

REPORT 11

NAPA STATE HOSPITAL

July 25-29, 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
ACLS	Advanced cardiac life support
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AED	Anti-epilepsy drug
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ART	Assault Reduction Taskforce
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
B & B	Bladder and Bowel
BCC	Behavioral Consultation Committee
BCLS	Basic cardiac life support
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 In-Sight 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
DJD	Degenerative joint disease
DPCIP	Discharge Planning and Community Integration Program
DMH	Department of Mental Health
DOJ	Department of Justice
DON	Director of Nursing
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)

DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis
EAP	Employee Assistance Program
ED	Executive Director
EKG	Electrocardiogram
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
ETU	Enhanced Treatment Unit
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FPA	Focused Psychological Assessment
FQRP	Forensic Quality Review Panel
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
FTS	Follow Through Staff
GAF	Global Assessment of Functioning [Score]
GI	Gastrointestinal
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
IM	Intramuscularly
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
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
MBSS	Modified barium swallow study
MDO	Mentally Disordered Offender
MERS	Medical Event/Emergency Reporting/Response System

MFT	Marriage and Family Therapist
MH	Mental health
MI	Mental illness; myocardial infarction
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
MOU	Memorandum of Understanding
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NAO	New admission orientation
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NFA	Neuropsychological Focused Assessment
NG	Nasogastric
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift

NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPH [insulin]	Neutral Protamine Hagedorn [insulin]
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support
PC	Penal Code
PCP	Primary Care Physician
PEG	Percutaneous endoscope gastrostomy
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIM	Potentially inappropriate medications
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMNP	Physical Nutritional Management Plan
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POC	Plan of Correction
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate

PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PTFA	Physical therapy functional assessment
PWT	Program-Wide Trainer
QOD	Abbreviation for "every other day"
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior

SLP	Speech Language Pathology/Pathologist
SLU	Social Learning Unit
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
STA	Secure Treatment Area
START	Simple Triage and Rapid Treatment
STOP-A	Selected Treatment of Psychomotor Agitation (algorithm)
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
Tx	Treatment
UCR	Urgent Care Room
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
VRMC	Violence Risk Management Committee
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits

WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L), visited Napa State Hospital (NSH) from July 25 to 29, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

As stated in previous reports, key indicator data are not necessarily EP outcome measures nor can they stand alone as a means of formulating judgment regarding facility performance, but they can provide users of the data with a general view of system performance across a number of domains. Taken as a whole, most of the facility's key indicator data suggest stable or improved performance during the review period.

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. NSH has achieved and/or maintained substantial compliance with most of the EP requirements. The achievements and areas of need are outlined in corresponding sections of the report.
- b. DMH provided a status report on the implementation of Aggression Reduction Strategies forthcoming from the March Strategic Planning Conference. Completed actions include, but are not limited to:
 - The Medical Directors' Committee has initiated aggressive pharmacotherapeutic protocols for management of aggression at the facilities and approved the use of a protocol (STOP-A Algorithm) at PSH.
 - The Medical Directors' Committee has approved a report with recommendation for implementing routine, random drug testing for all forensic patients and formulary restrictions for commonly abused/diverted prescription medications. Implementation plan is due by mid-September.
 - DMH formalized a process whereby Forensic Chiefs will provide written recommendations to DMH on proposed legislation.

- The Therapeutic Strategies and Interventions (TSI) statewide task force is changing the curriculum to focus on aggression types, prison culture and enhanced aggression reduction techniques.
 - The Executive Directors' Council subgroup on aggression is working on coordination of statewide violence data.
 - ASH plans to open its Specialty/Enhanced Staffing Unit in August.
 - Draft revisions have been completed to the MOU that will improve the 7301 transfer mechanism by shortening the process, clarifying criteria and simplifying the application.
- c. Under the leadership of the current Executive Director, NSH has made significant strides to improve its quality management functions. This progress included improved oversight by the Quality Council, review and analysis of incident management data including but not limited to key indicator data and corrective actions to minimize harm to individuals and staff. Based on data presented by the facility, many steps have been implemented in this direction including the following:
- Some individuals who required a level of custodial security that cannot be provided at the facility were identified and recently transferred to more appropriate settings within DMH (one individual was transferred to CDCR under legislation 7301). These individuals were selected based on a review and analysis of aggression data and risk assessment methods consistent with currently generally accepted standards.
 - Resources have been allocated to establish an integrated campus-wide personal alarm system and to enhance the hospital's Grounds Security and Grounds Presence teams as measures to improve safety on hospital grounds.
 - The facility designated space for a planned specialty (enhanced staffing) unit and developed entry and exit criteria for the individuals requiring this level of care.
 - The review of data on aggression on Program IV led the hospital to increase staffing on several units in that program.
 - The facility initiated a daily morning executive meeting to review special events that require immediate attention by facility leadership.
 - The risk management procedure was streamlined to improve effectiveness in meeting the facility's needs. The monitor found evidence of improved implementation, including correction of the deficiencies that were identified in the previous report.
 - Senior psychiatrists completed four Drug Utilization Evaluations dealing with medications used to treat aggression or that are associated with problematic behaviors. This resulted in the removal of a medication (bupropion) from formulary status to non-formulary status to reduce the risk to individuals.
 - In response to analysis of aggression patterns, the facility developed interim guidelines and a consulting contract, to improve pain management using opiate analgesics.. These are the forerunners of revised Administrative Directives on this topic.
- d. The monitor's review of the facility's key indicator data showed some hopeful trends in the leveling off of the previous increase in aggression to self (the facility needs to explain the shift in self-harm that began in August 2009 and peaked at the

end of 2010). Aggression to peers and staff has declined in the past several months as have repeated episodes of aggression. This is a welcome observation.

- e. As previously stated by this monitor, the development of plans to reduce aggression (i.e. the DMH Strategic Action Plan) is necessary to achieve substantial compliance; but it is not sufficient; only action is. The facility has taken several constructive actions to this end. However, further action is necessary, including further implementation of the DMH Strategic Action Plan specifically in reference to the proper implementation of the enhanced staffing/specialty unit at the facility and/or institution of a DMH integrated system based on thorough violence assessment to place individuals upon their admission in the most appropriate setting within the system. Without these actions, the recent gains will constitute short-lived fragments rather than durable transformation, and the risks to individuals and staff will continue at an unacceptable level.
- f. The death of an individual while in prone containment and the prone containment of another individual that resulted in a serious injury should be clear signals of the dangers inherent in this containment position. The EP prohibits the use of this method and these dangers have been addressed by the Joint Commission, SAMHSA and accrediting and review bodies as well as in professional literature. The hospital should take all means necessary to discourage staff from restraining individuals face down on the floor.
- g. The facility has declined in its compliance with EP requirements in Section D.1 regarding psychiatric reassessments. A critical factor here is that the facility did not adequately address a significant finding previously made by this monitor regarding a breakdown of the system of psychiatric coverage/reassessments during absences of the attending psychiatrist and despite warnings by this monitor about the gravity of this situation and its potential for tragic outcomes. This finding was mentioned in Reports 8 and 9 and discussed with all concerned parties in person. The facility needs to strengthen its medical leadership function. This is essential to adequately correct significant and recurrent breakdown points that have significant potential for harm to the individuals.
- h. NSH must improve the medical leadership's participation in the sentinel event reviews and analyses in order to assess the performance of medical and/or psychiatric systems, as indicated. For example, the facility initiated an intensive analysis of a serious injury sustained during containment (in January 2011) and documented participation by a designee of the Medical Director in this process. However, this did not happen and the analysis was never completed. As a result, the review of the psychiatric care in this case was not conducted as it should have been.
- i. 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 of life of individuals. While all 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. NSH has made and maintained significant progress in numerous processes of care outlined in the EP. However, further work is needed to ensure the following:
 - Full and proper implementation of the systemic corrections outlined in the DMH Strategic Action Plan to reduce aggression;

- Improved psychiatric reassessments and system of psychiatric coverage during absences of the attending psychiatrists; and
- Improved review and analysis of sentinel events, including the performance of psychiatric/medical systems in these events.

4. Staffing

The table below shows the staffing pattern at NSH as of June 17, 2011:

Napa State Hospital Vacancy Totals as of 6/17/11				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.0	5.0	0.0	0%
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	1.0	0.0	0%
Chief Psychologist	1.0	0.0	1.0	100%
Clinical Dietician (see Registered Dietician)	0.0	0.0	0.0	
Clinical Laboratory Technologist	3.0	2.0	1.0	33%
Clinical Social Worker	62.4	51.6	10.8	17%
Coordinator of Nursing Services	1.0	0.0	1.0	100%
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	88.8	1.2	1%
Hospital Worker	3.0	3.0	0.0	0%
Health Record Technician I	10.0	9.0	1.0	10%
Health Record Technician II Sp	1.0	1.0	0.0	0%
Health Record Technician II Sup	1.0	1.0	0.0	0%

Napa State Hospital Vacancy Totals as of 6/17/11

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Health Record Technician III	1.0	0.0	1.0	100%
Health Services Specialist	29.0	23.0	6.0	21%
Institution Artist Facilitator	1.0	1.0	0.0	0%
Licensed Vocational Nurse	44.0	43.0	1.0	2%
Medical Transcriber	6.0	6.0	0.0	0%
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	26.5	13.0	33%
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	19.4	2.6	12%
Podiatrist	1.0	0.8	0.2	20%
Program Assistant	5.0	4.0	1.0	20%
Program Consultant (RT, PSW)	0.0	0.0	0.0	0%
Program Director	8.0	5.0	3.0	38%
Psychiatric Nursing Education Director	2.0	1.0	1.0	50%
Psychiatric Technician*	343.9	263.1	80.8	23%
Psychiatric Technician Assistant	206.0	187.7	18.3	9%
Psychiatric Technician Instructor	4.0	4.0	0.0	0%

Napa State Hospital Vacancy Totals as of 6/17/11

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Psychologist-HF, (Safety)	52.1	38.90	13.20	25%
Public Health Nurse II/I	3.0	2.0	1.0	33%
Radiologic Technologist	2.0	2.0	0.0	0%
Registered Dietician	10.0	12.0	-2.0	-20%
Registered Nurse**	374.1	344.8	29.3	8%
Registered Nurse, Pre-Registered	0.0	0.0	0.0	0%
Rehabilitation Therapist	65.7	58.9	6.8	10%
Supervising Rehabilitation Therapist	2.0	2.0	0.0	0%
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	19.0	3.0	14%
Sr. Psychiatric Technician (Safety)	52.0	48.0	4.0	8%
Sr. Voc. Rehab. Counselor/Voc. Rehab.	1.0	1.0	0.0	0%
Staff Psychiatrist	61.3	58.3	3.0	5%
Supervising Psychiatric Social Worker	2.0	1.0	1.0	50%
Supervising Registered Nurse	14.0	12.0	2.0	14%
Teacher-Adult Educ./Vocational Instructor	6.5	6.0	0.5	8%
Unit Supervisor	32.0	31.0	1.0	3%
Vocational Instructor/Carpentry	1.0	1.0	0.0	0%
Vocational Instructor/Upholstery	1.0	1.0	0.0	0%

* Plus 33.7 hourly Psychiatric Technician FTEs

** Plus 28.7 hourly Registered Nurse FTEs

Key vacancies at this time include psychologists, clinical social workers, psychiatric technicians and senior psychiatrists.

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, 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 tour Metropolitan State Hospital August 29 to September 2, 2011 for a follow-up evaluation.
2. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<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 all EP requirements in Section C.1. 2. NSH has maintained substantial compliance with the requirements of Section C.2 (with the exception of C.2.I, which has moved from partial to substantial compliance). 3. NSH began implementation of streamlined versions of the WRPs to lessen the documentation burden while maintaining adequate attention to the individuals' needs. 4. NSH has provided positive clinical outcome data regarding the delivery of substance use services. <p>Areas of need include:</p> <ol style="list-style-type: none"> 1. <i>Ensure that implementation of the streamlined versions of the WRP reviews is guided by clear operational guidelines as well as feedback from practitioners and other facilities.</i> 2. <i>Ensure proper and full implementation of the streamlined WRP templates with the following goals:</i> <ol style="list-style-type: none"> a. <i>Better formulation of treatment and rehabilitation objectives and alignment of these objectives with the historical and present status sections of the case formulation; and</i> b. <i>More optimal balance between time spent in documentation and time spent in direct care.</i> 3. <i>Improve the case loads for psychologists on the long-term units.</i> 4. <i>Address significant increase in cancellation of medical appointments due to staffing issues.</i> 5. <i>Address the fact that Mall cancellations continue to be high relative to other facilities.</i> 6. <i>Provide off-site community re-integration programming for individuals that can participate in such programming. These off-site</i>

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		<p><i>activities should have appropriate objectives and interventions that address the individual's needs for community reintegration.</i></p> <p><i>7. Strengthen the interventions provided for Mall group non-adherence. Analyze reasons for individuals not adhering to their Mall groups and support them with effective strategies to change behavior.</i></p>
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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></p> <ol style="list-style-type: none"> 1. Debbi Fatheree, Psychiatric Technician, WRP Mentor (streamlining) 2. Katie Cooper, PsyD, Mall Director 3. Patricia Tyler, MD, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Current streamlined versions of the WRP reviews 2. NSH Streamlining Guidelines to Determine if a Full Monthly or a (short) Monthly WRP Review Form Needs to be Completed, July 2011 3. NSH WRP Essential Data 4. NSH Clinical Chart Auditing Form summary data (December 2010 - May 2011) 5. NSH WRP Observation Monitoring summary data (December 2010 - May 2011) 6. NSH WRP Team Facilitator Observation Monitoring Form summary data (December 2010 - May 2011) 7. NSH data regarding staffing ratios on admissions and long-term units (December 2010 - May 2011) 8. WRP Conference Schedule for week of July 25 - 28 <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit Q3) for monthly review of MMD on 7/28/11 2. WRPC (Program I, unit T6) for review of JJS on 7/25/11 3. WRPC (Program I, unit T8) for review of CDS on 7/26/11 4. WRPC (Program II, unit Q11) for annual review of IFI on 7/28/11 5. WRPC (Program II, unit T17) for monthly review of RP on 7/26/11 6. WRPC (Program II, unit T2) for 7-day review of DMR on 7/28/11 7. WRPC (Program II, unit T2) for review of JT on 7/26/11 8. WRPC (Program II, unit T2) for review of LVV on 7/27/11 9. WRPC (Program IV, unit A7) for review of JB on 7/28/11

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		<p>10. WRPC (Program V, unit Q8) for 60-day review of OM on 7/28/11 11. WRPC (Program V, unit T4) for 7-day review of TDB on 7/25/11</p>
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, 3 and 4, January 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. • Ensure that the departure of the Senior Master WRP Trainer, Dr. McKinney, does not result in a decline in the quality of WRP mentoring. • Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners. <p>Findings:</p> <p>During this review period, NSH continued to collaborate with DMH in the WRP streamlining project. The streamlined WRP Monthly Review was piloted with seven WRPTs (1/24/11-2/4/11) and the streamlined Quarterly and Annual WRPs were piloted by five teams (2/14/11- 3/4/11). The streamlined instruments were implemented hospital-wide after revisions were made based on feedback from all facilities and training of the WRPTs provided by Seniors. A monthly statewide teleconference led by DMH HOM team leader Rob Schaufenbil has been established for ongoing review of progress and to address questions/issues as they arise.</p> <p>During March 2011, the statewide group revised all audits affected by the streamlined changes to the WRP.</p> <p>The following is a summary of training/mentoring activities during this review period:</p> <ol style="list-style-type: none"> 1. WRP Master Trainers Katie Cooper and Debbi Fatheree trained the psychiatry Seniors on the streamlined Monthly Review (2/15/2011) and on the streamlined Quarterly/Annual (in March 2011). Further

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		<p>training was provided in April 2011 and May 2011.</p> <ol style="list-style-type: none"> 2. The Seniors from each discipline trained all clinical staff on the streamlined Monthly Review (in February 2011) and the streamlined Quarterly/Annual beginning March 2011. Beginning in June 2011, a "Captain" was designated for each Program to coordinate the ongoing training of each Program's clinicians. 3. Self-auditing data have been analyzed by one of the WRP Master Trainers and appropriate feedback was provided to the WRPT. The appropriate Senior(s) were included in this process. 4. NSH continued the previously mentioned WRP Handouts as a teaching tool and resource. The handouts were revised, as needed, to reflect the streamlining of the WRP. 5. The Mentoring and Monitoring Access Database is no longer being used by Psychiatry Seniors. 6. The training of newly hired psychiatrists and psychologists has been shifted to the Seniors. Additionally, WRP Master Trainer Debbi Fatheree was available for mentoring upon request by the clinician or discipline senior. 7. The "Focus of the Week" topics were on nursing documentation in the WRP. <p>Recommendation 2, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 11% of the quarterly and annual WPRCs held each month (December 2010 - May 2011):</p> <table border="1" data-bbox="982 1256 1881 1403"> <tr> <td data-bbox="982 1256 1079 1403">1.</td> <td data-bbox="1079 1256 1787 1403"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 1256 1881 1403">100%</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>	100%
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		<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></p>	<p>95%</p>
<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: This monitor reviewed the current versions of the streamlined WRP reviews and found that, if properly implemented, these tools were sufficient to meet the requirements of the EP. However, the current guideline regarding the use of the short monthly WRP form vs. the more detailed template lacked operational clarity. After discussion with the section leaders, the facility's representative in this area, Patricia Tyler, MD, Staff Psychiatrist initiated a draft guideline that provided necessary operational guidance to ensure that the short form is not used in situations that required more detailed review by the WRPTs.</p> <p>The monitor and his experts attended 11 WRPCs. The meetings showed evidence of adequate process, which is sufficient to maintain substantial compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize draft guideline regarding the use of the streamlined monthly WRP review. 2. Ensure that implementation of the streamlined versions of the WRP reviews is guided by clear operational guidelines as well as feedback from practitioners and other facilities. 			

