, two of the eight nursing staff were on 1:1 observation. One of these staff members was observing an individual in the courtyard, but was not paying attention to the individual in her care and had her back to her for a period of time. Supervising staff intervened when this was pointed out. • All units toured had refurbished bathrooms with stalls with piano hinges and without high supports that represent a suicide hazard. • Individuals on T-11 (census: 44) offered the observation that restrictions that had been in place for specific individuals were lifted just before the Court Monitor's visit. The facility agreed to review the therapeutic environment on this unit. • Staff and individuals on A-7 spoke about the property destruction that occurs on the unit. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to address suicide and other safety hazards as resources permit.</p>
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, July 2010: Continue efforts to keep common areas of the units clean.</p> <p>Findings: The common areas were clean and being cleaned on the units toured.</p>

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		<p>Recommendation 2, July 2010: Address problems in performing daily hygiene and care of an individual's personal environment as treatment issues.</p> <p>Findings: The facility reports that Program Manager rounds were revised in September 2010 with managers directed to spot-check at least three bedrooms on each unit. Issues identified related to cleanliness are communicated to the treatment teams to be addressed in the WRP.</p> <p>Other findings: The units reviewed and the rooms on the S complex toured were a comfortable temperature.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The facility's internal audit of all individuals with the problem of incontinence found that in all cases, the expectations for treatment and the personal care of the individuals were met. This is consistent with the findings reported below.</p> <p>Other findings: As shown below, the WRPs of all 12 individuals sampled who were</p>

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		<p>identified as having the problem of incontinence addressed the problem in Focus 6:</p> <table border="1" data-bbox="1024 302 1671 802"> <thead> <tr> <th>Individual</th> <th>WRP Date</th> <th>Focus 6</th> </tr> </thead> <tbody> <tr><td>BB</td><td>1/26</td><td>6.7</td></tr> <tr><td>BT</td><td>2/5</td><td>6.14</td></tr> <tr><td>DP</td><td>1/21</td><td>6.12</td></tr> <tr><td>FT</td><td>1/31</td><td>6.2</td></tr> <tr><td>GR</td><td>2/13</td><td>6.18</td></tr> <tr><td>GT</td><td>1/5</td><td>6.11</td></tr> <tr><td>JB</td><td>2/16</td><td>6.3</td></tr> <tr><td>JM</td><td>1/20</td><td>6.5</td></tr> <tr><td>LT</td><td>2/15</td><td>6.4</td></tr> <tr><td>NF</td><td>2/8</td><td>6.15</td></tr> <tr><td>PM</td><td>2/10</td><td>6.23</td></tr> <tr><td>SP</td><td>1/4</td><td>6.11</td></tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Individual	WRP Date	Focus 6	BB	1/26	6.7	BT	2/5	6.14	DP	1/21	6.12	FT	1/31	6.2	GR	2/13	6.18	GT	1/5	6.11	JB	2/16	6.3	JM	1/20	6.5	LT	2/15	6.4	NF	2/8	6.15	PM	2/10	6.23	SP	1/4	6.11
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I.3.d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall 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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, July 2010: Continue current practice of addressing sexual incidents in WRPs.</p> <p>Findings: See findings below.</p>																																							

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	to instances of sexual contact; and	<p>Other findings: As shown in the table, two of the eight sexual incidents reviewed were not adequately addressed in the individual's clinical record. In contrast, the facility reviewed the clinical records of 20 victims of sexual incidents in the review period and found that in all cases the record contained documentation of the event and the action taken, in all relevant cases the individual was advised why the intervention was necessary and that the individual was provided a safe and secure environment.</p> <table border="1" data-bbox="953 524 1871 1421"> <thead> <tr> <th data-bbox="953 524 1108 565">Individual</th> <th data-bbox="1108 524 1346 565">Incident Type</th> <th data-bbox="1346 524 1871 565">Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 565 1108 748">AV</td> <td data-bbox="1108 565 1346 748">Sexual assault aggressor</td> <td data-bbox="1346 565 1871 748">Four IDNs describe incident. Team met with AV. Unit psychologist met with AV. Teaching provided. Discussed consequences of the behavior. AV placed on CIO with male staff only.</td> </tr> <tr> <td data-bbox="953 748 1108 824">EH</td> <td data-bbox="1108 748 1346 824">Sex btw Adults victim</td> <td data-bbox="1346 748 1871 824">IDN describes allegation. EH assured of his safety and given emotional support.</td> </tr> <tr> <td data-bbox="953 824 1108 1049">ID</td> <td data-bbox="1108 824 1346 1049">Sexual assault aggressor</td> <td data-bbox="1346 824 1871 1049">Physician's note describes incident. Placed on CIO for safety as others made threats to harm him. Psychologist's note cites a consult with PBS. Will get updated BGs and present them to the WRPT.</td> </tr> <tr> <td data-bbox="953 1049 1108 1125">DL*</td> <td data-bbox="1108 1049 1346 1125">Sexual assault</td> <td data-bbox="1346 1049 1871 1125">No IDN for 9/14. No mention of incident in WRPs of 10/1 & 10/21.</td> </tr> <tr> <td data-bbox="953 1125 1108 1349">TR</td> <td data-bbox="1108 1125 1346 1349">Sex btw Adults Victim</td> <td data-bbox="1346 1125 1871 1349">IDN states this is the first report of what are allegedly repeated events by staff members. Given STAT medication. WRPs 11/24 and 1/22/11 state only that the allegations are under investigation.</td> </tr> <tr> <td data-bbox="953 1349 1108 1421">GW*</td> <td data-bbox="1108 1349 1346 1421">Sex btw Adults</td> <td data-bbox="1346 1349 1871 1421">No IDN and no mention of the incident in the 12/2 and 12/29 WRPs.</td> </tr> </tbody> </table>	Individual	Incident Type	Response	AV	Sexual assault aggressor	Four IDNs describe incident. Team met with AV. Unit psychologist met with AV. Teaching provided. Discussed consequences of the behavior. AV placed on CIO with male staff only.	EH	Sex btw Adults victim	IDN describes allegation. EH assured of his safety and given emotional support.	ID	Sexual assault aggressor	Physician's note describes incident. Placed on CIO for safety as others made threats to harm him. Psychologist's note cites a consult with PBS. Will get updated BGs and present them to the WRPT.	DL*	Sexual assault	No IDN for 9/14. No mention of incident in WRPs of 10/1 & 10/21.	TR	Sex btw Adults Victim	IDN states this is the first report of what are allegedly repeated events by staff members. Given STAT medication. WRPs 11/24 and 1/22/11 state only that the allegations are under investigation.	GW*	Sex btw Adults	No IDN and no mention of the incident in the 12/2 and 12/29 WRPs.
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		<p>DH</p>	<p>Sexual Abuse</p>	<p>Two IDNs describe the allegation. Door alarm provided for his safety. Physical assessment completed & MOD consulted. Advised against false allegations.</p>
		<p>MF</p>	<p>Sexual Assault</p>	<p>IDN described allegation. MD physical assessment completed and sent QVMC for further evaluation. Door alarm to be activated when in bedroom. Encouraged to come to staff if feeling threatened.</p>
		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that expectations for addressing sexual incidents are clear and monitor implementation.</p>		
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, July 2010: Continue current practice.</p> <p>Findings: The facility reports that current compliance of non-clinical Mall providers currently providing service is 77%.</p> <p>Compliance: Partial compliance—nearing substantial.</p> <p>Current recommendation: Continue to provide the required training to non-clinical Mall providers.</p>		

J. First Amendment and Due Process

J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	As of the tour conducted in July 2010, NSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
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