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		<p>3. Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period.</p> <p>4. Continue to monitor this requirement.</p>												
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 100% based on an average sample of 32% of the quarterly and annual WRPCs held each month during the review period (December 2010 - May 2011). 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 92% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 1003 1885 1308"> <tr> <td data-bbox="982 1003 1079 1045">1.</td> <td data-bbox="1079 1003 1787 1045"><i>The team psychiatrist was present.</i></td> <td data-bbox="1787 1003 1885 1045">84%</td> </tr> <tr> <td data-bbox="982 1045 1079 1120">2.</td> <td data-bbox="1079 1045 1787 1120"><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td data-bbox="1787 1045 1885 1120">100%</td> </tr> <tr> <td data-bbox="982 1120 1079 1230">3.</td> <td data-bbox="1079 1120 1787 1230"><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td data-bbox="1787 1120 1885 1230">100%</td> </tr> <tr> <td data-bbox="982 1230 1079 1308">4.</td> <td data-bbox="1079 1230 1787 1308"><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td data-bbox="1787 1230 1885 1308">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 items 2-4 but data for</p>	1.	<i>The team psychiatrist was present.</i>	84%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%	4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	100%
1.	<i>The team psychiatrist was present.</i>	84%												
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4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	100%												

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		<p>item 1 showed a decline from 91% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 32% of the quarterly and annual WRPCs held each month during the review period (December 2010 - May 2011). 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 recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH WRP Clinical Chart Audit, NSH reported a compliance rate of 100% based on an average sample of 12% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011). Comparative data indicated that NSH has maintained a compliance rate of at least 90% since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH reported a compliance rate of 100% based on an average sample of 40% of the quarterly and annual WRPCs held each month during the review period (December 2010 - May 2011). 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>

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<p>C.1.f</p>	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 100% for the review period, based on a 32% sample of quarterly and annual WRPs due in the review months. 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>
<p>C.1.g</p>	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 32% of the quarterly and annual WRPCs held each month during the review period (December 2010 - May 2011). The facility reported a rate of 100% with the indicator regarding the identification of someone to be responsible for implementation of this requirement. 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>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Address decreased attendance by Psychiatrists, Psychologists and Social Workers. <p>Findings: NSH presented core WRPT member attendance data based on an average sample of 32% of quarterly and annual WRPCs held during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="982 857 1747 1203"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>87%</td> <td>91%</td> </tr> <tr> <td>Psychiatrist</td> <td>79%</td> <td>83%</td> </tr> <tr> <td>Psychologist</td> <td>76%</td> <td>83%</td> </tr> <tr> <td>Social Worker</td> <td>77%</td> <td>82%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>79%</td> <td>80%</td> </tr> <tr> <td>Registered Nurse</td> <td>95%</td> <td>96%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>82%</td> <td>90%</td> </tr> </tbody> </table> <p>The facility's data showed adequate rates of attendance by core members including the individual, with improved attendance since the last review. There is room for further improvement to ensure that the rates approach or exceed 90%.</p>		Previous review period	Current review period	Individual	87%	91%	Psychiatrist	79%	83%	Psychologist	76%	83%	Social Worker	77%	82%	Rehabilitation Therapist	79%	80%	Registered Nurse	95%	96%	Psychiatric Technician	82%	90%
	Previous review period	Current review period																								
Individual	87%	91%																								
Psychiatrist	79%	83%																								
Psychologist	76%	83%																								
Social Worker	77%	82%																								
Rehabilitation Therapist	79%	80%																								
Registered Nurse	95%	96%																								
Psychiatric Technician	82%	90%																								

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																					
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Continue corrective measures to improve staffing ratios in long-term units. <p>Findings: The facility provided data showing case loads of 1:15 for all core disciplines in admission teams, the same as in the last review. The data for the long-term units are as follows:</p> <table border="1" data-bbox="982 857 1671 1166"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>MDs</td> <td>1:27</td> <td>1:27</td> </tr> <tr> <td>PhDs</td> <td>1:35</td> <td>1:34</td> </tr> <tr> <td>SWs</td> <td>1:29</td> <td>1:29</td> </tr> <tr> <td>RTs</td> <td>1:27</td> <td>1:26</td> </tr> <tr> <td>RNs</td> <td>1:22</td> <td>1:21</td> </tr> <tr> <td>PTs</td> <td>1:27</td> <td>1:21</td> </tr> </tbody> </table> <p>The above data showed that the facility has maintained acceptable compliance but further work is needed to improve the ratios for psychologists.</p> <p>Compliance: Substantial.</p>		Previous review period	Current review period	MDs	1:27	1:27	PhDs	1:35	1:34	SWs	1:29	1:29	RTs	1:27	1:26	RNs	1:22	1:21	PTs	1:27	1:21
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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.1.j	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as C.1.a through C.1.f.</p> <p>Findings: Same as C.1.a through C.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as C.1.a through C.1.f.</p>

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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. Amy Davis, LCSW, Coordinator of Substance Recovery Services 2. Brandon Park, PhD, Staff Psychologist 3. Camille Gentry-Kaijankoski, Acting Chief of Rehabilitation Therapy Services 4. Christen Adams, Clinical Dietitian 5. Debbi Fatheree, PT, Psychiatric Technician, WRP Mentor (streamlining) 6. Deena Rosen, Assistant Director of Dietetics 7. Dolly Matteucci, Executive Director 8. James Young, DO, Acting Assistant Medical Director 9. Jennie Gilmore, Acting Senior Rehabilitation Therapist 10. Jennifer Deterville, Acting Senior Rehabilitation Therapist 11. Jessica Tuttle, Clinical Dietitian 12. Joanne Merrill, MA, Clinical Dietitian 13. Jonathan Berry, MD, Acting Senior Psychiatrist 14. Katie Cooper, PsyD, Mall Director 15. Kumiko Kato, MPH, Clinical Dietitian 16. Laufey Gunnarsdottir, Clinical Dietitian 17. Linderpal Dhillon, Clinical Dietitian 18. Lynn Wurzel, Clinical Dietitian 19. Lynne Fredricksen, Assistant Director of Dietetics 20. Patricia Tyler, MD, Staff Psychiatrist 21. Patrick Nolan, MD, Acting Chief of Psychiatry 22. Phyllis Moore, Acting Senior Rehabilitation Therapist 23. Susan Jette, Acting Senior Rehabilitation Therapist 24. Tony Rabin, PhD, Acting Chief of Psychology 25. Wen Pao, Director of Dietetics

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		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 114 individuals: AG, ALF, AOS, AS, AW, BJ, BS, BWB, BX, CB, CC, CS, DAF, DB, DBP, DD, DFS, DJC, DKB, DP, EG, ELN, ES, EWK, FBT, FJU, FKM, FM, FMC, GAR, GCS, GG, GMW, GT, ING, JB, JCQ, JCS, JDK, JI, JJB, JK, JLA, JLB, JM, JR, JRM, JS, JTC, JTS, KB, KJK, KK, KMB, KS, KZ, LAC, LK, LKM, LM, LRJ, MC, MCA, MDP, MDW, MER, MG, MGG, MJP, MLL, MM, MMP, MP, MRO, MT, MW, MWP, NFF, NH, NLP, NP, PA, PB, PFC, PM, RA, RAB, RAM, RB, RDR, RJ, RJF, RJR, RKH, RS, RSS, RT, RW, RWS, SAR, SC, SH, TC, TDB, TGP, TJM, TM, TMC, TR, UAQ, VH, YAQ, YMW and ZCP 2. One WRP per team for the following 50 individuals: AB, ADS, APC, BX, CDB, CKR, CRH, CWP, DBG, DFS, DJS, DLB-1, DLB-2, DMB, EWK, GVC, JAW, JJB, JLB, JMM, JRV, KBR, KLF, KMB-1, KMB-2, LAC, LAG, LAP, MAF, MCA, MEW, MGG, MJP, MRO, OAM, PG, RB, REO, RGP, RGZ, RH, RKH, RTF, SSC, SV, TJC, TS, VH, VM and WCF 3. NSH Streamlining Guidelines to Determine if a Full Monthly or a Short Monthly WRP Review Form Needs to be Completed, July 2011 4. NSH WRP Essential Data 5. Samples of streamlined WRPs 6. NSH WRP Observation Monitoring summary data (December 2010 - May 2011) 7. NSH Clinical Chart Auditing Form summary data (December 2010 - May 2011) 8. NSH Chart Auditing Form summary data (December 2010 - May 2011) 9. Neuropsychology evaluation for DJC 10. Intellectual & Academic Assessment for RB 11. Updated DMH WRP Audits 12. Lesson Plans for the following Cognitive Remediation Groups: <ul style="list-style-type: none"> • Symptom Management for MGG • Coping Skills (I&AD) for TGP • Self Esteem (I&AD) for JCS • Reality Orientation (S&A) for DJC • Cognitive Skills (S&A) for DJC
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		<ul style="list-style-type: none"> • Cognitive Skill Development - Brain Games for RB • Reality Orientation (S&A) for RAB • Cognitive Awareness (S&A) for JLB • Self Esteem - Art for JR • Cognitive Skills Development for JJB • Variety Hour for JJB • Enhancing Motivation - Music and Interaction for MCA <ol style="list-style-type: none"> 13. List of Substance Recovery Services groups schedule for the week 14. Readiness Ruler (regarding readiness to make a change in substance use behavior and appropriate stage of treatment) 15. Revised NSH Staging Questionnaire (regarding readiness to make a change in substance use behavior and appropriate stage of treatment) 16. Staging questionnaire revisions and results for pre-contemplative and contemplative stages of change (NSH also used readiness ruler this period) 17. Summary data substance abuse process and clinical outcomes 18. NSH Consumer Satisfaction Survey summary data 19. NSH WRP Substance Abuse Auditing Form summary data (December 2010 - May 2011) 20. Revised Mall Procedure 9.1, Screening for Substance Recovery Services 21. Revised Mall Procedure 9.3, Determining Stage for Individual in Substance Recovery Treatment 22. Mall Procedure 9.5, Unit-Based AA/NA Meetings 23. Revised Mall Procedure 9.4 Hospital Wide AA/NA Meetings 24. Data regarding WRP education groups and individuals enrolled 25. Data regarding medication education groups and individuals enrolled 26. By Choice training data 27. Cognitive Remediation Plans 28. Lesson Plan for Cognitive Remediation Mall Group 29. Substance Abuse Recovery Course Material 30. Lesson plans for Substance Abuse Recovery
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		<p>31. List of enrichment activities offered during this review period 32. List of exercise groups/activities offered during this review period 33. List of scheduled exercise groups 34. List showing scheduled and cancelled medical appointments 35. Review of MAPP lists for Mall hours schedule 36. Supplemental Activity List</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, Unit T17) for monthly review of RP 2. WRPC (Program II, Unit T4) for 7-day review of TDB 3. WRPC (Program V, Unit Q8) for 60-day review of OM 4. Mall Group: Symptom Management 5. Mall Group: Discharge Planning - CONREP Preparation 6. Mall Group: Leisure Skills 7. Mall Group: Computer Class 8. Substance Recovery - Maintenance Group, facilitated by Michelle Bowie, RN, Supervising Registered Nurse, Substance Recovery Services 9. Substance Recovery - Enhancing Motivation Group (pre-contemplation stage), facilitated by Jack Aamot, PsyD, Staff Psychologist 10. Smart Recovery Group (all stages), facilitated by individual MG and co-facilitated by Barry Wagener, RN, Mall Services
C.2.a	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 32% of the WRPCs held each month during the review period (December 2010 - May 2011). Comparative data indicated that NSH has maintained a compliance</p>

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		<p>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.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, January 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 (December 2010 - May 2011). Based on an average sample of 21% 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> <p>Other findings: A review of the charts of six individuals admitted during the review period (ELN, JCS, LRJ, MGG, MJP and TGP) found compliance in all cases.</p> <p>Compliance: Substantial.</p>

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		<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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 21% 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 six individuals admitted during the review period (ELN, JCS, LRJ, MGG, MJP and TGP) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p>

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		<table border="1" data-bbox="993 191 1650 423"> <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>13%</td> <td>100%</td> </tr> <tr> <td>Monthly</td> <td>14%</td> <td>95%</td> </tr> <tr> <td>Quarterly</td> <td>23%</td> <td>98%</td> </tr> <tr> <td>Annual</td> <td>28%</td> <td>99%</td> </tr> </tbody> </table> <p data-bbox="993 467 1873 532">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="993 576 1902 678">Other findings: A review of the charts of six individuals admitted during the review period (ELN, JCS, LRJ, MGG, MJP and TGP) found compliance in all cases.</p> <p data-bbox="993 722 1140 787">Compliance: Substantial.</p> <p data-bbox="993 831 1457 896">Current recommendation: Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	13%	100%	Monthly	14%	95%	Quarterly	23%	98%	Annual	28%	99%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	13%	100%															
Monthly	14%	95%															
Quarterly	23%	98%															
Annual	28%	99%															
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	<p data-bbox="993 946 1591 979">Current findings on previous recommendations:</p> <p data-bbox="993 1019 1457 1084">Recommendation 1, January 2010: Continue to monitor this requirement.</p> <p data-bbox="993 1128 1894 1312">Findings: NSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 11% to 86% of the relevant population for each sub-indicator during the review period (December 2010 - May 2011).</p> <table border="1" data-bbox="993 1349 1885 1414"> <tr> <td data-bbox="993 1349 1087 1414">2.</td> <td data-bbox="1087 1349 1791 1414"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</i></td> <td data-bbox="1791 1349 1885 1414">95%</td> </tr> </table>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a</i>	95%												
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		<p><i>thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></p>	
		<p>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></p>	<p>93%</p>
		<p>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></p>	<p>96%</p>
		<p>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></p>	<p>97%</p>
		<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> <p>Recommendation 2, January 2010: Provide a summary of changes in the number, range and content of cognitive rehabilitation interventions during the review period.</p> <p>Findings: The number of core cognitive remediation groups decreased from 93 in January 2011 to 84 in July 2011 but group hours increased from 110 to 121 over the same period of time. No significant changes in group curricula were reported.</p> <p>Other findings: This monitor reviewed the charts of the following eight individuals who were diagnosed with a variety of cognitive disorders:</p> <ol style="list-style-type: none"> 1. Mild Mental Retardation (RAB and RB); 2. Cognitive Disorder NOS (JJB and MCA); 	

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		<p>3. Borderline Intellectual Functioning (JLB and JR); and</p> <p>4. Dementia Due to General Medical Condition with Behavioral Disturbance (DJC and KJK).</p> <p>In addition, this monitor reviewed the charts of six individuals diagnosed with seizure disorders (DFS, DP, JB, KMB, RS and TMC).</p> <p>The reviews found general evidence that NSH has maintained progress in the following areas:</p> <ol style="list-style-type: none"> 1. Review of seizure activity and cognitive functioning in the Present Status section of the case formulation; 2. The use of learning-based objectives and interventions to address the needs of individuals diagnosed with cognitive impairments and/or seizure disorders; 3. Caution in the use of old-generation anticonvulsants, with some exceptions; 4. The performance of cognitive assessments/screening and/or neuropsychological testing to determine the level and scope of cognitive dysfunction and assist in the cognitive diagnosis; 5. Provision of formal and informal cognitive remediation interventions for individuals diagnosed with cognitive disorders. Examples include the following: <ul style="list-style-type: none"> • Cognitive Skills (S&A) for DJC • Cognitive Skill Development - Brain Games for RB • Cognitive Awareness (S&A) for JLB • Cognitive Skills Development for JJB 6. Timely neurological consultations to address the needs of individuals with seizure disorders; and 7. Caution in the use of long-term high risk medications (anticholinergic and benzodiazepines) for individuals diagnosed with cognitive impairments, with a few exceptions.
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		<p>The review found the following process deficiencies:</p> <ol style="list-style-type: none"> 1. The objective for KJK did not appear to be related to the diagnosis of cognitive dysfunction and the corresponding group interventions did not include cognitive remediation. 2. The group interventions did not appear to address (MCA) or adequately address (JR) the individual's cognitive dysfunction. 3. The objective for some individuals suffering from a seizure disorder was not attainable for the individuals (DP and RS). <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.
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH reported a</p>

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		<p>compliance rate of 100% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011). The compliance data for the requirements in C.2.d.ii to C.2.d.vi ranged from 95% to 100%. Comparative data indicated that NSH has maintained compliance rates of at least 90% since the last review period.</p> <p>Other findings: This monitor reviewed one WRP per team for the following 50 individuals: AB, ADS, APC, BX, CDB, CKR, CRH, CWP, DBG, DFS, DJS, DLB-1, DLB-2, DMB, EWK, GVC, JAW, JJB, JLB, JMM, JRV, KBR, KLF, KMB-1, KMB-2, LAC, LAG, LAP, MAF, MCA, MEW, MGG, MJP, MRO, OAM, PG, RB, REO, RGP, RGZ, RH, RKH, RTF, SSC, SV, TJC, TS, VH, VM and WCF. This review found that, in general, the facility has maintained substantial compliance with this requirement.</p> <p>The streamlined WRPs contained appropriate modifications in the structure of the case formulation. The significant changes included consolidating the six Ps of the case formulation, focusing the review of symptoms on current relevant symptoms, aligning the interventions and response section with each corresponding objective and combining discharge criteria and discharge barriers. If properly and consistently implemented, these modifications can lessen the documentation burden while maintaining proper attention to the most relevant needs of the individuals.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure proper and full implementation of the streamlined WRP templates, including consistent alignment of the present status review with the review of the individual's progress in each objective. 2. Continue to monitor this requirement.
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C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	Same as above.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	Same as above.
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;	Same as above.
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	Same as above.
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.	Same as above.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, NSH reported a compliance rate of 100% based on an average sample of 24% of the quarterly and annual WRPs due each month during the review period (December 2010 -</p>

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		<p>May 2011). 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 16 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. Fifteen records were in substantial compliance (AS, DAF, JDK, KZ, LKM, MC, MDP, MER, MMP, MP, PA, RA, RJR, RWS and TM) and one record was not in compliance (ZCP).</p> <p>This monitor also reviewed the records of seven individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. Six records were in substantial compliance (AOS, ELN, JM, KZ, MW and NH) and one record was not in compliance (JLA).</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> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging	Please see sub-cells for compliance findings.

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	<p>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>C.2.f.i</p>	<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, January 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 24% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011). The facility reported a mean compliance rate of 100% for these requirements. 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 five charts (ELN, JCS, LRJ, MJP and TGP) and partial compliance in one (MGG). The strengths formulation in the chart of MGG was limited to repeating the individual's words and did not include meaningful delineation of the strengths.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>C.2.f.ii</p>	<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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Other findings: Chart reviews found substantial compliance in all charts (ELN, JCS, LRJ, MGG, MJP and TGP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.f.iii</p>	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Other findings: Chart reviews found substantial compliance in three charts (ELN and JCS and MJP) and partial compliance in three (LRJ, MGG and TGP). The main deficiencies involved disconnection between the objectives and the corresponding present status reviews, objectives that lack specificity (e.g. "will cope with diagnosis") and objectives not addressing the individual's main problem of assaulting others (LRJ).</p>

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		<p>The newly streamlined template of the WRP improves the linkage between the present status reviews and the individual's progress in each objective.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure proper implementation of the streamlined WRP templates to properly align the present status review with the review of the individual's progress in each objective.
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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Other findings: Chart reviews found substantial compliance in five charts (ELN, JCS, LRJ, MGG and MJP) and partial compliance in one (TGP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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<p>C.2.f.v</p>	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Same as above.</p> <p>Other findings: Chart reviews found substantial compliance in all cases (ELN, JCS, LRJ, MGG, MJP and TGP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.f.vi</p>	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH has revised the STA Mall program and schedules due to safety concerns, especially for transitioning patients from units. Two hours of Mall groups daily are provided in the Central Malls for the STA open unit individuals and the Program 4 civilly committed individuals; the remaining Mall hours are in the units and/or Program buildings. Additionally, specialty groups are offered in the Central Malls in the afternoon. About 400 individuals were served in off-unit Malls during morning and afternoon sessions daily.</p>

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NSH has increased the number of individuals as co-providers, up to 26 during this review period. As many as 25 Mall groups in the open units now have an individual as a co-provider.

NSH presented the following data for the review period (December 2010 - May 2011):

Number of individuals by category		
	Mean scheduled hours	Mean attended hours
N	1144	1144
Hours:		
0-5	51	635
6-10	226	241
11-15	422	215
16-20	425	53

Mall Attendance		
	Previous period	Current period
Mean number of individuals		
0-5 hours	560	635
6-10 hours	292	241
11-15 hours	226	215
16-20+ hours	73	53

This monitor reviewed the charts of 10 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. Staff interview indicated that this discrepancy is partly due to failure by some of the group providers to turn in the Mall rosters at all or in a timely manner for them to be logged into MAPP (e.g. MDW, MWP, and RAM). WRP documentation shows that individuals are

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attending groups that are not reflected in the MAPP (e.g. MWP and RAM). NSH needs to correct this situation to get an accurate account of Mall groups held, attended, etc.

The following table summarizes the monitor's findings:

Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
AW	12	12	5
DKB	18	19	8
FM	11	8	2
GAR	4	6	1
JRM	11	16	0
MDW	5	5	2
MWP	9	10	0
RAM	8	10	0
RW	7	8	2
TR	19	19	4

As seen in the table above, there were differences in the number of Mall hours listed in the individual's WRP and the MAPP scheduled hours (DKB, FM, GAR, JRM, MWP, RAM and RW). The documentation for MWP shows that he is attending groups. According to the documentation in MWP's Present Status section, he is "enrolled in eight hours of active treatment. Eight hours are recommended as M needs time on the unit to rest. Direct interaction with groups of his peers . . . causes overstimulation . . . can become the victim of hostility from peer . . . will encourage . . . to attend more when he is able to." Review on focus 10 reads, "M has attended several active treatment groups successfully." Similarly, the Present Status documentation (6/30/2011) for RAM showed that he does attend some groups, ". . . continues to refuse most active treatment groups. However, attends groups that he enjoys . . . he is currently unable to remain in groups without becoming increasingly paranoid . . . he is

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		<p>making slow progress and becoming less assaultive . . . the current plan is to encourage but not insist on attendance at groups."</p> <p>NSH is offering 20 hours of Mall services and individual and group therapy each week. However, the WRPTs also take into consideration the individual's physical, psychological, and psychiatric factors when enrolling individuals in PSR services, and where necessary the teams enroll the individuals in fewer hours (e.g. MWP and RAM) to ensure that the individuals are not overwhelmed with too many such activities until they are ready to participate in more groups.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: According to NSH, Community Integration groups have been suspended temporarily due to safety concerns and reactions from the community following past events of violence. However, these individuals continue to be enrolled in community re-entry Mall groups.</p> <p>This monitor reviewed the records of four civilly committed individuals (CC, LAC, NH and PFC). The table below shows their medical, psychiatric, and behavioral status:</p>

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		<table border="1" data-bbox="991 228 1896 678"> <thead> <tr> <th>ID</th> <th>Off-site program</th> <th>Psychiatric diagnoses</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td>CC</td> <td>No</td> <td>Schizophrenia</td> <td>Met discharge criteria, but LA County rejects placement due to history of arson</td> </tr> <tr> <td>LAC</td> <td>No</td> <td>Assaultive, schizophrenia</td> <td>Risk of assault</td> </tr> <tr> <td>NH</td> <td>No</td> <td>BPD, antisocial, SIB,</td> <td>In community entry program</td> </tr> <tr> <td>PFC</td> <td>No</td> <td>Schizophrenia, paranoid ideation, delusional</td> <td>Met discharge criteria</td> </tr> </tbody> </table> <p data-bbox="991 722 1896 824">As the table above shows, at least two of the individuals (CC and PFC) are candidates for community integration off-site activities, but this is not possible due to program suspension.</p> <p data-bbox="991 868 1354 938">Compliance: Rating deferred at this time.</p> <p data-bbox="991 982 1459 1052">Current recommendation: Continue to monitor this requirement.</p>	ID	Off-site program	Psychiatric diagnoses	Status	CC	No	Schizophrenia	Met discharge criteria, but LA County rejects placement due to history of arson	LAC	No	Assaultive, schizophrenia	Risk of assault	NH	No	BPD, antisocial, SIB,	In community entry program	PFC	No	Schizophrenia, paranoid ideation, delusional	Met discharge criteria
ID	Off-site program	Psychiatric diagnoses	Status																			
CC	No	Schizophrenia	Met discharge criteria, but LA County rejects placement due to history of arson																			
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PFC	No	Schizophrenia, paranoid ideation, delusional	Met discharge criteria																			
C.2.f.viii	<p data-bbox="373 1096 955 1416">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</p>	<p data-bbox="991 1096 1579 1123">Current findings on previous recommendation:</p> <p data-bbox="991 1166 1459 1235">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1279 1902 1416">Findings: Using the DMH Mall Alignment Monitoring Form, NSH assessed its compliance based on a mean sample of 12% of the quarterly and annual WRPs due each month for the review period (December 2010 - May 2011)</p>																				

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	groups that link directly to the objectives in the individual's WRP and needs.	<p>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 11 individuals found substantial compliance in nine (ALF, FMC, JI, JTS, MM, NP, RJF, RKH and SAR), partial compliance in one (YMW) and noncompliance in one (TDB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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>

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		<p>Other findings: Chart reviews found substantial compliance in all cases (ELN, JCS, LRJ, MGG, MJP and TGP).</p> <p>Additionally, this monitor reviewed the records of 10 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	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 96% based on an average sample of 91% of individuals placed in seclusion and/or restraint each month during the review period (December 2010 - May 2011). 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 who experienced the use of seclusion and/or restraint during this review period. The review focused on the proper documentation of the events that led to the use of seclusion and/or restraint (the streamlined version of the WRP referred</p>

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		<p>to documentation on the IDN section of the chart). The following table outlines the reviews:</p> <table border="1" data-bbox="991 302 1881 607"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable note</th> </tr> </thead> <tbody> <tr> <td>FBT</td> <td>4/1/11</td> <td>4/1/11</td> </tr> <tr> <td>KS</td> <td>4/2/11</td> <td>4/2/11</td> </tr> <tr> <td>MRO</td> <td>5/8/11</td> <td>5/8/11</td> </tr> <tr> <td>RKH</td> <td>5/5/11</td> <td>5/5/11</td> </tr> <tr> <td>RT</td> <td>6/3/11 and 6/4/11</td> <td>6/3/11 and 6/4/11</td> </tr> <tr> <td>VH</td> <td>4/17/11</td> <td>4/17/11</td> </tr> </tbody> </table> <p>This review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	Date of applicable note	FBT	4/1/11	4/1/11	KS	4/2/11	4/2/11	MRO	5/8/11	5/8/11	RKH	5/5/11	5/5/11	RT	6/3/11 and 6/4/11	6/3/11 and 6/4/11	VH	4/17/11	4/17/11
Individual	Date of seclusion and/or restraint	Date of applicable note																					
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RKH	5/5/11	5/5/11																					
RT	6/3/11 and 6/4/11	6/3/11 and 6/4/11																					
VH	4/17/11	4/17/11																					
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 32% of the quarterly and annual WRPCs held each month during the review period (December 2010 - May 2011). 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 assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in four charts (ELN, JCS, MGG and TGP) and partial compliance in two (LRJ and MJP). The charts of LRJ and MJP did not adequately address the individuals' progress towards achievement of discharge criteria.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 32% of the quarterly and annual WRP. 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 proper completion of Mall progress notes that address interventions provided under Focus 1. The review found substantial compliance in four charts (JCS, MGG, MJP and TGP) and partial compliance in two (ELN and LRG).</p>

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		<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>
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 12% of quarterly and annual WRPs due each month during the review period (December 2010 - May 2011) 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 found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in nine WRPs in the charts (BJ, EWK, JI, JTS, MM, NP, RJF, RKH and YAQ). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor</p>

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		<p>correspondence between the objectives and recommended PSR Mall services, were noted in the remaining three WRPs (ALF, FMC and SAR).</p> <p>Other findings: This monitor reviewed the records of 16 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>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 24% of quarterly and annual WRPs due each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1044 1887 1156"> <tr> <td data-bbox="991 1044 1087 1156"></td> <td data-bbox="1087 1044 1793 1156"><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 1044 1887 1156">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 13 individuals found that 10 WRPs in the charts contained objectives written in a measurable/observable manner (AG, BJ, EWK, JI, JRM, LAC, LK, MM, MWP and YAQ) and three did not</p>		<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%
	<i>The WRP includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</i>	100%			

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		<p>(ALF, FMC and SAR).</p> <p>A review of the records of 10 individuals found that the objectives in all ten WRPs in the charts were directly linked to a relevant focus of hospitalization (BJ, EWK, ING, JCQ, JCS, JI, MCA, MG, MM and YAQ).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: See C.2.f.viii.</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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Facilitator Observation Audit, NSH assessed its compliance based on an average sample of 11% of Mall group facilitators each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="989 1341 1887 1414"> <tr> <td>15.</td> <td><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td>98%</td> </tr> </table>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	98%
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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 WRPs of eight individuals found that all specified the strengths of the individual in all active interventions reviewed (CS, GCS, JTC, KS, MWP, RAM, RKH and YAQ). In some cases, the WRPTs had documented strengths under "Functional Status" in the Present Status sections of the individuals' WRPs.</p> <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, January 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 12% of quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 WRPs of eight individuals found that the individual's vulnerabilities were documented in the case formulation section in all eight WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AG, BJ, BWB, EWK, MM, NFF, TDB and YAQ).</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Facilitator Mall Observation Monitoring Form, NSH assessed compliance based on an average sample of 11% of the Mall group facilitators each month during the review period (December 2010 - May 2011), 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 eight individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section and documented in all eight WRPs (BJ, JCQ, JI, MDW, MM, RJF, TDB and YAQ).</p> <p>A review of documented cognitive levels for six individuals (BJ, JCQ, JI, PM, TDB and YAQ) and the groups to which they were assigned found that the group offered were at the individuals' functional 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, January 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 the</p>

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		<p>last month of the review period and n equals the number of progress notes received by the WRPTs:</p> <table border="1" data-bbox="991 302 1793 456"> <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>719</td> <td>675</td> <td>881</td> <td>422</td> <td>579</td> <td>655</td> </tr> <tr> <td>n</td> <td>611</td> <td>594</td> <td>784</td> <td>380</td> <td>492</td> <td>572</td> </tr> <tr> <td>%C</td> <td>85%</td> <td>88%</td> <td>89%</td> <td>90%</td> <td>85%</td> <td>87%</td> </tr> </tbody> </table> <p>A review of the charts of seven individuals found that six contained progress notes and the information from the progress notes was incorporated into the Present Status section of the individual's WRP (AG, BJ, EWK, JI, NFF and YAQ); this was not the case in the remaining individual's WRP.</p> <p>Other findings: This monitor reviewed the records of 16 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. Fifteen records were in substantial compliance (AS, JDK, KZ, LKM, MC, MDP, MER, MMP, MP, PA, RA, RJR, RWS, TM and ZCP) and one record was not in compliance (DAF).</p> <p>Current recommendation: Continue to monitor this requirement.</p>		P1	P2	P3	P4	P5	Mean	N	719	675	881	422	579	655	n	611	594	784	380	492	572	%C	85%	88%	89%	90%	85%	87%
	P1	P2	P3	P4	P5	Mean																								
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C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The facility continues to provide PSR Mall groups for four hours a day five days a week, albeit under a modified structure. Now, only three</p>																												

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		<p>hours a day of PSR Mall services are provided in Central Malls, and the remaining hours are provided in the units. The modifications were put in place due to safety factors and staffing needs to transition individuals to off-unit activities.</p> <p>The facility provided the following data:</p> <table border="1" data-bbox="993 451 1776 683"> <thead> <tr> <th></th> <th>Scheduled hours</th> <th>Attended hours</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1144</td> <td>1144</td> </tr> <tr> <td>0-5</td> <td>51</td> <td>635</td> </tr> <tr> <td>6-10</td> <td>226</td> <td>241</td> </tr> <tr> <td>11-15</td> <td>422</td> <td>215</td> </tr> <tr> <td>16-20</td> <td>425</td> <td>53</td> </tr> </tbody> </table> <p>As seen in the table above, the majority of individuals had attended 0-5 hours of Mall groups during this review period. NSH should work to improve attendance of these individuals, especially with regard to their core Mall groups. WRPTs should address these issues as early as possible. WRPTs should also explain in the Present Status section why the individual chooses to not attend the Mall groups and how the team is addressing these issues. In the event the individual's mental illness and/or physical health are barriers to attendance, these factors should also be stated in the Present Status section.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Scheduled hours	Attended hours	N	1144	1144	0-5	51	635	6-10	226	241	11-15	422	215	16-20	425	53
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C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p>																		

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		<p>Findings:</p> <p>According to staff information and data reviewed, data was not available in WaRMSS for December 2010 - February 2011, and indicated no scheduling or provision of bedside treatment in April or May. NSH cared for one bed-bound individual in May. The individual was scheduled for 16 hours of active treatment and three hours were actually provided. This individual passed away so it is not clear to what extent health status or the timing of the individual's passing affected provision of scheduled treatment. In any event, bed-bound individuals require active interventions during their bed-bound status, more so than individuals who are ambulatory. Ambulatory individuals can be active on their own, but not the bed-bound individual. NSH should ensure that the needs of the bed-bound individuals are attended to. NSH appears to collate and enter data in WaRMMS and other databases towards the end of the review period. By now NSH should have a system to enter data on a monthly basis so that data problems can be corrected quickly and ongoing analysis conducted to give feedback to the relevant staff/groups for them to address deficiencies.</p> <p>This monitor reviewed the chart of the individual identified as bed-bound (HJV). Mall notes were present in the chart. Based on the notes, Mall activities were not held with the individual, because "facilitator was on leave." Attendance was scored as "0", progress as "participates minimally with minimal prompts", and progress as "Acceptable progress." As can be seen, the notes are confusing, with information that is not aligned with the sessions scheduled, participation by the individual, and progress made (these problems of continue to be a problem of software and/or provider not paying attention to change check-boxes from the previous month). Documentation in the Present Status of the individual's WRP indicated that the individual was reluctant to attend groups even when able, receives "room-side 1:1 for Mall group activities. He entertains staff initiated supported activities." The information is the same across WRPs. Documentation also showed that By Choice Incentive system was active</p>
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		<p>with the individual. The By Choice card was held at the Nursing Station as the individual could not hold the card himself. Points were allocated to mealtimes to encourage the individual to increase his intake. Documentation also showed that Supplemental Activities were offered to the individual on a weekly basis. The individual was said to have participated on average in two of five hours of activities offered per week.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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="991 894 1919 1159"> <thead> <tr> <th></th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>5/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>1929</td> <td>1824</td> <td>1711</td> <td>1669</td> <td>1603</td> <td>1613</td> <td>1725</td> </tr> <tr> <td>Groups cancelled</td> <td>902</td> <td>792</td> <td>575</td> <td>635</td> <td>300</td> <td>225</td> <td>572</td> </tr> <tr> <td>Cancellation rate (%C)</td> <td>47%</td> <td>43%</td> <td>34%</td> <td>38%</td> <td>19%</td> <td>14%</td> <td>33%</td> </tr> </tbody> </table> <p>The mean cancellation rate of 33% during this review period is high; the mean cancellation rate was 22% in the previous review period. There has been a steady reduction in cancellations across the months with a low of 14% cancellation in May 2011.</p> <p>The facility presented the following data regarding Mall group</p>		12/10	1/11	2/11	3/11	4/11	5/11	Mean	Groups scheduled	1929	1824	1711	1669	1603	1613	1725	Groups cancelled	902	792	575	635	300	225	572	Cancellation rate (%C)	47%	43%	34%	38%	19%	14%	33%
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		<p>facilitation by discipline:</p> <table border="1" data-bbox="991 266 1860 769"> <thead> <tr> <th colspan="3">Average weekly hours provided by discipline</th> </tr> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Psychiatry Admissions (2)</td> <td>2</td> <td>1</td> </tr> <tr> <td>Psychiatry Long-Term (4)</td> <td>2</td> <td>2</td> </tr> <tr> <td>Psychology Admissions (5)</td> <td>3</td> <td>3</td> </tr> <tr> <td>Psychology Long-Term (10)</td> <td>4</td> <td>3</td> </tr> <tr> <td>Social Work Admissions (5)</td> <td>3</td> <td>3</td> </tr> <tr> <td>Social Work Long-Term (10)</td> <td>4</td> <td>4</td> </tr> <tr> <td>Rehab Therapy Admissions (7)</td> <td>6</td> <td>4</td> </tr> <tr> <td>Rehab Therapy Long-Term (15)</td> <td>11</td> <td>10</td> </tr> <tr> <td>Nursing (10)</td> <td>2</td> <td>6</td> </tr> <tr> <td>Administration</td> <td>2</td> <td>1</td> </tr> </tbody> </table> <table border="1" data-bbox="991 846 1883 1224"> <thead> <tr> <th>Discipline</th> <th>Hours Scheduled/ Week</th> <th>Hours Provided/ Week</th> <th>Percentage of Scheduled Hours Fulfilled</th> </tr> </thead> <tbody> <tr> <td>Psychiatry</td> <td>122</td> <td>49</td> <td>40%</td> </tr> <tr> <td>Psychology</td> <td>209</td> <td>113</td> <td>54%</td> </tr> <tr> <td>Social Work</td> <td>278</td> <td>136</td> <td>49%</td> </tr> <tr> <td>Rehab Therapy</td> <td>478</td> <td>321</td> <td>67%</td> </tr> <tr> <td>Nursing</td> <td>871</td> <td>325</td> <td>37%</td> </tr> <tr> <td>Other</td> <td>461</td> <td>255</td> <td>55%</td> </tr> <tr> <td>Administration</td> <td>410</td> <td>199</td> <td>49%</td> </tr> </tbody> </table> <p data-bbox="991 1268 1902 1408">As the tables above shows, lack of facilitators is a major factor contributing to Mall cancellations. Disciplines have provided only between 40% and 67% of their required hours of Mall support. It is not possible for Mall groups to be held regularly as scheduled with such low</p>	Average weekly hours provided by discipline				Previous review period	Current review period	Psychiatry Admissions (2)	2	1	Psychiatry Long-Term (4)	2	2	Psychology Admissions (5)	3	3	Psychology Long-Term (10)	4	3	Social Work Admissions (5)	3	3	Social Work Long-Term (10)	4	4	Rehab Therapy Admissions (7)	6	4	Rehab Therapy Long-Term (15)	11	10	Nursing (10)	2	6	Administration	2	1	Discipline	Hours Scheduled/ Week	Hours Provided/ Week	Percentage of Scheduled Hours Fulfilled	Psychiatry	122	49	40%	Psychology	209	113	54%	Social Work	278	136	49%	Rehab Therapy	478	321	67%	Nursing	871	325	37%	Other	461	255	55%	Administration	410	199	49%
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		<p>participation from providers. NSH has to correct this situation.</p> <p>Current recommendation: Continue to monitor this requirement.</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, January 2010: Continue current practice.</p> <p>Findings: Staff information and document review indicated that since the last review, NSH has taken steps to increase the involvement of individuals in supplemental activities besides being participants in the activities. The facility has made up a training curriculum to train individuals as co-providers for the supplemental activities and has trained 18 Rehabilitation Therapists on the training manual. These Rehabilitation Therapists subsequently trained 13 individuals as co-providers who then have been assisting the primary providers in Leisure, Art, Relaxation, Fitness, and Music activities.</p> <p>The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 1042 1890 1308"> <thead> <tr> <th></th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>5/11</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1827</td> <td>1723</td> <td>1614</td> <td>1791</td> <td>1611</td> <td>1672</td> <td>10,238</td> </tr> <tr> <td>Hours offered</td> <td>1910</td> <td>1843</td> <td>1713</td> <td>1872</td> <td>1728</td> <td>1776</td> <td>10,842</td> </tr> <tr> <td>Compliance rate</td> <td>100+</td> <td>100+</td> <td>100+</td> <td>100+</td> <td>100+</td> <td>100+</td> <td>100+</td> </tr> </tbody> </table> <p>As can be seen in the table above, NSH provided a mean of 433 hours of supplemental activities per week during this review period. The facility</p>		12/10	1/11	2/11	3/11	4/11	5/11	Mean	Hours scheduled	1827	1723	1614	1791	1611	1672	10,238	Hours offered	1910	1843	1713	1872	1728	1776	10,842	Compliance rate	100+	100+	100+	100+	100+	100+	100+
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		<p>has continued to increase the hours of supplemental activities provided and the range of activities offered. Supplemental activities are better organized, providers are trained, and individuals are motivated to attend the activities,</p> <p>Current recommendation: Continue current practice.</p>																														
C.2.i.xii	<p>is consistently reinforced by staff on the therapeutic milieu, including living units.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, NSH assessed its compliance based on observations of 100% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 857 1887 1424"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>89%</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the milieu are interacting with individuals, not simply observing them.</i></td> <td>91%</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>95%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>96%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>94%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>91%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and courteous manner.</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>96%</td> </tr> <tr> <td>10.</td> <td><i>Staff react calmly in an escalating situation.</i></td> <td>92%</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	89%	2.	<i>Some staff in the milieu are interacting with individuals, not simply observing them.</i>	91%	3.	<i>There are unit recognition programs.</i>	90%	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	95%	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	96%	6.	<i>Staff respect confidentiality.</i>	94%	7.	<i>Some staff are actively engaged in listening.</i>	91%	8.	<i>Staff interact with individuals in a respectful and courteous manner.</i>	98%	9.	<i>Staff respect privacy.</i>	96%	10.	<i>Staff react calmly in an escalating situation.</i>	92%
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		<p>Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for items 3, 4, 5, 8 and 9, and improved compliance for the remaining items:</p> <table border="1" data-bbox="991 376 1887 682"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>72%</td> <td>89%</td> </tr> <tr> <td>2.</td> <td>80%</td> <td>91%</td> </tr> <tr> <td>6.</td> <td>84%</td> <td>94%</td> </tr> <tr> <td>7.</td> <td>74%</td> <td>91%</td> </tr> <tr> <td>10.</td> <td>84%</td> <td>92%</td> </tr> </tbody> </table> <p>Other findings: A review of the charts of 12 individuals found that 11 contained milieu interventions appropriate to the active intervention (AG, BWB, CS, JTC, KS, NLP, RKH, TDB, TJM, UAQ and YMW) and one did not (JRM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			1.	72%	89%	2.	80%	91%	6.	84%	94%	7.	74%	91%	10.	84%	92%
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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 recommendations:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: The facility presented the following data on exercise groups:</p> <table border="1" data-bbox="991 1312 1871 1424"> <thead> <tr> <th></th> <th>12/10</th> <th>1/11</th> <th>2/11</th> <th>3/11</th> <th>4/11</th> <th>5/11</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>338</td> <td>301</td> <td>291</td> <td>282</td> <td>281</td> <td>293</td> </tr> </tbody> </table>		12/10	1/11	2/11	3/11	4/11	5/11	Number of groups offered	338	301	291	282	281	293							
	12/10	1/11	2/11	3/11	4/11	5/11																	
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		Number of grps needed @ 1x/wk	75	72	75	75	78	78
		Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%
	<p>As the table above shows, NSH continues to provide sufficient numbers of exercise groups for individuals to participate in. When touring the units, this monitor observed postings of activities on the units.</p> <p>The facility also presented the following data:</p>							
		BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned			
		25 - 30	451	348	77%			
		31 - 35	286	233	81%			
		36 - 40	125	99	79%			
		>40	84	72	85%			
	<p>Staff interview indicated that individuals with medical and physical issues were not enrolled in exercise groups.</p> <p>This monitor reviewed charts of five individuals with high BMIs (CS, DBP, GMW, MLL and RJF). Four of the individuals were enrolled in exercise groups but not DPB, though he is in a leisure group. In the case of RJF, WRP documentation in the Present Status section showed that the individual's BMI is 51 and that he does not attend the exercise groups. The weight gain is attributed to his medication (Seroquel and perphenazine). The WPRT has allocated By Choice points to motivate him to attend his groups and has had multiple discussions with him about food and exercise. This case should be referred to PBS for assessment and intervention, given the high risk and non-adherence. GMW has a BMI of 39.1; a focus had recently been opened with in intervention to have him in a "Nature Walk" group, and documentation shows that he is attending some of his walking groups. CS has a BMI of 38.18 and has an open focus</p>							

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		<p>for walking through supplemental activities and leisure activities. The individual had indicated he wanted to drop Art group to focus on walking. MLL, with a BMI of 40.3, had been enrolled in a Fitness group but there is no discussion in the Present Status section about his participation in the groups.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
C.2.k	<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, January 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 1005 1883 1414"> <tr> <td data-bbox="991 1005 1066 1154">1.</td> <td data-bbox="1066 1005 1753 1154"><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="1753 1005 1883 1154">100% (100%)</td> </tr> <tr> <td data-bbox="991 1154 1066 1378">2.</td> <td data-bbox="1066 1154 1753 1378"><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="1753 1154 1883 1378">97% (11%)</td> </tr> <tr> <td data-bbox="991 1378 1066 1414">3.</td> <td data-bbox="1066 1378 1753 1414"><i>Discharge: There is documentation in the Medical</i></td> <td data-bbox="1753 1378 1883 1414">100%</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100% (100%)	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	97% (11%)	3.	<i>Discharge: There is documentation in the Medical</i>	100%
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3.	<i>Discharge: There is documentation in the Medical</i>	100%									

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		<p><i>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></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>NSH had evaluated all individuals with a need for family therapy and provided family support, education, therapies as possible given the families' willingness and ability to participate.</p> <p>This monitor reviewed charts of 14 individuals with assessed need for family therapy (AG, AW, CB, CC, DB, DD, ES, GT, LM, MM, NH, RW, TC and TR). Documentation showed that all 14 individuals and/or their families were receiving appropriate information and/or services appropriate to their needs and ability and willingness to participate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	
<p>C.2.1</p>	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2011:</p> <ul style="list-style-type: none"> • Continue implementing and formalize facility-wide systems addressing and tracking non-adherence issues. • Ensure that WRPs addressing refusals are individualized, addressing the reason for refusals. 	

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	<p>accepted professional standards of care.</p>	<p>Findings: See F.7.b.ii.</p> <p>Recommendation 3, January 2011: 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 11% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="993 636 1887 1011"> <tr> <td>1.</td> <td><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate interventions for each objective.</i></td> <td>98%</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 (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found that NSH has continued to make consistent improvements in this area since the last review, resulting in the majority of the WRPs reviewed for Focus 6 including appropriate objectives and interventions. This comports with</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	96%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	98%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	98%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	99%	5.	<i>There are appropriate interventions for each objective.</i>	98%
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		<p>NSH's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because NSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 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. <p>Findings: The following is a summary of significant activities during this review period:</p> <p>1. The Coordinator of SRS has collaborated with the Acting Medical</p>

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		<p>Director, Acting Assistant Medical Director and Chief of Medical Ancillary Services to update all Administrative Directives related to use of opiates and illicit substance use to increase effectiveness and treatment outcomes. Projected completion date is September 2011. The directives include the following:</p> <ol style="list-style-type: none"> a. AD 553 Pain Management; b. AD 557 Comprehensive Substance Recovery Services; and c. AD 764 Drug Testing as a Component of Substance Recovery for Individuals Served. <ol style="list-style-type: none"> 2. The facility revised its Mall Procedures 9.1, Screening for Substance Recovery Services and 9.3, Determining Stage for Individual in Substance Recovery Treatment to reflect the use of the Readiness Ruler in place of the URICA and revised referral process for the screening of individuals. 3. SRS provided training to all admission social workers regarding the use of the Readiness Ruler. 4. Developed Mall Procedure 9.5, Unit-Based AA/NA Meetings in response to the suspension of community-led AA/NA meetings due to safety and security issues following last fall's tragedy. 5. Revised Mall Procedure 9.4, Hospital Wide AA/NA Meetings to include implementation of a Spanish-language AA meeting at the S-Complex Morning Mall with a community provider. SRS is awaiting approval from Executive Policy Team to resume community-led AA/NA meetings. 6. SRS staff have been added to the notification list for any confirmed positive urine drug screens. In response to positive screens SRS has provided on-site consultation to units including education, materials, debriefings, and recommendations for treatment enhancement and for safety and security measures. 7. SRS established a partial day program which consists of core Substance Recovery (SR) groups staged at preparation and action, maintenance, and contemplation. These groups were complemented by four supportive SR groups during the morning Mall hours to integrate
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		<p>SR knowledge, improve practical application and practice skills learned in the core treatments groups. This is intended to improve outcome measures and especially discharge readiness for CONREP.</p> <p>8. SRS has collaborated with the Pain Management Committee and offered pain management groups. The group objectives were to identify and address addictive thinking and behavior patterns related to opiate and other potentially addictive prescription medications for those individuals identified as high risk or who are requesting the group.</p> <p>9. SRS is collaborating with the forensic service to institute a referral system to address inconsistencies regarding substance abuse history during discharge planning.</p> <p>10. The Substance Recovery Advisory Committee (SRAC) has continued to address high-risk substance use and contraband-related situations. The committee included professional experts, providers and members of the Hospital Police Special Operations Team and K9 unit.</p> <p>In addition, monthly state wide SRS teleconferences were initiated in May 2011 chaired by HOM team member Dr. Charles Broderick. The goal was to facilitate the standardization of SRS screening and treatment across the facilities.</p> <p>Recommendation 3, January 2010: Same as C.2.o.</p> <p>Findings: Same as C.2.o.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Provide process and clinical outcome data for substance abuse services during the review period.</p> <p>Findings: The following is a summary of the facility's data regarding process outcomes:</p> <table border="1" data-bbox="991 560 1908 1421"> <thead> <tr> <th>Indicators</th> <th>Jul-Sep 10</th> <th>Oct-Dec 10</th> <th>Jan-Mar 11</th> <th>Apr-Jun 11</th> </tr> </thead> <tbody> <tr> <td>Total individuals with Substance Abuse diagnosis</td> <td>717</td> <td>705</td> <td>692</td> <td>691</td> </tr> <tr> <td>Total individuals screened including admission URICA</td> <td>198</td> <td>41</td> <td>23</td> <td>348</td> </tr> <tr> <td>Individuals screened in alternate languages</td> <td>14</td> <td>0</td> <td>0</td> <td>9</td> </tr> <tr> <td>Number of individuals receiving additional/ expanded screenings with Addiction Severity Index</td> <td>14</td> <td>5</td> <td>0</td> <td>9</td> </tr> <tr> <td>Number of individuals to be screened</td> <td>26</td> <td>39</td> <td>8</td> <td>6</td> </tr> <tr> <td>Number/Hours of group interventions offered per week (excluding NA/AA)</td> <td>84/146</td> <td>87/140</td> <td>108/184</td> <td>95/181</td> </tr> <tr> <td>• Pre-contemplation groups</td> <td>44</td> <td>43</td> <td>67</td> <td>57</td> </tr> <tr> <td>• Contemplation groups</td> <td>35</td> <td>33</td> <td>50</td> <td>40</td> </tr> <tr> <td>• Preparation groups</td> <td>24</td> <td>18</td> <td>25</td> <td>35</td> </tr> <tr> <td>• Action groups</td> <td>22</td> <td>18</td> <td>23</td> <td>30</td> </tr> <tr> <td>• Maintenance groups</td> <td>6</td> <td>8</td> <td>16</td> <td>19</td> </tr> <tr> <td>• All Stages groups</td> <td>12</td> <td>17</td> <td>N/A</td> <td>N/A</td> </tr> </tbody> </table>	Indicators	Jul-Sep 10	Oct-Dec 10	Jan-Mar 11	Apr-Jun 11	Total individuals with Substance Abuse diagnosis	717	705	692	691	Total individuals screened including admission URICA	198	41	23	348	Individuals screened in alternate languages	14	0	0	9	Number of individuals receiving additional/ expanded screenings with Addiction Severity Index	14	5	0	9	Number of individuals to be screened	26	39	8	6	Number/Hours of group interventions offered per week (excluding NA/AA)	84/146	87/140	108/184	95/181	• Pre-contemplation groups	44	43	67	57	• Contemplation groups	35	33	50	40	• Preparation groups	24	18	25	35	• Action groups	22	18	23	30	• Maintenance groups	6	8	16	19	• All Stages groups	12	17	N/A	N/A
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	<ul style="list-style-type: none"> • Monolingual Spanish groups 	3	3	3	1										
	<ul style="list-style-type: none"> • AA/NA groups 	4	3	0	12										
	Group interventions scheduled	1041	1002	747	864										
	Group interventions held	650 (62%)	681 (68%)	578 (77%)	663 (77%)										
	Number of individuals enrolled in group interventions (excluding AA/NA):	633	686	634	549										
	<ul style="list-style-type: none"> • Pre-contemplation 	235	257	221	109										
	<ul style="list-style-type: none"> • Contemplation 	162	164	142	68										
	<ul style="list-style-type: none"> • Preparation 	64	96	82	34										
	<ul style="list-style-type: none"> • Action 	82	117	76	31										
	<ul style="list-style-type: none"> • Maintenance 	62	34	28	13										
	<ul style="list-style-type: none"> • Monolingual Spanish 	14	18	18	9										
	<ul style="list-style-type: none"> • AA/NA (average weekly attendance) 	65	30	36	90										
	<ul style="list-style-type: none"> • AA/NA (number of non-distinct individuals attending AA/NA) 	853	354	450	879										
<p>The following is a summary of NSH's clinical outcome data during the quarter of April-June 2011.</p> <table border="1"> <thead> <tr> <th>Indicators</th> <th>Apr-Jun 11</th> </tr> </thead> <tbody> <tr> <td>Number enrolled on first day of quarter</td> <td>549</td> </tr> <tr> <td>Advanced at least one stage of change or sustained in maintenance</td> <td>296/54%</td> </tr> <tr> <td>Refused treatment or regressed at least one stage of change</td> <td>77/14%</td> </tr> <tr> <td>Did not advance in stage of change</td> <td>176/32%</td> </tr> </tbody> </table>						Indicators	Apr-Jun 11	Number enrolled on first day of quarter	549	Advanced at least one stage of change or sustained in maintenance	296/54%	Refused treatment or regressed at least one stage of change	77/14%	Did not advance in stage of change	176/32%
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		Out to Court/Other/Discharged	294
		Number of individuals completing curriculum with repeat measures	31
		Pre/Post-Test Increase Score Mean	1%
		<p>The data for the previous three quarters (July 2010-September 2010, October 2010-December 2010 and January 2011-March 2011) are not presented here because the previous stage of change data were pulled from WaRMSS and based on assessments that were utilized by the WRPTs. During the last quarter (April to June, 2011), the outcome data regarding advancement in the stage of change were based on the following structured tools:</p> <ol style="list-style-type: none"> 1. The use of URICA as a screening tool for individuals who were admitted before April 1, 2011. 2. The use of the Readiness Ruler (RR) to assess the individual's stage of change subsequent to admission. <p>During the last quarter, the individuals' current Readiness Ruler score was compared to the last score the individuals had on the URICA. Due to this change in data collection, the data is not comparable to previous quarters. There are several reasons for the significant difference in the number of individuals showing change compared to the data prior to April 1, 2011:</p> <ol style="list-style-type: none"> 1. NSH utilizes pairs of the stages of change in Substance Recovery groups, (i.e., Pre-Contemplation-Contemplation, Preparation-Action). Thus when an individual advanced a stage within these pairings, the WRPTs may neglect to update the stage of change listed in the objective status in the WRP. Thus, by taking stage of change data from the WRP, the data tended to under-report stage advancement. 2. The Readiness Ruler is a self evaluation and many individuals assessed themselves at Maintenance. As a result, the assessment data for the 	

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		<p>April 2011 - June 2011 quarter were skewed toward Maintenance.</p> <p>3. The URICA on the other hand, skewed individuals toward Pre-Contemplation and Contemplation stages.</p> <p>Thus when the facility compared the individuals' scores on the URICA and the RR, a significant increase in percentage of individuals who advanced at least one stage of change was reported. The facility reported that during the fall of 2011, the facility's data will be based on the use of RR for all individuals with a substance abuse diagnosis and the score will be based on comparisons between RR scores upon admission and subsequent RR scores.</p> <p>The facility began piloting the NSH Staging Questionnaire as mentioned in the previous report. This questionnaire contains 14 items to assess readiness for change and appropriate stage of treatment. The questionnaire included operational criteria to minimize the subjectivity and bias of the individuals' self-evaluation using the Readiness Ruler (RR) and addressed other possible limitations of the RR method (e.g. its validity for individuals who are psychiatrically unstable upon admission and for individuals who are cognitively impaired). The use of this questionnaire would also allow for comparisons across facilities.</p> <p>The facility reported that SRS began to communicate directly with WRPTs about the results of the NSH Staging Questionnaires. This provides a mechanism to ensure that objective and standardized methods are utilized in developing WRPs and that groups is appropriate to the stage of change</p> <p>The pre- and post-test outcome data were based on an academic knowledge test and do not have a direct relationship to the team's or the individuals' assessment of stage of change.</p> <p>The following is a summary of the facility's consumer satisfaction</p>
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		<p>surveys:</p> <table border="1"> <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>Learned new skills</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>124</td> <td>36</td> <td>62</td> <td>130</td> </tr> <tr> <td>• Disagree</td> <td>15</td> <td>6</td> <td>8</td> <td>12</td> </tr> <tr> <td>Group was helpful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>134</td> <td>39</td> <td>69</td> <td>137</td> </tr> <tr> <td>• Disagree</td> <td>5</td> <td>3</td> <td>1</td> <td>6</td> </tr> <tr> <td>Understood information</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>129</td> <td>40</td> <td>63</td> <td>134</td> </tr> <tr> <td>• Disagree</td> <td>10</td> <td>2</td> <td>7</td> <td>8</td> </tr> <tr> <td>Group leader respectful</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Agree</td> <td>138</td> <td>42</td> <td>70</td> <td>139</td> </tr> <tr> <td>• Disagree</td> <td>1</td> <td>0</td> <td>0</td> <td>2</td> </tr> </tbody> </table> <p>Using the DMH Substance Abuse Auditing Form, NSH assessed its compliance with this requirement based on an average sample of 16% of individuals with a current diagnosis of substance abuse (December 2010 - May 2011). The facility reported compliance rates ranging from 99% to 100% with the previously mentioned six indicators. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Recommendation 3, January 2010: Continue to provide a summary of any process improvements in the delivery of SRS.</p> <p>Findings: Same as in C.2.n.</p>	Indicators	Jan-Mar 10	Apr-Jun 10	Jul-Sep 10	Oct-Dec 10	Learned new skills					• Agree	124	36	62	130	• Disagree	15	6	8	12	Group was helpful					• Agree	134	39	69	137	• Disagree	5	3	1	6	Understood information					• Agree	129	40	63	134	• Disagree	10	2	7	8	Group leader respectful					• Agree	138	42	70	139	• Disagree	1	0	0	2
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		<p>Other findings: The monitor observed the following substance use education groups:</p> <ul style="list-style-type: none"> • Substance Recovery (Maintenance Stage), facilitated by Michelle Bowie, RN, Supervising Registered Nurse, Substance Recovery Services; • Substance Recovery - Enhancing Motivation (Pre-Contemplation Stage), facilitated by Jack Aamot, PsyD, Staff Psychologist; and • Smart Recovery (all stages), facilitated by individual MG and co-facilitated by Barry Wagener, RN, Mall Services. <p>There was general evidence of adequate instruction and content of education, relevance of material to individuals' needs and engagement of the individuals during sessions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement, including process and clinical outcome data and modify services to enhance outcomes.</p>
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, January 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 11% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (December 2010 - May 2011):</p>

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		Previous review period	Current review period
1.	<i>Instructional skills</i>	99%	98%
2.	<i>Course structure</i>	98%	97%
3.	<i>Instructional techniques</i>	99%	98.5%
4.	<i>Learning process</i>	98%	98%

Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.

Using the DMH Mall Facilitator Observation Monitoring Form NSH assessed compliance from observation of an 8% sample of all facilitators during the review months (December 2010 - May 2011):

1.	<i>Session starts and ends on time.</i>	95%
2.	<i>Facilitator greets participants to begin the session.</i>	99%
3.	<i>There is a brief review of work from prior session.</i>	97%
4.	<i>Facilitator introduces the day's topic and goals.</i>	99%
5.	<i>Facilitator shows familiarity with lesson plan and materials.</i>	98%
6.	<i>Facilitator attempts to engage each participant in the session.</i>	99%
7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	98%
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>	98%

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		<table border="1"> <tr> <td data-bbox="989 191 1066 267">11.</td> <td data-bbox="1066 191 1774 267"><i>At conclusion, the facilitator summarizes the work done in the session.</i></td> <td data-bbox="1774 191 1894 267">96%</td> </tr> <tr> <td data-bbox="989 267 1066 418">12.</td> <td data-bbox="1066 267 1774 418"><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 data-bbox="1774 267 1894 418">98%</td> </tr> <tr> <td data-bbox="989 418 1066 495">13.</td> <td data-bbox="1066 418 1774 495"><i>The room is arranged in a way that is as conducive to learning as possible.</i></td> <td data-bbox="1774 418 1894 495">97%</td> </tr> <tr> <td data-bbox="989 495 1066 532">14.</td> <td data-bbox="1066 495 1774 532"><i>Lesson plan is available and followed.</i></td> <td data-bbox="1774 495 1894 532">98%</td> </tr> </table> <p data-bbox="989 573 1894 641">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="989 683 1140 751">Compliance: Substantial.</p> <p data-bbox="989 797 1457 865">Current recommendation: Continue to monitor this requirement.</p>	11.	<i>At conclusion, the facilitator summarizes the work done in the session.</i>	96%	12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	98%	13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	97%	14.	<i>Lesson plan is available and followed.</i>	98%
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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="989 906 1577 938">Current findings on previous recommendation:</p> <p data-bbox="989 980 1457 1049">Recommendation, January 2010: Continue to monitor this requirement.</p> <p data-bbox="989 1091 1894 1382">Findings: Staff interview and documentation review showed that since the last review, NSH continued to train SRS providers. Twenty-two new staff were trained during this review period. Continued training is provided to new employees and nursing staff. NSH also provides training for 27 psychiatric technician interns who train regularly at NSH. Dr. Steven Grinstead provided a full-day training (June 27, 2011) on addiction and chronic pain management.</p>												

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		<p>NSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="993 302 1885 456"> <tr> <td>Number of Substance Recovery Services (SRS) providers/co-providers</td> <td>72</td> </tr> <tr> <td>Number of certified SRS providers/co-providers</td> <td>72</td> </tr> <tr> <td>Percentage of SRS providers/co-providers who are certified</td> <td>100%</td> </tr> </table> <p>As seen in the table above, all providers at NSH who facilitated SRS groups during this review period were certified per facility policy.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Number of Substance Recovery Services (SRS) providers/co-providers	72	Number of certified SRS providers/co-providers	72	Percentage of SRS providers/co-providers who are certified	100%																	
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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, January 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="993 1159 1854 1386"> <thead> <tr> <th colspan="6">Missed Appointments Monitoring - Outside Facility Medical service</th> </tr> <tr> <th rowspan="2"></th> <th colspan="2">Appointments</th> <th colspan="3">Reasons for Cancellation</th> </tr> <tr> <th>Scheduled</th> <th>Cancelled</th> <th>Staffing</th> <th>Transportation</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Dec 10</td> <td>1071</td> <td>131</td> <td>66</td> <td>1</td> <td>Not given</td> </tr> </tbody> </table>	Missed Appointments Monitoring - Outside Facility Medical service							Appointments		Reasons for Cancellation			Scheduled	Cancelled	Staffing	Transportation	Other	Dec 10	1071	131	66	1	Not given
Missed Appointments Monitoring - Outside Facility Medical service																									
	Appointments		Reasons for Cancellation																						
	Scheduled	Cancelled	Staffing	Transportation	Other																				
Dec 10	1071	131	66	1	Not given																				

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		Jan 11	1038	109	44	5	Not given
		Feb 11	1016	56	47	6	Not given
		Mar 11	955	147	15	0	Not given
		Apr 11	807	69	16	0	Not given
		May 11	800	113	11	0	Not given
		Total	5687	625 (10%)	199 (31%)	12 (2%)	414 (67%)

As shown in the table above, more than 30% of cancellations were staffing-related, with few cancellations due to transportation. NSH needs to analyze the "other" reasons for cancellation to address this most significant cause of cancelled appointments.

According to NSH, cancellations attributed "staffing" were due to the requirement that that two staff accompany individuals for off-site activities. The facility found it extremely difficult to pull that many staff at a time for appointments given all the other off-unit activities that occur daily in the facility. According to the Mall Director, the rate of cancellations due to "staffing" began decreasing as staffing escort ratios for the "open" unit individuals were altered. The facility is exploring alternatives for escorting so that cancellations due to staffing continue to decrease.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

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<p>C.2.s</p>	<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, January 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 11% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011) 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 WRPs of ten individuals found that nine WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (ALF, AW, CS, DKB, JRM, KS, RAM, SAR and TDB); the teams had enrolled the individuals in groups that address their risks, medical and psychiatric conditions, leisure and supplemental interests, life goals, and discharge criteria needs. One WRP (FMC) did not meet all elements of this requirement. In some cases, the WRPTs have offered rationales for their decisions to not enroll individuals in certain groups or in the maximum of 20 hours of PSR Mall services. For example, JRM's team indicated that they decided to enroll him in 16 hours of PSR Mall services as he gets overwhelmed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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<p>C.2.t</p>	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, NSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 seven individuals found that six WRPs met the elements of this requirement (AW, DKB, FM, JRM, RJF and RW) and the remaining WRP (ALF) was missing one or more elements or did not satisfy the criteria for this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.u</p>	<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, January 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data:</p>

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		<table border="1" data-bbox="991 228 1824 605"> <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>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> <th>Apr-Jun 2011</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>1143</td> <td>1154</td> <td>1155</td> <td>1145</td> </tr> <tr> <td>Receiving service</td> <td>987</td> <td>954</td> <td>902</td> <td>894</td> </tr> <tr> <td>% receiving service</td> <td>86%</td> <td>83%</td> <td>78%</td> <td>78%</td> </tr> </tbody> </table> <p data-bbox="991 646 1892 824">As the table above shows, NSH is serving less than 90% of the individuals in need of WRP education. NSH should ensure that all individuals, in the absence of a justifiable reason otherwise, are enrolled in WRP education groups to ensure that they receive timely information to progress towards discharge.</p> <p data-bbox="991 870 1902 1049">According to the Mall Director, Mall groups that offer WRP education include Personal Wellness, WRP Education, and Orientation. A review of the records of nine records found that eight individuals were enrolled in a WRP education group (BX, FJU, FKM, MGG, MWP, PM, SH and TDB) and one was not (RAM).</p> <p data-bbox="991 1094 1140 1157">Compliance: Substantial.</p> <p data-bbox="991 1203 1457 1266">Current recommendation: Continue to monitor this requirement.</p>	Individuals in need of WRP Education during the current and previous three Mall terms						Jul-Sept 2010	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	With identified need	1143	1154	1155	1145	Receiving service	987	954	902	894	% receiving service	86%	83%	78%	78%
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C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and	Current findings on previous recommendation:																									

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	<p>staff regularly asks individuals about common and/or serious side effects they may experience.</p>	<p>Recommendation, January 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 facility provided the following data:</p> <table border="1" data-bbox="991 561 1873 824"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>Jul-Sep 2010</th> <th>Oct-Dec 2010</th> <th>Jan-Mar 2011</th> <th>Apr-Jun 2011</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>654</td> <td>640</td> <td>645</td> <td>638</td> </tr> <tr> <td># of individuals receiving service</td> <td>562</td> <td>559</td> <td>540</td> <td>512</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor 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.</p>	Individuals Needing and Provided Medication Education Groups						Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	# of individuals needing service	654	640	645	638	# of individuals receiving service	562	559	540	512
Individuals Needing and Provided Medication Education Groups																						
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# of individuals needing service	654	640	645	638																		
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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 recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Implement the plan to assist individuals not going to assigned treatment activities [described in cell C.2.i.x]. • Continue to monitor this requirement. 																				

Findings:

The table below showing the mean census for the previous and current review periods and the mean number of individuals meeting the non-adherence criteria is a summary of the facility's data:

Number of Individuals Non-Adherent to WRP							
	12/10	1/11	2/11	3/11	4/11	5/11	Mean
Avg Monthly Census	1148	1158	1158	1150	1146	1146	1151
Zero Attendance	145	120	98	92	80	68	101
%C	13%	10%	8%	8%	7%	6%	9%

The table above shows that a mean of 9% of individuals met the non-adherence criteria during this review period. This data would mean that over 90% of the individuals are attending at least one of their scheduled Mall groups each month of the review period.

According to NSH, one full-time and two part-time (retired annuitant) NRT therapists are providing services to individuals in need. Data were not presented for the cases served by these NRT staff. According to NSH, beginning in August 2011, the NRT staff will interview individuals to assess and address the reasons for the non-adherence, e.g., group selection, motivational issues, and psychiatric stability. According to NSH, this will allow them to work with existing resources to resolve barriers to treatment participation.

According to NSH, 80% of the non-adherent individuals were from the 10 locked units in the STA. Mall Services is working with units to identify and resolve systems issues impacting non-adherence. However, the facility did not indicate what the systems issues might be.

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		<p>NSH also stated that 20% of the non-adherent individuals were transferred or admitted during the 30 days measured. Mall services plans on contacting the WRPTs to assist in group enrollment if necessary. It is difficult to understand why the WRPTs should not be addressing this issue, and require Mall Services assistance. The WRPTs should know when an individual is transferred and it is the WRPT that assigns individuals to Mall groups.</p> <p>NSH has also decided to consult with PBS for individuals who "refuse treatment." PBS is expected to conduct strengths-based interviews, identify motivation for treatment, and if deemed appropriate develop a PBS plan. NSH did not present data on the number of individuals referred to PBS since March 2011.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses: NSH has maintained substantial compliance with most requirements in section D.1. Since the implementation of the EP, the facility has significantly strengthened its practice with the exception of a few wobbles. The timeliness and substance of initial/brief admission, integrated/comprehensive and inter-unit transfer assessments align with EP requirements.</p> <p>Areas of need include:</p> <ol style="list-style-type: none"> 1. <i>During this review period, facility compliance with the requirements in Section D.1 regarding psychiatric reassessments has declined. The primary reason is that the facility did not adequately address a significant finding previously made by this monitor regarding a breakdown of the system of psychiatric coverage/reassessments during absences of the attending psychiatrist and despite warnings by this monitor about the gravity of that situation and its potential for tragic outcomes. This finding was mentioned in Reports 8 and 9 and discussed with all concerned parties in person. The facility needs to strengthen its medical leadership function. This is essential to adequately correct significant and recurrent breakdown points that have significant potential for harm to the individuals.</i> 2. <i>Ensure that psychiatric reassessments consistently include adequate linkage between the rationale for psychopharmacological management plans and the current status of the individual as described in the interval history, mental status examination and diagnosis.</i> 3. <i>Improve timeliness of the weekly psychiatric reassessments.</i> <p>Summary of Progress on Psychological Assessments: As of the tour conducted in December 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</p>

Section D: Integrated Assessments

		<p>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:</p> <ol style="list-style-type: none">1. As of this tour, NSH has maintained substantial compliance with all requirements of this section for 18 months (four consecutive tours).2. The facility needs to maintain the current nursing mentoring and training system to continue to produce clinically focused nursing admission assessments. <p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <p>As of this tour, NSH has maintained compliance with all of the requirements of this section for 18 months (four consecutive tours) and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments:</p> <p>As of this tour has maintained compliance with all of the requirements of this section for 18 months (four consecutive tours) and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Social History Assessments:</p> <p>As of the tour conducted in January 2011, 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 and DMH now has responsibility for oversight and maintenance of compliance.</p> <p>Summary of Progress on Court Assessments:</p> <p>As of the tour conducted in January 2011, 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 and DMH now has responsibility for oversight and 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, DO, 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 29 individuals: AAL, AW, CWS, DJS, ELN, FBT, FKM, FR, JAS, JCS, JJB, JTS, KLF, KS, LRJ, MCA, MGG, MJP, MRO, MSH, OJR, PEM, PMP, RKH, RT, SJD, TGP, TNN and VH 2. Monthly Psychiatric Progress Notes for the following 48 individuals: AAB, AR, AW, BE, BF, CCD, CM, DAL, DB, DDF, DLJ, ES, FAD, GB-1, GB-2, JAW, JB, JJR, JK-1, JK-2, KFR, KLF, LG, LHM, LK, MC, MLL, MLS, MMF, MNR, PDD, RB-1, RB-2, RB-3, RFH, RG, RH, RS, RWE, SLH, TC, TG, TLR, TN, VC, WB, WLB and WP 3. Memorandum from Acting Medical Director, Psychiatric Coverage and Second Position Utilization, dated July 25, 2011 4. Documentation of reviews by psychology and the chief psychiatrist in the chart of NH 5. Admission assessments (brief and comprehensive) for D.1 charts 6. NSH Comprehensive Psychiatric Assessment summary data (December 2010 - May 2011) 7. NSH Medical Initial Admission Assessment Auditing summary (December 2010 - May 2011) 8. NSH Monthly PPN Audit summary data (December 2010 - May 2011) 9. NSH Weekly PPN Auditing summary data (December 2010 - May 2011) 10. NSH Physician Transfer Note Auditing summary (December 2010 - May 2011)

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<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Integrated/Comprehensive Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (December 2010 - May 2011). The average samples were 26% of integrated/comprehensive assessments and 11% 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="1001 672 1898 1049"> <thead> <tr> <th colspan="3">Integrated/Comprehensive Assessment</th> </tr> </thead> <tbody> <tr> <td>9.</td> <td><i>There is documentation that includes current psychiatric diagnoses</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>That includes psychiatric history, including a review of present and past history</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>There is documentation that includes diagnostic formulation; past history, history of present illness, and mental status exam to justify the diagnosis</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>If a differential diagnosis is documented, there is documentation as applicable, to finalize the diagnosis</i></td> <td>95%</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="1001 1196 1898 1419"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.</td> <td><i>The monthly progress note contains the following:</i></td> <td></td> </tr> <tr> <td>3.a</td> <td><i>The 5 Axis diagnoses</i></td> <td>100%</td> </tr> <tr> <td>3.c</td> <td><i>A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.</i></td> <td>90%</td> </tr> </tbody> </table>	Integrated/Comprehensive Assessment			9.	<i>There is documentation that includes current psychiatric diagnoses</i>	100%	2.	<i>That includes psychiatric history, including a review of present and past history</i>	98%	7.	<i>There is documentation that includes diagnostic formulation; past history, history of present illness, and mental status exam to justify the diagnosis</i>	100%	8.	<i>If a differential diagnosis is documented, there is documentation as applicable, to finalize the diagnosis</i>	95%	Monthly PPN			3.	<i>The monthly progress note contains the following:</i>		3.a	<i>The 5 Axis diagnoses</i>	100%	3.c	<i>A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.</i>	90%
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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>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.															
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</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</th> <th>Previous Period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Direct care (FTE)</td> <td>54</td> <td>54</td> </tr> <tr> <td>Supervisory (FTE)</td> <td>12</td> <td>12</td> </tr> <tr> <td>Board-certified</td> <td>44 (68%)</td> <td>44 (68%)</td> </tr> <tr> <td>Board-eligible</td> <td>21 (32%)</td> <td>21 (32%)</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>	Psychiatric positions	Previous Period	Current period	Direct care (FTE)	54	54	Supervisory (FTE)	12	12	Board-certified	44 (68%)	44 (68%)	Board-eligible	21 (32%)	21 (32%)
Psychiatric positions	Previous Period	Current period															
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		<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>Recommendation 1, January 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Provide information of the number and percentage of psychiatrists who were repriviledged during the review period using the current PPQPP. <p>Findings: All nine psychiatrists who were scheduled for re-privileging during this reporting period were re-priviledged using the quality indicators that were described previously.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide information of the number and percentage of psychiatrists who were repriviledged during the review period using the current PPQPP.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>
D.1.c.i	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, NSH</p>

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		<p>assessed compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 58% of admissions each month during the review period (December 2010 - May 2011). The facility reported mean compliance rates of 98% with the requirements in D.1.c.i and D.1.c.i.1 to D.1.c.i.5 and 99% with the completion of a plan of care including preventive health screening and health maintenance. 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: A review of the charts of ten individuals (AAL, DJS, ELN, FKM, JCS, LRJ, MGG, MJP, TGP and TNN) found evidence of substantial compliance in all cases. The assessments were completed in nine charts and one individual refused the examination with documentation of appropriate follow-up attempts to complete the examination (ELN).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent completion of the violence risk assessment within 24 hours of admission.
D.1.c.i.1	a review of systems;	Same as above.
D.1.c.i.2	medical history;	Same as above.
D.1.c.i.3	physical examination;	Same as above.
D.1.c.i.4	diagnostic impressions; and	Same as above.
D.1.c.i.5	management of acute medical conditions;	Same as above.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p>

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		<p>Findings:</p> <p>During this review period, NSH implemented streamlined templates for a "Brief Admission Psychiatric Assessment" to be completed within 24 hours of admission (if the admission occurred off-hours and the on-call psychiatrist, not the attending psychiatrist, has completed the assessment) and a "Comprehensive Psychiatric Assessment" to be completed within 24 hours (by the attending psychiatrist if the admission occurred during work hours) or within seven days of admission (if the Brief Admission Assessment had been completed by the on-call psychiatrist). This means that all individuals would have received either brief assessment within 24 hours and a comprehensive assessment within seven days or a comprehensive assessment within 24 hours. The purpose of the streamlined template was to reduce paperwork while meeting generally accepted standards in the timeliness and content of the admission assessment.</p> <p>The facility undertook a pilot project from 12/07/10 to 12/31/10 assessing the feasibility of the new assessment tools and held mandatory training sessions on April 21 and 26, 2011, providing instruction to the remaining psychiatrists before the new assessments were implemented on May 1, 2011. A Comprehensive Psychiatric Assessment auditing tool was employed to monitor documentation compliance.</p> <p>The facility reported that all individuals admitted to NSH received a psychiatric assessment including a psychopharmacology plan and plan to address identified risks within 24 hours of admission. The facility reported that the assessments were in accordance with the Joint Commission standards and requirements of Title 22. As of this tour, this monitor will request self-auditing data only for the integrated/comprehensive assessments.</p> <p>The charts of ten individuals were reviewed to assess the timeliness and</p>
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		<p>content of the admission assessment within 24 hours of admission. Three of these individuals (DJS, FKM and LRJ) had a comprehensive assessment completed within 24 hours and are addressed in D.1.c.iii. Six individuals (AAL, JCS, MGG, MJP, TGP and TNN) had assessments completed using the initial tool and one individual (ELN) received admission assessment using the newer brief tool. Of these seven assessments, five were in substantial compliance (ELN, JCS, MGG, MJP and TNN) and one (TGP) was in partial compliance (due to incomplete violence risk assessment). There was evidence of non-compliance in the assessment of AAL (due to lack of a violence risk assessment).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent and adequate completion of the risk assessment as part of the initial/brief assessment.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	Same as above.
D.1.c.ii.2	complete mental status examination;	Same as above.
D.1.c.ii.3	admission diagnoses;	Same as above.
D.1.c.ii.4	completed AIMS;	Same as above.
D.1.c.ii.5	laboratory tests ordered;	Same as above.
D.1.c.ii.6	consultations ordered; and	Same as above.
D.1.c.ii.7	plan of care.	Same as above.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement and ensure completion of the integrated assessments in all cases.</p>

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		<p>Findings: Using the DMH Integrated/Comprehensive Assessment Psychiatry Section Audit, the facility a sample of 26% of Integrated/Comprehensive Assessments due each month during the review period (December 2010 - May 2011). The compliance rates ranged from 94% to 100% for all the requirements in D.1.c.iii. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all cells in D.1.c.iii.</p> <p>Other findings: The charts of ten individuals were reviewed including six individuals (AAL, JCS, MGG, MJP, TGP and TNN) whose assessments were completed using the older Integrated Assessment tool and four individuals (DJS, ELN, FKM and LRJ) who received assessments using the newer comprehensive assessment tools.</p> <p>This review found substantial compliance in seven cases (AAL, DJS, ELN, JCS, LRJ, MJP and TNN). The charts of three individuals were found in partial compliance due to violence risk assessments that were inadequate (TGP), incomplete (FKM) or inconsistent with the individual's history (MGG).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent and adequate completion of the risk assessment as part of the integrated/comprehensive assessment.
D.1.c.iii.1	psychiatric history, including a review of present and past history;	Same as above.

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D.1.c.iii.2	psychosocial history;	Same as above.															
D.1.c.iii.3	mental status examination;	Same as above.															
D.1.c.iii.4	strengths;	Same as above.															
D.1.c.iii.5	psychiatric risk factors;	Same as above.															
D.1.c.iii.6	diagnostic formulation;	Same as above.															
D.1.c.iii.7	differential diagnosis;	Same as above.															
D.1.c.iii.8	current psychiatric diagnoses;	Same as above.															
D.1.c.iii.9	psychopharmacology treatment plan; and	Same as above.															
D.1.c.iii.10	management of identified risks.	Same as above.															
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.															
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 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:</p> <table border="1"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2" style="text-align: center;">Number of individuals in category</td> </tr> <tr> <td>Rule Out</td> <td style="text-align: center;">11</td> <td style="text-align: center;">7</td> </tr> <tr> <td>Deferred</td> <td style="text-align: center;">2</td> <td style="text-align: center;">11</td> </tr> <tr> <td>NOS</td> <td style="text-align: center;">67</td> <td style="text-align: center;">90</td> </tr> </tbody> </table> <p>Given the current census in the facility, the above data indicate that NSH has maintained progress in the finalization and timely update of diagnoses.</p>	Diagnostic category	Previous Period	Current Period		Number of individuals in category		Rule Out	11	7	Deferred	2	11	NOS	67	90
Diagnostic category	Previous Period	Current Period															
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Rule Out	11	7															
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		<p>Recommendation 2, January 2010: Provide documentation of continuing medical education (CME) to psychiatry staff during the review period including data on the number and disciplines of attendees. Improve MD attendance at these activities.</p> <p>Findings: The monitor reviewed the facility's list of CME activities during the review period, including title of activity, speaker/affiliation and number of MD and other attendees. The review found that NSH has continued to provide comprehensive and adequate continuing education to its medical staff and that attendance at these events was variable.</p> <p>Other findings: The charts of the following 11 individuals who have received diagnoses listed as NOS for three or more months were reviewed:</p> <table border="1" data-bbox="1003 781 1887 1243"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>AW</td> <td>Psychosis NOS and Mood Disorder NOS</td> </tr> <tr> <td>FR</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>JAS</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>JJB</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>JTS</td> <td>Dementia NOS</td> </tr> <tr> <td>KLF</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>MCA</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>MSH</td> <td>Psychosis NOS</td> </tr> <tr> <td>OJR</td> <td>Dementia NOS</td> </tr> <tr> <td>PMP</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>SJD</td> <td>Psychotic Disorder NOS</td> </tr> </tbody> </table> <p>This review found substantial compliance in nine charts, partial compliance in one (FR) and noncompliance in one (JAS).</p>	Initials	Diagnosis (NOS)	AW	Psychosis NOS and Mood Disorder NOS	FR	Depressive Disorder NOS	JAS	Depressive Disorder NOS	JJB	Cognitive Disorder NOS	JTS	Dementia NOS	KLF	Psychotic Disorder NOS	MCA	Cognitive Disorder NOS	MSH	Psychosis NOS	OJR	Dementia NOS	PMP	Cognitive Disorder NOS	SJD	Psychotic Disorder NOS
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SJD	Psychotic Disorder NOS																									

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. Provide documentation of continuing medical education (CME) to psychiatry staff during the review period including data on the number and disciplines of attendees. Improve MD attendance at these activities.
D.1.d.ii	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 recommendations: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 recommendations: Same as in D.1.a and D.1.d.i.</p>
D.1.d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: 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> <p>Findings: The facility reported that only one individual (NH) received "no diagnosis" on Axis I during this review period and that a diagnosis of malingering was suspected.</p> <p>Other findings: This monitor reviewed progress note documentation in the chart of this individual and found evidence of adequate review and justification of the individual's diagnostic status.</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>

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<p>D.1.e</p>	<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, January 2010: Continue to monitor this requirement and ensure timely completion of the weekly psychiatric reassessments (during the first 60 days of hospitalization).</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 27% of individuals with length of stay less than 60 days during the review period (December 2010 - May 2011). 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 11% 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> <p>Other findings: This monitor reviewed the charts of ten individuals 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 substantial compliance in three charts (JCS, LRJ and MJP) and partial compliance in seven (AAL, DJS, ELN, FKM, MGG, TGP and TNN). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Improve timeliness of the weekly psychiatric reassessments.
D.1.f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure adequate assessment of the individual's response to the use of Stat medications. <p>Findings:</p> <p>NSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 11% 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 ranged from 96% to 98%. The facility's compliance data showed that it has maintained rates of at least 90% since the last review.</p> <p>Other findings:</p> <ol style="list-style-type: none"> 1. The facility did not adequately address a significant finding previously made by this monitor regarding a breakdown of the system of psychiatric coverage/reassessments during absences of the attending psychiatrist and despite warnings by this monitor about the gravity of that situation and the potential for a tragic outcome. This finding was mentioned in the exit notes of the ninth tour and the body of Report 9 and discussed with all concerned parties in person. 2. The monitor reviewed Psychiatric Progress Notes for the following 48 individuals: AAB, AR, AW, BE, BF, CCD, CM, DAL, DB, DDF, DLJ, ES, FAD, GB-1, GB-2, JAW, JB, JJR, JK-1, JK-2, KFR, KLF, LG, LHM, LK, MC, MLL, MLS, MMF, MNR, PDD, RB-1, RB-2, RB-3, RFH, RG, RH, RS, RWE, SLH, TC, TG, TLR, TN, VC, WB, WLB and WP. The review found general evidence of adequate reassessments. However, a number of

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charts included either inadequate linkage between the treatment plans and the individuals' status as described in the reassessments (e.g. AAB, BF, RB and WP) or inadequate overall content of the reassessment (e.g. FAD).

3. The monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period to assess the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The following table outlines the reviews:

Individual	Date of seclusion and/or restraint	PRN/Stat
FBT	4/1/11	Ziprasidone (PRN)
KS	4/2/11	Fluphenazine and lorazepam (PRN)
MRO	5/8/11	Lorazepam, haloperidol and benztropine (Stat)
RKH	5/5/11	Haloperidol (PRN)
RT	6/3/11 and 6/4/11	Lorazepam and chlorpromazine (PRN) partial
VH	4/17/11	Lorazepam (PRN)

This review found substantial compliance with the requirements regarding the use of emergency medications in five charts and partial compliance in one (VH).

Compliance:

Partial.

Current recommendations:

1. Strengthen the medical leadership function. This is needed to adequately address significant and recurrent breakdown points in the system of care (e.g. psychiatric coverage/reassessments during

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		<p>absences of the attending psychiatrists).</p> <p>2. Ensure that psychiatric reassessments consistently include adequate linkage between the rationale for psychopharmacological management plans and the current status of the individual as described in the interval history, mental status examination and diagnosis</p>
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	Same as above.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	Same as above.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	Same as above.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	Same as above.
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;	Same as above.
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	Same as above.
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	Same as above.

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	<p>to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>																			
<p>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 recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 21% of the individuals who experienced inter-unit transfer per month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="1003 932 1900 1162"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</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 for all items.</p> <p>Other findings: The charts of seven individuals who experienced inter-unit transfers during this review period were reviewed. The following is an outline:</p>	1.	<i>Psychiatric course of hospitalization,</i>	93%	2.	<i>Medical course of hospitalization,</i>	95%	3.	<i>Current target symptoms,</i>	97%	4.	<i>Psychiatric risk assessment,</i>	98%	5.	<i>Current barriers to discharge,</i>	98%	6.	<i>Anticipated benefits of transfer.</i>	99%
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		<table border="1" data-bbox="1003 228 1486 537"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>PEM</td> <td>4/4/11</td> </tr> <tr> <td>CWS</td> <td>4/20/11</td> </tr> <tr> <td>AAL</td> <td>5/19/11</td> </tr> <tr> <td>JCS</td> <td>5/25/11</td> </tr> <tr> <td>TNN</td> <td>5/27/11</td> </tr> <tr> <td>TGP</td> <td>5/31/11</td> </tr> <tr> <td>MGG</td> <td>6/8/11</td> </tr> </tbody> </table> <p data-bbox="1003 578 1896 683">There was evidence of substantial compliance in five charts (AAL, CWS, JCS, PEM and TNN). The assessments of MGG and TGP were in partial compliance due to generic plans of care.</p> <p data-bbox="1003 727 1150 792">Compliance: Substantial.</p> <p data-bbox="1003 837 1335 865">Current recommendations:</p> <ol data-bbox="1003 875 1829 943" style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistency in the individualization of the plans of care. 	Initials	Date of transfer	PEM	4/4/11	CWS	4/20/11	AAL	5/19/11	JCS	5/25/11	TNN	5/27/11	TGP	5/31/11	MGG	6/8/11
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MGG	6/8/11																	

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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 the tour conducted in December 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.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 generally accepted professional standards of care, shall:	
D.2.d.i	expressly state the clinical question(s) for	

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	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.viii	use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	
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	

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	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 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	

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	<p>questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	
<p>D.2.g</p>	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	

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3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Gary Walters, RN, Acting Nurse Administrator 2. Michelle Patterson, RN, ACNS 3. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Nursing Admission Assessment Monitoring Audit summary data, December 2010 - May 2011 2. NSH Nursing Integrated Assessment Monitoring Audit summary data, December 2010 - May 2011 3. Records for the following 39 individuals: AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML 4. NSH training rosters
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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 24% mean sample of admissions each month during the review period (December 2010 - May 2011) and</p>

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		<p>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>A review of Nursing Admission Assessments for 39 individuals (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found that NSH had maintained the quality of the Nursing Admission Assessments and all 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 27% mean sample of admissions each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 782 1890 933"> <tr> <td data-bbox="991 782 1087 933">1.</td> <td data-bbox="1087 782 1795 933"><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="1795 782 1890 933">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 39 individuals (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found that NSH had also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings also comport with NSH's data.</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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		<p>Other findings: The Statewide MH-C 9024 Comprehensive Nursing Assessment and MH-C 9025 Admission Nursing Assessment forms were revised and implemented in June 2011 on all the admission units (A9, T2, T3, T4 and Q7).</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 597 1887 898"> <tr> <td data-bbox="991 597 1087 898">2.</td> <td data-bbox="1087 597 1793 898"><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 597 1887 898">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 1117 1887 1305"> <tr> <td data-bbox="991 1117 1087 1305">2.</td> <td data-bbox="1087 1117 1793 1305"><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 1117 1887 1305">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%						

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D.3.a.iii	vital signs;	<p><u>Admission Assessments</u> 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> 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.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 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 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.vi	use of assistive devices;	<p><u>Admission Assessments</u> 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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		<p>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.vii	activities of daily living;	<p><u>Admission 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> <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 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.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>

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		<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.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: NSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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, January 2011: Continue current practice.</p> <p>Findings: NSH training rosters verified that all RNs who were required to complete competency-based training regarding Nursing Assessments attended and passed the training.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Substantial.</p>
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, NSH assessed its compliance based on a 24% mean sample of admissions each month during the review period (December 2010 - May 2011) and 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>A review of Nursing Admission Assessments for 39 individuals (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven	<p>Current findings on previous recommendation:</p>

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	<p>days of admission; and</p>	<p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, NSH assessed its compliance based on a 27% mean sample of admissions each month during the review period (December 2010 - May 2011) and reported a mean compliance rate of 90%. 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 39 individuals (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
<p>D.3.d.iii</p>	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, NSH assessed its compliance based on a mean sample of 28% of WRPCs observed each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1302 1917 1416"> <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>95%</td> <td>96%</td> </tr> </tbody> </table>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	95%	96%
	Previous period	Current period						
<i>Registered Nurse attendance at WRPC</i>	95%	96%						

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		<i>Psychiatric Technician attendance at WRPC</i>	82%	90%
<p>A review of the charts of 39 individuals (AAC, AB, ADS, AJM, AMK, BX, CCD, CCR, CJM, CRH, DAM, DAR, DHF, DJS, EN, JAW, JCG, JCP, JCQ, JLA, JW, KKG, KMB, KRB, KWC, MAP, MGG, MJP, MM, NH, PMM, SEC, SJR, SRW, SSR, TNN, TP, WLB and WML) found that an RN attended the WRPC in 38 cases and a PT attended the WRPC in 36 cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>				

4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Camille Gentry-Kaijankoski, Acting Chief of Rehabilitation Therapy Services 2. Jennie Gilmore, Acting Senior Rehabilitation Therapist 3. Jennifer Deterville, Acting Senior Rehabilitation Therapist 4. Phyllis Moore, Acting Senior Rehabilitation Therapist 5. 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 December 2010 - May 2011 2. Records of the following 14 individuals who had IA:RTS assessments from December 2010 - May 2011: AOS, AS, DT, DWW, ELN, JM, KJK, MBT, NH, PMB, RJC, RNB, RNB and WL 3. List of individuals who had Occupational Therapy assessments from December 2010 - May 2011 4. Records of the following four individuals who had Occupational Therapy assessments from December 2010 - May 2011: BE, JDK, JJR and RWS 5. List of individuals who had Physical Therapy assessments from December 2010 - May 2011 6. Records of the following six individuals who had Physical Therapy assessments from December 2010 - May 2011: KZ, MP, NA, PA, ZCP and ZEK 7. List of individuals who had Speech Therapy assessments from December 2010 - May 2011 8. Records of the following five individuals who had Speech Therapy assessments from December 2010 - May 2011: BMS, MDP, MER, MP and RJR 9. List of individuals who had Vocational Rehabilitation assessments

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		<p>from December 2010 - May 2011</p> <p>10. Records of the following six individuals who had Vocational Rehabilitation assessments from December 2010 - May 2011: ERN, GF, JCE, JLA, RG and SHT</p> <p>11. List of individuals who had CIPRTA assessments from December 2010 - May 2011</p> <p>12. Records of the following four individuals who had CIPRTA assessments from December 2010 - May 2011: JWS, MDP, MW and PM</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, January 2011: Continue current practice.</p> <p>Findings: 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: Revise and update current RT focused assessment tools 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>
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, January 2011: Continue to monitor this requirement.</p>

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		<p>Findings: 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 22% of Integrated Rehabilitation Therapy Assessments due each month for the review period December 2010 - May 2011 (total of 60 out of 268) 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 14 individuals to assess compliance of IA:RTS Assessments with timeliness found 13 records in compliance and one record not in compliance (RNB) as assessment was not in the record.</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 December 2010 - May 2011 (total of six) 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 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 71% of Physical Therapy Focused Assessments due each month for the review period December 2010 - May 2011 (total of 49 out of 69) and reported a mean compliance rate of 100%. Comparative data indicated that NSH maintained a compliance</p>
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		<p>rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found five records in compliance and one record not in compliance (NA).</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 87% of Speech Therapy Focused Assessments due each month for the review period December 2010 - May 2011 (total of 53 out of 61) 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 five 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 December 2010 - May 2011 (total of 10) 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 six 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</p>
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		<p>compliance with timeliness (14 days from referral) based on an average sample of 100% of CIPRTA assessments due each month for the review period December 2010 - May 2011 (total of 18) 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, January 2011: 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 22% of Integrated Rehabilitation Therapy Assessments due each month for the review period December 2010 - May 2011 (total of 60 out of 268) 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 13 individuals to assess compliance of IA:RTS Assessments with D.4.b.i 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.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period December 2010 - May 2011 (total of six) 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 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 71% of Physical Therapy Focused Assessments due each month for the review period December 2010 - May 2011 (total of 49 out of 69) 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 Physical Therapy Focused Assessments with D.4.b.i criteria found five records in substantial compliance and one record in partial compliance (ZEK).</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 87% of Speech Therapy Focused Assessments due each month for the review period December 2010 - May 2011 (total of 53 out of 61) 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 five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, 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 December 2010 - May 2011 (total of 10) 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 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 December 2010 - May 2011 (total of 18) 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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D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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 22% of Integrated Rehabilitation Therapy Assessments due each month for the review period December 2010 - May 2011 (total of 60 out of 268):</p> <table border="1" data-bbox="991 636 1885 786"> <tr> <td>3.</td> <td><i>Identifies the individual's current functional status, and</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The skills and supports needed to facilitate transfer to the next level of care;</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 13 individuals to assess compliance of IA:RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, 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 December 2010 - May 2011 (total of six):</p> <table border="1" data-bbox="991 1305 1885 1416"> <tr> <td>3.</td> <td><i>Identifies the individual's current functional status, and</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The skills and supports needed to facilitate transfer</i></td> <td>100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer</i>	100%
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D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p data-bbox="991 906 1577 938">Current findings on previous recommendation:</p> <p data-bbox="991 979 1457 1044">Recommendation, January 2011: Continue to monitor this requirement.</p> <p data-bbox="991 1089 1902 1304">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 22% of Integrated Rehabilitation Therapy Assessments due each month for the review period December 2010 - May 2011 (total of 60 out of 268):</p> <table border="1" data-bbox="991 1344 1887 1416"> <tr> <td data-bbox="991 1344 1087 1385">5.</td> <td data-bbox="1087 1344 1776 1385"><i>Identifies the individual's life goals,</i></td> <td data-bbox="1776 1344 1887 1385">100%</td> </tr> <tr> <td data-bbox="991 1385 1087 1416">6.</td> <td data-bbox="1087 1385 1776 1416"><i>Strengths, and</i></td> <td data-bbox="1776 1385 1887 1416">100%</td> </tr> </table>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%
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		<table border="1" data-bbox="991 191 1890 230"> <tr> <td data-bbox="991 191 1087 230">7.</td> <td data-bbox="1087 191 1776 230"><i>Motivation for engaging in wellness activities.</i></td> <td data-bbox="1776 191 1890 230">100%</td> </tr> </table> <p data-bbox="991 272 1890 341">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p data-bbox="991 383 1890 487">A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p data-bbox="991 529 1890 711">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 December 2010 - May 2011 (total of 18):</p> <table border="1" data-bbox="991 747 1890 863"> <tr> <td data-bbox="991 747 1087 786">5.</td> <td data-bbox="1087 747 1776 786"><i>Identifies the individual's life goals,</i></td> <td data-bbox="1776 747 1890 786">100%</td> </tr> <tr> <td data-bbox="991 786 1087 824">6.</td> <td data-bbox="1087 786 1776 824"><i>Strengths, and</i></td> <td data-bbox="1776 786 1890 824">100%</td> </tr> <tr> <td data-bbox="991 824 1087 863">7.</td> <td data-bbox="1087 824 1776 863"><i>Motivation for engaging in wellness activities.</i></td> <td data-bbox="1776 824 1890 863">100%</td> </tr> </table> <p data-bbox="991 906 1890 974">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p data-bbox="991 1016 1890 1120">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 data-bbox="991 1162 1142 1230">Compliance: Substantial.</p> <p data-bbox="991 1273 1457 1341">Current recommendation Continue to monitor this requirement.</p>	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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7.	<i>Motivation for engaging in wellness activities.</i>	100%												

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D.4.c	<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, January 2011: Continue to enhance current practice and provide training on updated integrated and focused assessment tools.</p> <p>Findings: The facility reported that one speech therapist required training on the speech therapy focused assessment and was trained to competency during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of the January 2010 tour.</p> <p>Compliance: Substantial.</p>

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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christen Adams, Clinical Dietitian 2. Deena Rosen, Assistant Director of Dietetics 3. Jessica Tuttle, Clinical Dietitian 4. Joanne Merrill, MA, Clinical Dietitian 5. Kumiko Kato, MPH, Clinical Dietitian 6. Laufey Gunnarsdottir, Clinical Dietitian 7. Linderpal Dhillon, Clinical Dietitian 8. Lynn Wurzel, Clinical Dietitian 9. Lynne Fredricksen, Assistant Director of Dietetics 10. Wen Pao, Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for December 2010 - May 2011 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from December 2010 - May 2011 for each assessment type 3. Records of the following three individuals with type D.5.a assessments from December 2010 - May 2011: JK, MB and ML 4. Records of the following two individuals with type D.5.b assessments from December 2010 - May 2011: BS and DS 5. Records of the following individual with type D.5.c assessment from December 2010 - May 2011: KB 6. Records of the following five individuals with type D.5.d assessments from December 2010 - May 2011: AW, JS, LH, MP and RD 7. Records of the following six individuals with type D.5.e assessments from December 2010 - May 2011: ES, GG, KK, MS, MT and NP 8. Records of the following five individuals with type D.5.f assessments from December 2010 - May 2011: DK, DR, EL, PB and SC 9. Records of the following seven individuals with type D.5.g

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		<p>assessments from December 2010 - May 2011: CCR, EG, EG, MM, PM, RP and TM</p> <p>10. Records of the following seven individuals with type D.5.i assessments from December 2010 - May 2011: GT, HC, KC, LGS, RSS, SB and SS</p> <p>11. Records of the following two individuals with type D.5.j.i assessments from December 2010 - May 2011: JC and RJ</p> <p>12. Records of the following ten individuals with type D.5.j.ii assessments from December 2010 - May 2011: BC, DEG, EM, GL, JK, JM, JY, MLS, RDR and TH</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, January 2011: 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.a assessments due each month for the review period December 2010 - May 2011 (total of three):</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.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of	Current findings on previous recommendations:																																	

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	admission.	<p>Recommendation, January 2011: 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.b assessments due each month for the review period December 2010 - May 2011 (total of six):</p> <table border="1" data-bbox="991 524 1890 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>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 nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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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="989 984 1896 1016">Current findings on previous recommendations:</p> <p data-bbox="989 1057 1896 1122">Recommendation, January 2011: Continue to monitor this requirement.</p> <p data-bbox="989 1162 1896 1349">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 December 2010 - May 2011 (total of one):</p> <table border="1"> <tr> <td data-bbox="989 1382 1087 1421">1.</td> <td data-bbox="1087 1382 1776 1421"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1776 1382 1896 1421">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%												
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Section D: Integrated Assessments

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		<p>A review of the record of one individual to assess compliance with Nutrition type D.5.c criteria found the record 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, January 2011: 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 December 2010 - May 2011 (total of 26):</p> <table border="1" data-bbox="991 933 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</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</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>identified</i></td> <td></td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>N/A</td> </tr> <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>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 five individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>identified</i>		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	N/A	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.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p>																																	

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		<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 December 2010 - May 2011 (total of 46):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>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 actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%
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D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	<p data-bbox="993 834 1577 867">Current findings on previous recommendation:</p> <p data-bbox="993 906 1457 971">Recommendation, January 2011: Continue to monitor this requirement.</p> <p data-bbox="993 1019 1902 1198">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 December 2010 - May 2011 (total of 16):</p> <table border="1" data-bbox="993 1235 1887 1414"> <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</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</i>	100%
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			<i>appropriate</i>	
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																														
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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 54% of Nutrition Type D.5.g assessments due each month for the review period December 2010 - May 2011 (total of 116 out of 213):</p> <table border="1" data-bbox="989 821 1887 1417"> <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</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</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, January 2011: 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 32% of Nutrition assessments (all types) due each month of the review period December 2010 - May 2011 (523 out of 1610). 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, January 2011: 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 18% of Nutrition Type D.5.i assessments due each month for the review period December 2010 - May 2011 (total of 152 out of 829):</p> <table border="1" data-bbox="991 1192 1887 1417"> <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> </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%
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		<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, January 2011: 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 December 2010 - May 2011 (total of 72):</p> <table border="1" data-bbox="991 748 1887 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>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> </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 nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%
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Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="989 190 1087 266">12.</td> <td data-bbox="1087 190 1776 266"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1776 190 1890 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">13.</td> <td data-bbox="1087 266 1776 342"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1776 266 1890 342">100%</td> </tr> <tr> <td data-bbox="989 342 1087 418">14.</td> <td data-bbox="1087 342 1776 418"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1776 342 1890 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 459">15.</td> <td data-bbox="1087 418 1776 459"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1776 418 1890 459">100%</td> </tr> <tr> <td data-bbox="989 459 1087 500">16.</td> <td data-bbox="1087 459 1776 500"><i>Assessment is concise</i></td> <td data-bbox="1776 459 1890 500">100%</td> </tr> <tr> <td data-bbox="989 500 1087 540">17.</td> <td data-bbox="1087 500 1776 540"><i>Assessment is legible</i></td> <td data-bbox="1776 500 1890 540">100%</td> </tr> <tr> <td data-bbox="989 540 1087 581">18.</td> <td data-bbox="1087 540 1776 581"><i>Each page of the assessment is signed</i></td> <td data-bbox="1776 540 1890 581">100%</td> </tr> </table> <p data-bbox="989 613 1898 716">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 data-bbox="989 760 1839 862">A review of the records of two individuals to assess compliance with Nutrition type D.5.j.i criteria found both records in substantial compliance.</p> <p data-bbox="989 906 1140 976">Compliance: Substantial.</p> <p data-bbox="989 1019 1457 1089">Current recommendation: Continue to monitor this requirement.</p>	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	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.j.ii	Every individual will be assessed annually.	<p data-bbox="989 1133 1577 1166">Current findings on previous recommendation:</p> <p data-bbox="989 1206 1457 1276">Recommendation, January 2011: Continue to monitor this requirement.</p> <p data-bbox="989 1317 1881 1421">Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance based on an average sample of 18% of Nutrition Type D.5.j.ii</p>																					

Section D: Integrated Assessments

		<p>assessments due each month for the review period December 2010 - May 2011 (total of 85 out of 465):</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>	100%
5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
7.	<i>Nutrition education is documented</i>	100%
8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
9.	<i>Progress is monitored, measured, and evaluated</i>	100%
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
11.	<i>Recommendations are appropriate and complete</i>	100%
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%
15.	<i>Assessment utilizes approved abbreviations</i>	100%
16.	<i>Assessment is concise</i>	100%
17.	<i>Assessment is legible</i>	100%
18.	<i>Each page of the assessment is signed</i>	100%

Section D: Integrated Assessments

		<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 10 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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Section D: Integrated Assessments

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	As of the tour conducted in January 2011, 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.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	

Section D: Integrated Assessments

7. Court Assessments		
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	As of the tour conducted in October 2010, 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 all requirements of this section.</p>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Divina Jones, LCSW, Acting Senior Social Worker 2. John Wyman, LCSW, Acting Senior Social Worker 3. Monique Jansma, LCSW, Acting Chief of Social Work 4. Selena Coumanis, CSW, Acting Senior Social Worker <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 47 individuals: AG, ALF, AW, BJ, BW, BWB, CB, CC, CS, DB, DES, DKB, DTB, ES, EWK, FM, FMC, GAR, GCS, GHS, GT, JI, JRM, JTC, KS, LCA, LK, LM, MGR, MM, MWP, NFF, NLP, OM, RAM, RB, RJF, RKH, RP, RW, SAR, TC, TDB, THS, TR, YAQ, and YMW 2. NSH's progress report on Discharge Planning and Community Integration 3. List of individuals who have met discharge criteria and are still hospitalized 4. List of individuals under civil commitment 5. Records of individuals assessed to need family therapy <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, Unit T17) for monthly review of RP 2. WRPC (Program II, Unit T4) for 7-day review of TDB 3. WRPC (Program V, Unit Q8) for 60-day review of OM

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, January 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 12% of quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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>A review of the records of six individuals found that all six 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 (AW, DKB, GAR, JTC, RW and YMW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.b	the individual's level of psychosocial functioning;	Current findings on previous recommendation:

Section E: Discharge Planning and Community Integration

		<p>Recommendation, January 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 12% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 nine individuals found that all nine WRPs included the individual's psychosocial functioning in the Present Status section (BJ, BWB, CS, GCS, JTC, KS, MWP, NFF and RAM).</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, January 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 12% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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>

Section E: Discharge Planning and Community Integration

		<p>A review of the records of 11 individuals (AW, CS, GHS, JTC, KS, MWP, NLP, RAM, RKH, TR and YMW) found that the WRPs generally documented the individual's discharge barriers, status towards meeting the discharge criteria, and matters related to placement that act as barriers preventing the individual from transitioning to a more integrated environment. However, the WRPs do not consistently document the discussion with the individual and the individual's input regarding his/her discharge matters (e.g. understand, agree, accept, unsure, not in agreement with the placement setting), even though such discussions occur during the WRPs, as evidenced by the three treatment teams observed by this monitor (OM, RP and TDB). Documentation of discussion with the individual and some statement about what the individual had stated was found in five WRPs (AW, GHS, MWP, RAM, and YMW). In the case of AW, the individual's participation was found under the Discharge Criteria section: "Some of the coping skills she mentioned during this conference include prayer and talking to staff when she is overwhelmed."</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, January 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 12% of the quarterly and annual WRPs due each month during the review period</p>

Section E: Discharge Planning and Community Integration

		<p>(December 2010 - May 2011), 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 10 individuals found that all 10 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (CS, GHS, JTC, KS, MWP, NLP, RAM, RKH, TR and YMW).</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, January 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 32% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), and 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>A review of the records of 11 individuals found that five WRPs contained documentation indicating that the individual was an active participant in the discharge process (AW, GHS, MWP, RAM, and YMW). The remaining six WRPs contained no documentation that the individual participated in</p>

Section E: Discharge Planning and Community Integration

		<p>the discussion (CS, JTC, KS, NLP, RKH and TR). While the documentation is sparse, the teams do discuss these matters with the individual (as evidenced by observation of WRPCs). Seniors and trainers should encourage WRPTs to document the individual's participation and input in the Present Status section of the WRP.</p> <p>This monitor observed three WRPCs (OM, RP and TDB). Two met full compliance and one met partial compliance (OM).</p> <p>A review of the records of 13 individuals found that 10 WRPs in the charts contained objectives written in a measurable/observable manner (AG, BJ, EWK, JI, JRM, LCA, LK, MM, MWP and YAQ) and three (ALF, FMC and SAR) did not.</p> <p>A review of the records of eight individuals found that all eight WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (AW, DKB, GAR, JTC, NLP, RW, TR and YMW).</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 sub-cells for compliance findings.

Section E: Discharge Planning and Community Integration

E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 12% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 12 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in 10 WRPs (AG, AW, BJ, BWB, JI, MM, NFF, NLP, TR and YAQ). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining two WRPs (FMC and SAR).</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, January 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 12% of</p>

Section E: Discharge Planning and Community Integration

		<p>quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 10 individuals found that nine WRPs identified the staff member responsible for the interventions (BJ, BW, BWB, DTB, MGR, NFF, RB, THS and YAQ). The remaining WRP did not do so for one or more interventions (DES).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 12% of quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 11 individuals found that nine WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AG, CB, DB, ES, LM, MM, RW, TC and TR). The remaining two WRPs did not specify a time</p>

Section E: Discharge Planning and Community Integration

		<p>frame or the stated time frame was not aligned with the next scheduled WRPC (FMC and SAR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p>Compliance: Substantial.</p>												
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p> <p>Findings: Documentation review found that 67 individuals had been referred for discharge during this review period. Twenty were discharged, and 47 are still hospitalized. As seen in the facility's data summarized in the table below, the individuals still waiting to be discharged were referred for discharge between January and June 2011.</p> <table border="1"> <thead> <tr> <th>ID</th> <th>Referral Date</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td>AH</td> <td>1/6/2011</td> <td>Sex offender registrant. San Diego County having difficulty placing him.</td> </tr> <tr> <td>CL</td> <td>1/12/2011</td> <td>Few LPS beds in SF County. SW speaks to conservator monthly for placement.</td> </tr> <tr> <td>CC</td> <td>6/6/2011</td> <td>Firesetter. LA County will not place him or contract out to another county.</td> </tr> </tbody> </table>	ID	Referral Date	Status	AH	1/6/2011	Sex offender registrant. San Diego County having difficulty placing him.	CL	1/12/2011	Few LPS beds in SF County. SW speaks to conservator monthly for placement.	CC	6/6/2011	Firesetter. LA County will not place him or contract out to another county.
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Section E: Discharge Planning and Community Integration

		CP	5/16/2011	LA County does not contract placement for 290 (sex) registrants. Unplaceable. SW continues to contact county 1xwk to seek resolution.
		CJ	5/18/2011	CONREP agreed discharge criteria were met then changed its mind. Now wants CJ to improve in other areas. SW works almost daily with CJ to complete this.
		DB	4/25/2011	Plans in Fresno. CONREP has significant concerns about medication compliance. He has moved back and forth from discharge-ready to not for several cycles.
		DM	6/20/2011	The referral will be made once individual has heard back from CONREP regarding his change in venue request.
		DE	1/31/2011	Has a court order for discharge (6/10/11); Sacramento CONREP will refer him to Northstar or Southpoint (first bed available).
		EA	6/1/2011	SF County has too few LPS beds. SW speaks monthly with conservator to find placement.
		ER	1/18/2011	Murcon from San Francisco County. He is in competency group preparing to return to court and face charges.
		FN	3/7/2011	Hypersexual behavior and assaultive history complicate placement. SW has been in contact with his county contact regarding placement (working toward a VA bed).
		FG	6/10/2011	Judge granted placement. SW working with CONREP to find placement.
		FN	5/16/2011	Waiting for FCLS discharge assessments.
		FR	6/1/2011	Southbay CONREP feels he is ready. COT packet is being assembled.
		GD	6/29/2011	A letter has been sent to the court and individual will be returning as competent.

Section E: Discharge Planning and Community Integration

		GT	4/14/2011	His mother passed away this month. He is currently not ready for discharge.
		HJ	4/18/2011	No longer appropriate for discharge. Individual wants to be discharged to Sacramento County. Individual is no longer working towards discharge; he is ambivalent given his wife also is at the facility.
		HOJ	3/15/2011	Waiting for bed from Vallejo. Anticipate placement in July or August.
		IJ	1/26/2011	IJ was recommended for COT and FCLS responded with concerns and did not approve team's recommendation. The team continues to think she is ready.
		IA	6/14/2011	Following an injury the team plans to reassess for competency.
		JN	4/1/2011	JN's instant offense was murder. He murdered again when he was released. County refuses to re-place him in the community.
		JC	6/2/2011	SF County has too few LPS beds. JC converted from Murcon in January. Team is to assist him in preparing to leave and to show any placements that he is directable.
		KJ	5/23/2011	CONREP wanted him on IM Medication and doctor had concerns. KJ was placed on Risperdal Consta. CONREP and FCLS agreed on three months in March. Team believed CONREP was too strict but negotiated with CONREP for release.
		KE	3/25/2011	NSH sent letter to the wrong court, delaying placement. Currently, Stanislaus County Court turned him down. DA has not been responsive as to cause for rejection.
		MR	3/10/2011	County cannot find a placement to assume risk

Section E: Discharge Planning and Community Integration

			secondary to swallowing.	
		MD	3/10/2011	Santa Clara County will not place, stating MD beats up people when in a lower level of care.
		MT	1/28/2011	SW emailed the gatekeeper for LA County weekly. Social worker sent discharge packet on 7/18/11.
		NB	6/20/2011	Being discharged in July to Crestwood.
		NA	1/25/2011	SF County has too few LPS beds. Sexually acted out on female staff in July, a new behavior. Placement unlikely.
		RJ	6/29/2011	Passed CAI and did well in competency groups. Letter written July 10.
		RF	6/6/2011	CONREP interview scheduled for 7/18/11.
		RC	2/3/2011	RC is psychotic. Strong history of assault. Age-related behavioral change has resulted in his behavior becoming more predictable. He should be discharged. County says they cannot place.
		SV	3/10/2011	Conservator unresponsive to appeals to place. SV needs outside the family placement. Should occur within next 30 to 60 days. Some difficulty given history of assaultive behavior.
		SA	5/23/2011	UC Davis found SA is low risk. Case is highly political. DA continues to stall. SA going to court July 27th, 2011.
		SD	May 2011	SW called the clerk of court and CONREP. Awaiting a court order for release.
		ST	6/28/2011	LA County does not contract with any placement that takes 290 (sex) restraints, so he is not placeable.
		SC	6/28/2011	Passed 1370 criteria and letter to court written in June.

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		SM	2/11/2011	SM killed a police officer and faces the death penalty. District Attorney will not place due to instant offense.
		TR	1/12/2011	Court denied placement. TR has filed a writ. TR has cancer for the second time, which has impaired his ability to remain focused on discharge.
		TA	6/27/2011	TA will be discharged to a locked psychiatric facility. Placement should occur by late July/early August.
		VC	5/5/2011	Passed COT in April. Napa State is waiting for the order to release him to Sacramento.
		WA	5/2/2011	Has been here 20 years. San Mateo has accepted him. They are holding a bed.
		WAA	6/3/2011	On hold due to psychosis. Team believes he is ready, but will likely have residual symptoms post-discharge.
		WT	4/1/2011	Health issues complicated placement. In remission for cancer.
		WM	5/18/2011	Requires total nursing care and is combative. Marin County has had trouble finding a placement given the level of care he requires.
		YT	6/9/2011	LA County resisted placement. YT contested renewal and won. He is voluntarily waiting for benefits to fall into place so that he has a safe placement.
		<p>As shown in the table above, most of the individuals still hospitalized were subject to external barriers (lack of bed, CONREP and court delays/disagreement).</p> <p>One case is awaiting assessment (FN, referred on 5/16/11).</p>		

Section E: Discharge Planning and Community Integration

		<p>One is a case of disagreement between the FLCS and WRPT as to the readiness of the individual (JI, referred on 1/26/11). The two parties should have made a decision by now and come to an agreement if the referral should go forward or be removed from the list and be provided appropriate services to FCLS' satisfaction.</p> <p>KE is a case of internal barrier potentially delaying a timely discharge due to sending a letter to the wrong court (referral date 3/25/11). However, subsequent to the letter getting into the right hands the court turned down the referral, and per the facility the DA has not explained the cause for the rejection.</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, January 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 12% of the quarterly and annual WRPs due each month during the review period (December 2010 - May 2011), 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 the records of nine individuals found that all nine WRPs contained documentation of the assistance (skills, supports, transition assistance) needed by the individual in the new setting (BJ, EWK, FM, JRM, MM, NFF, RJF, TDB and YAQ).</p>

Section E: Discharge Planning and Community Integration

		<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	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services: NSH has maintained substantial compliance with the requirements in Section F.1.</p> <p>Areas of need include:</p> <ol style="list-style-type: none">1. <i>Ensure consistent monitoring of individuals receiving high-risk medications for the risk of pancreatic dysfunction.</i>2. <i>Ensure that the WRP objectives that address TD are attainable for the individuals and properly tailored to the individuals' needs.</i> <p>Summary of Progress on Psychological Services: As of this tour, NSH has maintained compliance with all of the requirements of this section for 18 months.</p> <p>Areas of need include:</p> <ol style="list-style-type: none">1. <i>NSH should give greater emphasis to preventive services through proactive milieu interventions for individuals identified during the initial assessment as having a history of maladaptive behaviors.</i>2. <i>Behavioral interventions should give greater emphasis to building the individual's capacity for self-monitoring and coping and less on external support for attention.</i>3. <i>Behavioral assessments should place greater emphasis on data collection and analysis of setting events, antecedents, motivational operations, and precursors.</i>4. <i>Behavioral intervention plans should utilize all of the preventive elements identified in the structural and functional assessments in order to make the challenging behaviors irrelevant, inefficient, and ineffective.</i> <p>Summary of Progress on Nursing Services: While the Nursing Department has yet to attain substantial compliance</p>

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	<p>with every requirement of the EP in this section, specifically nursing reassessments regarding changes in status, extraordinary progress has been made in the areas of overall medication administration practices and the EP requirements related to PRN and Stat medications. The facility should continue the process of implementing systems based on quality standards of practice to guide the nursing assessment/reassessment process and the associated documentation in the area of changes in status.</p> <p>Summary of Progress on Rehabilitation Therapy Services: NSH has maintained substantial compliance with all requirements of Section F.4 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Services: NSH has maintained compliance with all of the requirements of this section for 18 months and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Pharmacy Services: As of the tour conducted in December 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, some decline in practice was noted and the facility must address the deficiencies outlined in subsection F.1.a in order to maintain gains in this area.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on Infection Control: NSH has been in substantial compliance in all cells for three consecutive tours (including the current tour). Although this falls short of the negotiated threshold, the practices of the Infection Control Department have significantly improved over the past five years and have been maintained. The facility should maintain the current practices and update systems in alignment with changes in clinical practices.</p> <p>Summary of Progress on Dental Services: As of this tour, NSH has attained compliance with all of the requirements of this section. Although the Dental Department has not maintained compliance for the required duration, their progress has been consistent. The facility should maintain the current dental practices and update systems in alignment with changes in clinical dental practices.</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 Eliapo-Yra, RN, HSS, Central Nursing Services 2. James Young, DO, 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 40 individuals: AMM, APD, ASM, CCS, DDC, DED, DLH, DRH, DRM, EL, FGP, GDM, GFL, GJ, GSC, GVC, HSR, JCS, JM, JND, JP, LAC, MAM, MH, MLL, MQT, MRB, NEF, OEF, PJM, RJJ, RLH, RSS, SAG, SHL, SLH, TAS, TEF, TTR and VH 2. NSH Comprehensive Psychiatric Assessment Auditing summary data (December 2010 - May 2011) 3. NSH Monthly PPN Audit summary data (December 2010 - May 2011) 4. NSH PRN and Stat monitoring summary data (December 2010 - May 2011) 5. NSH Movement Disorder Monitoring summary data (December 2010 - May 2011) 6. NSH Polypharmacy database 7. NSH Tardive Dyskinesia database 8. NSH aggregated data regarding adverse drug reactions (December 2010 - May 2011) 9. Last 57 ADRs for this reporting period 10. ADR aggregate reports for the current period 11. Six Drug Utilization Evaluations (DUEs) completed by NSH during this review period 12. NSH aggregated data regarding medication variances (December 2010 - May 2011) 13. Last ten MVRs for this reporting period 14. MVR aggregate report for the current period

Section F: Specific Therapeutic and Rehabilitation Services

		<p>15. Three Intensive Case Analyses (ICAs) completed during this review period</p> <p>16. Pharmacy and Therapeutics Committee Minutes (December 2010 - May 2011)</p> <p>17. Psychiatric outcome data for the previous and current reporting period on the following: Aggression, Abuse/Neglect/Exploitation, Polypharmacy, Restraint and Seclusion, Prescribed Medications to High Risk populations, Severe Adverse Drug Reactions, and Substance Abuse Services</p>
<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 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: The following is a summary of the updates in the medication guidelines during this review period:</p> <ol style="list-style-type: none"> 1. A guideline expanding on DUE requirements; 2. An informational item involving a class warning for all antipsychotic medications indicating they may induce neonatal dyskinetic movements; 3. An updated table in the clozapine protocol reflecting standard doses of newly approved second-generation antipsychotics; 4. A protocol for the use of lurasidone, a newly approved second-generation antipsychotic medication; and 5. A new table on the intervention required at various prolactin serum concentrations in individuals with hyperprolactinemia.

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		<p>The above updates were communicated to the medical staff at the facility.</p> <p>Recommendation 3, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the DMH Admission Integrated/Comprehensive Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 26% and 11%, respectively. Compliance rates ranged from 97% to 100% for the indicators that were previously outlined and that adequately addressed the requirements in F.1.a.i to F.1.a.v.ii. Comparative data showed that the facility has maintained compliance rates of at least 90% since the last review.</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 monitor this requirement.
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	Same as above.
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	Same as above.
F.1.a.iii	tailored to each individual's symptoms;	Same as above.
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Same as above.
F.1.a.v	monitored appropriately for side effects;	Same as above.
F.1.a.vi	modified based on clinical rationales;	Same as above.

Section F: Specific Therapeutic and Rehabilitation Services

F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as above.											
F.1.a.viii	Properly documented.	<p>The facility presented data for December 2010 to May 2011 as follows:</p> <table border="1" data-bbox="991 414 1890 604"> <tr> <td data-bbox="991 414 1449 490">Admission (Initial) Psychiatric Assessment</td> <td data-bbox="1449 414 1795 490">8.a, 8.b and 8.c</td> <td data-bbox="1795 414 1890 490">91%</td> </tr> <tr> <td data-bbox="991 490 1449 566">Integrated Assessment (Psychiatry)</td> <td data-bbox="1449 490 1795 566">7 and 10</td> <td data-bbox="1795 490 1890 566">95%</td> </tr> <tr> <td data-bbox="991 566 1449 604">Monthly PPN</td> <td data-bbox="1449 566 1795 604">2.b, 2.g, 3 and 5.a-d</td> <td data-bbox="1795 566 1890 604">97%</td> </tr> </table>			Admission (Initial) Psychiatric Assessment	8.a, 8.b and 8.c	91%	Integrated Assessment (Psychiatry)	7 and 10	95%	Monthly PPN	2.b, 2.g, 3 and 5.a-d	97%
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> Continue to monitor this requirement. Improve documentation of the individual's response to the administration of PRN/Stat medications. <p>Findings:</p> <p>NSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 11% of individuals who have been hospitalized for 90 or more days during the review period (December 2010 - May 2011). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 13% and 13% of PRN and Stat medications given per month. Comparative data indicated that NSH has maintained a compliance rate of at least 90% for all of the indicators since the previous review period. The following tables summarize the data:</p> <table border="1" data-bbox="991 1307 1890 1421"> <thead> <tr> <th colspan="3" data-bbox="991 1307 1890 1347">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1347 1081 1421">6.</td> <td data-bbox="1081 1347 1795 1421"><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency</i></td> <td data-bbox="1795 1347 1890 1421">98%</td> </tr> </tbody> </table>			Monthly PPN			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency</i>	98%			
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F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Continue to monitor this requirement.</p> <p>Findings: NSH used the standardized DMH Monthly PPN Audit Form to assess compliance (December 2010 - May 2011). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and</p>																											

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		<p>corresponding mean compliance rates:</p> <table border="1" data-bbox="993 266 1887 570"> <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 = 14%)</i></td> <td>91%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 11%)</i></td> <td>95%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 8%)</i></td> <td>94%</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> <p>Recommendation 2, January 2010: Assess current methods used for tapering off benzodiazepines to minimize likelihood of withdrawal syndromes.</p> <p>Findings: The facility did not address this recommendation.</p> <p>Recommendation 3, January 2010: Provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:</p> <ol style="list-style-type: none"> Benzodiazepines for 60 days or more; Benzodiazepines and have any diagnosis of substance use disorder; Benzodiazepines and have any diagnosis of cognitive impairment; Anticholinergics for 60 days or more; Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above; Intra-class polypharmacy; and Inter-class polypharmacy. 	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 = 14%)</i>	91%	5.d.ii.	<i>Anticholinergics. (%S = 11%)</i>	95%	5.d.iii.	<i>Polypharmacy. (%S = 8%)</i>	94%
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		<p>Findings: NSH reported the following comparative data:</p> <table border="1"> <thead> <tr> <th data-bbox="989 302 1045 378"></th> <th data-bbox="1045 302 1610 378">Indicators</th> <th data-bbox="1610 302 1753 378">Previous period</th> <th data-bbox="1753 302 1896 378">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 378 1045 454">1.</td> <td data-bbox="1045 378 1610 454"><i>Total number of individuals receiving benzodiazepines for 60 days or more</i></td> <td data-bbox="1610 378 1753 454">112</td> <td data-bbox="1753 378 1896 454">114</td> </tr> <tr> <td data-bbox="989 454 1045 602">2.</td> <td data-bbox="1045 454 1610 602"><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i></td> <td data-bbox="1610 454 1753 602">61</td> <td data-bbox="1753 454 1896 602">55</td> </tr> <tr> <td data-bbox="989 602 1045 789">3.</td> <td data-bbox="1045 602 1610 789"><i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td data-bbox="1610 602 1753 789">19</td> <td data-bbox="1753 602 1896 789">19</td> </tr> <tr> <td data-bbox="989 789 1045 865">5.</td> <td data-bbox="1045 789 1610 865"><i>Total number receiving anticholinergics for 60 days or more</i></td> <td data-bbox="1610 789 1753 865">64</td> <td data-bbox="1753 789 1896 865">64</td> </tr> <tr> <td data-bbox="989 865 1045 1013">6.</td> <td data-bbox="1045 865 1610 1013"><i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td data-bbox="1610 865 1753 1013">9</td> <td data-bbox="1753 865 1896 1013">6</td> </tr> <tr> <td data-bbox="989 1013 1045 1089">7.</td> <td data-bbox="1045 1013 1610 1089"><i>Total number with intra-class polypharmacy</i></td> <td data-bbox="1610 1013 1753 1089">333</td> <td data-bbox="1753 1013 1896 1089">351</td> </tr> <tr> <td data-bbox="989 1089 1045 1166">8.</td> <td data-bbox="1045 1089 1610 1166"><i>Total number with inter-class polypharmacy</i></td> <td data-bbox="1610 1089 1753 1166">137</td> <td data-bbox="1753 1089 1896 1166">149</td> </tr> </tbody> </table> <p>The data showed that, considering the current census, 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</p>		Indicators	Previous period	Current period	1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	112	114	2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i>	61	55	3.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	19	19	5.	<i>Total number receiving anticholinergics for 60 days or more</i>	64	64	6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	9	6	7.	<i>Total number with intra-class polypharmacy</i>	333	351	8.	<i>Total number with inter-class polypharmacy</i>	137	149
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		<p>receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>The following tables outline the reviews of the charts of individuals receiving the above types of medication regimens on a long-term basis. The diagnoses are listed if they signified high risk conditions.</p> <p><u>Benzodiazepine use</u></p> <table border="1" data-bbox="991 743 1883 1279"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>EL</td> <td>Lorazepam</td> <td>Moderate Mental Retardation (diagnosis was removed in April)</td> </tr> <tr> <td>JND</td> <td>Clonazepam</td> <td>Alcohol Abuse</td> </tr> <tr> <td>MQT</td> <td>Clonazepam</td> <td>Moderate Mental Retardation</td> </tr> <tr> <td>OEF</td> <td>Clonazepam (discontinued)</td> <td>Amphetamine and Cocaine Dependence and Borderline Intellectual Functioning</td> </tr> <tr> <td>PJM</td> <td>Clonazepam (discontinued)</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>RLH</td> <td>Lorazepam</td> <td>Moderate Mental Retardation</td> </tr> <tr> <td>SAG</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>SLH</td> <td>Lorazepam</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>VH</td> <td>Lorazepam</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>This review found substantial compliance in eight charts and partial compliance in one (VH).</p>	Individual	Medication(s)	Diagnosis	EL	Lorazepam	Moderate Mental Retardation (diagnosis was removed in April)	JND	Clonazepam	Alcohol Abuse	MQT	Clonazepam	Moderate Mental Retardation	OEF	Clonazepam (discontinued)	Amphetamine and Cocaine Dependence and Borderline Intellectual Functioning	PJM	Clonazepam (discontinued)	Polysubstance Dependence	RLH	Lorazepam	Moderate Mental Retardation	SAG	Clonazepam	Polysubstance Dependence	SLH	Lorazepam	Borderline Intellectual Functioning	VH	Lorazepam	Borderline Intellectual Functioning
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		<p>At the time of the review, only one individual (TTR) was identified as receiving long-term anticholinergic treatment (diphenhydramine) and having a high-risk condition (Borderline Intellectual Functioning). This chart was in partial compliance.</p> <p>Only one individual (HSR) age 65 or above was identified as receiving long-term anticholinergic treatment at the time of the review. The monitor found noncompliance due to inattention to the individual's cognitive decline while receiving this treatment.</p> <p><u>Polypharmacy use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>APD</td> <td>Clozapine risperidone, bupropion, venlafaxine and divalproex</td> <td></td> </tr> <tr> <td>DRH</td> <td>Ziprasidone, risperidone, chlorpromazine and divalproex</td> <td></td> </tr> <tr> <td>DRM</td> <td>Loxapine, venlafaxine, trazodone and clonazepam</td> <td></td> </tr> <tr> <td>GDM</td> <td>Olanzapine, thiothixene and mirtazapine</td> <td></td> </tr> <tr> <td>JCS</td> <td>Risperidone, lamotrigine, bupropion, fluoxetine and trazodone</td> <td></td> </tr> <tr> <td>MAM</td> <td>Olanzapine, risperidone, buspirone and divalproex</td> <td></td> </tr> <tr> <td>RSS</td> <td>Lithium, quetiapine, sertraline, trazodone, zolpidem and divalproex</td> <td></td> </tr> <tr> <td>SHL</td> <td>Chlorpromazine, risperidone, lithium lamotrigine and clonazepam</td> <td>Opioid Dependence and PCP Dependence</td> </tr> <tr> <td>TAS</td> <td>Clozapine, olanzapine and sertraline</td> <td></td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	APD	Clozapine risperidone, bupropion, venlafaxine and divalproex		DRH	Ziprasidone, risperidone, chlorpromazine and divalproex		DRM	Loxapine, venlafaxine, trazodone and clonazepam		GDM	Olanzapine, thiothixene and mirtazapine		JCS	Risperidone, lamotrigine, bupropion, fluoxetine and trazodone		MAM	Olanzapine, risperidone, buspirone and divalproex		RSS	Lithium, quetiapine, sertraline, trazodone, zolpidem and divalproex		SHL	Chlorpromazine, risperidone, lithium lamotrigine and clonazepam	Opioid Dependence and PCP Dependence	TAS	Clozapine, olanzapine and sertraline	
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		<table border="1" data-bbox="991 191 1896 267"> <tr> <td data-bbox="991 191 1142 267">TEF</td> <td data-bbox="1142 191 1610 267">Olanzapine, mirtazapine, sertraline and divalproex</td> <td data-bbox="1610 191 1896 267"></td> </tr> </table> <p data-bbox="991 310 1646 337">This review found substantial compliance in all cases.</p> <p data-bbox="991 386 1142 448">Compliance: Substantial.</p> <p data-bbox="991 496 1896 597">Current recommendation: Continue to monitor this requirement, including data on the total number of individuals receiving long-term treatment with high-risk medications.</p>	TEF	Olanzapine, mirtazapine, sertraline and divalproex	
TEF	Olanzapine, mirtazapine, sertraline and divalproex				
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p data-bbox="991 646 1591 673">Current findings on previous recommendations:</p> <p data-bbox="991 719 1444 781">Recommendation 1, January 2010: Continue to monitor this requirement.</p> <p data-bbox="991 829 1896 1081">Findings: Using the DMH Monthly PPN Auditing Form, NSH assessed its compliance based on an average sample of 11% of individuals receiving these medications during the review period (December 2010 - May 2011). The compliance rate with the relevant indicator was 95%. Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1130 1896 1263">Recommendation 2, January 2010: Implement current plans to address refusal by some individuals receiving high risk treatments of necessary laboratory testing to monitor the status of these individuals.</p> <p data-bbox="991 1312 1528 1373">Findings: The facility reported the following actions:</p>			

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		<ol style="list-style-type: none"> 1. The Acting Medical Director prepared a report for the Quality Council in May 2011 on refusal of treatment. A refusal work group was established to address various clinical and administrative processes to improve the current rate of refusals. 2. In April 2011, the Acting Medical Director provided training to psychiatrists and physicians and surgeons on the Probate Code related to involuntary medical treatment. 3. The Acting Medical Director developed a PBS consultation form for individuals who are refusing medical treatment. The form was implemented in March 2011 in order to facilitate consultation with PBS teams, which have specialized training in dealing with difficult behaviors. PBS teams provide consultation to address treatment refusal even before appointments are scheduled. 4. In March and April 2011, the Acting Medical Director shared data on current refusals of medical treatment with the Medical Executive Committee (MEC) and Medical Staff meetings and solicited input on improving the current rate of refusals. 5. The Chief Physician and Surgeon is working on a process to improve the scheduling of appointments for the specialty clinics to prevent overcrowding in clinic areas and to improve safety and security. Overcrowding leads to longer clinic wait times, patient requests to return to the unit before the appointment, and refusals due to excessive wait time. Once the process is consistently implemented, a reduction in the rate of appointment refusals for dental and specialty medical clinics is anticipated. <p>Recommendation 3, January 2010: Ensure that current procedure regarding use of clozapine ensures adequate frequency of checking vital signs.</p> <p>Findings: The Acting Chief Psychiatrist provided a review of medication policies to staff psychiatrists, including DMH protocol on clozapine prescribing and</p>
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		<p>monitoring practices which include baseline and follow-up vital signs monitoring. This was provided by memo and discussed at the Medical Staff meeting.</p> <p>Other findings: This monitor reviewed the charts of 13 individuals who are receiving new-generation antipsychotic agents. Most of these individuals were suffering from a variety of metabolic disorders. Two of the individuals received iloperidone, which is one of the newest agents. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 634 1873 1391"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AMM</td> <td>Quetiapine and olanzapine</td> <td>Diabetes Mellitus, Hyperlipidemia and Hypertension</td> </tr> <tr> <td>ASM</td> <td>Risperidone</td> <td>None documented</td> </tr> <tr> <td>DDC</td> <td>Iloperidone (since 4/12/11)</td> <td>Hyperlipidemia</td> </tr> <tr> <td>DED</td> <td>Risperidone</td> <td>Hyperlipidemia and Hypertension</td> </tr> <tr> <td>DLH</td> <td>Iloperidone (since 1/25/11)</td> <td>None documented</td> </tr> <tr> <td>GSC</td> <td>Risperidone</td> <td>None documented</td> </tr> <tr> <td>GVC</td> <td>Risperidone and olanzapine</td> <td>Diabetes Mellitus, Hyperlipidemia and Hypertension</td> </tr> <tr> <td>JM</td> <td>Olanzapine</td> <td>Hyperlipidemia</td> </tr> <tr> <td>JP</td> <td>Quetiapine</td> <td>Hyperlipidemia and Hypertension</td> </tr> <tr> <td>LAC</td> <td>Olanzapine</td> <td>Obesity and Hyperlipidemia</td> </tr> <tr> <td>MH</td> <td>Clozapine</td> <td>Diabetes Mellitus, Hyperlipidemia and Hypertension</td> </tr> <tr> <td>MLL</td> <td>Olanzapine</td> <td>Diabetes Mellitus, Obesity and Hyperlipidemia</td> </tr> <tr> <td>MRB</td> <td>Clozapine</td> <td>Obesity and Hyperlipidemia</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	AMM	Quetiapine and olanzapine	Diabetes Mellitus, Hyperlipidemia and Hypertension	ASM	Risperidone	None documented	DDC	Iloperidone (since 4/12/11)	Hyperlipidemia	DED	Risperidone	Hyperlipidemia and Hypertension	DLH	Iloperidone (since 1/25/11)	None documented	GSC	Risperidone	None documented	GVC	Risperidone and olanzapine	Diabetes Mellitus, Hyperlipidemia and Hypertension	JM	Olanzapine	Hyperlipidemia	JP	Quetiapine	Hyperlipidemia and Hypertension	LAC	Olanzapine	Obesity and Hyperlipidemia	MH	Clozapine	Diabetes Mellitus, Hyperlipidemia and Hypertension	MLL	Olanzapine	Diabetes Mellitus, Obesity and Hyperlipidemia	MRB	Clozapine	Obesity and Hyperlipidemia
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		<p>The review found general evidence that the facility provided adequate monitoring for the metabolic and endocrine risks of treatment. However, there was no evidence of adequate laboratory monitoring for the risk of pancreatic dysfunction in a few individuals receiving high-risk medications, including quetiapine (JP) and risperidone (ASM and DED).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent monitoring of the risk of pancreatic dysfunction in individuals receiving high-risk medications. 						
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, January 2010:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent implementation of corrective measures regarding this requirement. <p>Findings: Using the DMH Movement Disorders Auditing Form, NSH assessed its compliance based on average samples ranging from 11% to 30% of individuals relevant to each indicator during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1227 1890 1414"> <tr> <td data-bbox="991 1227 1081 1304">1.</td> <td data-bbox="1081 1227 1793 1304"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 1227 1890 1304">100%</td> </tr> <tr> <td data-bbox="991 1304 1081 1414">2.</td> <td data-bbox="1081 1304 1793 1414"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1304 1890 1414">92%</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>	92%
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		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>	92%
		4.	<i>All individuals with movement disorders are appropriately treated.</i>	99%
		6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	99%
		7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	99%
		8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	88%
<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 provide data regarding the completion of a neurology consultation/Movement Disorders Clinic evaluation for individuals with complicated movement disorders. However, this monitor found consistent and adequate practice in this area (see below).</p> <p>Other findings: This monitor reviewed the charts of six individuals who were diagnosed with TD per the facility's database (CCS, FGP, GFL, GJ, NEF and RJJ). The database identified 41 individuals as having this diagnosis. The review found the following:</p> <ol style="list-style-type: none"> 1. There was evidence of current and adequate neurological evaluations at the Movement Disorders clinic in all charts. 2. The psychiatric progress notes provided adequate tracking of AIMS testing results in the charts of CCS, GFL, GJ, NEF and RJJ. 3. Admission and quarterly AIMS were completed in a timely manner in all charts (one individual declined quarterly follow-up testing) 4. The WRP included appropriate learning-based objectives in the charts 				

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		<p>of GFL, GJ and FGP.</p> <p>5. The treating psychiatrists utilized safer antipsychotic treatment options in the charts of GFL, GJ and FGP.</p> <p>The review found the following process deficiencies:</p> <ol style="list-style-type: none"> 1. An individual declined follow-up AIMS testing, but the treating psychiatrist did not provide information that should have been readily available based on simple observation (FGP). 2. The WRP included vague objective to address TD (CCS). 3. The objective listed for NEF was incomprehensible. 4. RJJ was diagnosed with mild dyskinesia but received an objective that was more suited for an individual with a more severe disorder. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure that the WRP objectives that address TD are attainable for the individuals and properly tailored to the individuals' needs.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010:</p> <ul style="list-style-type: none"> • Continue current efforts to improve reporting of ADRs. • Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ul style="list-style-type: none"> ○ The number of ADRs reported each month during the review period compared with number reported during the previous period; ○ Classification of probability and severity of ADRs; ○ Any negative outcomes for individuals who were involved in serious reactions;

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		<ul style="list-style-type: none"> ○ Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and ○ 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:</p> <table border="1" data-bbox="991 561 1887 1019"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>302</td> <td>364</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>4</td> <td>0</td> </tr> <tr> <td>Possible</td> <td>199</td> <td>273</td> </tr> <tr> <td>Probable</td> <td>96</td> <td>88</td> </tr> <tr> <td>Definite</td> <td>3</td> <td>3</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>174</td> <td>160</td> </tr> <tr> <td>Moderate</td> <td>120</td> <td>200</td> </tr> <tr> <td>Severe</td> <td>8</td> <td>4</td> </tr> </tbody> </table> <p>The facility reported that four ADRs were classified as severe (two of them involved the same individual) and that no permanent sequelae to the individuals occurred as a result of these reactions.</p> <p>NSH conducted intensive case analyses (ICAs) of all severe ADRs. One of the analyses concluded that the reaction was not an ADR and another analysis did not find causal relationship between a complaint of chest pain that started after the addition of a new medication (lisinopril) and the suspected medication. The third analysis addressed the occurrence of drug-induced seizures and two suspected medications were clozapine and</p>		Previous period	Current period	Total ADRs	302	364	Classification of Probability of ADRs			Doubtful	4	0	Possible	199	273	Probable	96	88	Definite	3	3	Classification of Severity of ADRS			Mild	174	160	Moderate	120	200	Severe	8	4
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		<p>bupropion.</p> <p>Other findings: Review of the facility's analyses found adequate methodology, findings and recommendations for corrective actions, as indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current efforts to increase reporting of ADRs. 2. Continue review and analysis of ADRs and the development and implementation of corrective actions, as indicated.
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to provide data on DUEs during the review period, including topic/methodology, findings, recommendations and actions taken.</p> <p>Findings: During this review period, NSH conducted six DUEs. The DUEs prioritized medication use for individuals with impulsive/aggressive behaviors. The following is an outline of these DUEs:</p> <ol style="list-style-type: none"> 1. The efficacy of lithium in the presence of assaultive behavior; 2. The efficacy and safety of propranolol use for impulsive and aggressive acts; 3. The use of bupropion in individuals with substance use diagnosis; 4. The use of non-steroidal anti-inflammatory drugs in individuals who have abnormal renal function; 5. The use of iloperidone with attention to polypharmacy and laboratory monitoring; and

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		<p>6. Augmentation of clozapine with other antipsychotic medications.</p> <p>The review of these DUEs found adequate methodology, findings and recommendations for corrective actions, as indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to conduct DUEs to assess the efficacy and safety of medication uses and develop and implement corrective actions, as indicated.</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, January 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>

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		Number of Medication Variances	Previous Period	Current Period
		Prescribing	182	55
		Transcribing	30	37
		Ordering/Procurement	3	4
		Dispensing	7	6
		Administration	127	138
		Drug Security	1	81
		Documentation	474	320
		Total medication variances	824	641
		Total Critical Breakdown Points	Previous Period	Current Period
		Total Critical Breakdown Points	771	574
		Potential MVRs	595	436
		Actual MVRs	176	138
		# Prescribing	182	55
		# Transcribing	28	34
		# Ordering/Procurement	2	4
		# Dispensing	5	6
		# Administration	92	99
		# Drug Security	1	81
		# Documentation	461	295
		Outcome A*	597	0
		Outcome B*	45	436
		Outcome C	104	116
		Outcome D	25	21
		Outcome E	0	1
		Outcome F	0	0
		Outcome G	0	0

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		<table border="1"> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table>	Outcome H	0	0	Outcome I	0	0	<p>*Outcomes A and B were redefined and are not directly comparable for the previous and current review periods.</p> <p>The facility conducted an intensive case analysis of the only medication variance that was reported as requiring an analysis. The variance occurred when staff inadvertently placed Debrox ear drops in the individual's eye, which resulted in temporary eye redness with no permanent sequelae. The analysis utilized appropriate methodology and included adequate findings and corrective actions.</p> <p>Recommendation 2, January 2010: Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p>Findings: The facility presented information showing adequate review and analysis of trends/patterns of medication variances during the review period. MVR. The analysis addressed the following:</p> <ol style="list-style-type: none"> 1. Apparent under-reporting of prescribing variances due to pharmacy factors; 2. Assessment of transcription omission of discontinuance orders in the Physicians' Ordering System (POS); 3. Assessment of factors contributing to ordering/procurement, dispensing, administration and documentation variances; 4. The change in categorization of drug security variances to include variances previously reported in the category of documentation and assessment of clusters in drug security variances; 5. Assessment of outcomes of variances; and 6. Assessment of (and interventions to address) congestion and
Outcome H	0	0							
Outcome I	0	0							

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		<p>distractions in the populated areas of medication administration rooms in certain units.</p> <p>In addition, NSH reported the following relevant performance improvement activities during this review period:</p> <ol style="list-style-type: none"> 1. The facility conducted spot checks of the unit auditing process, including comparison of findings in real time and training to address discrepancies. 2. Patterns of medication variances in different Programs were identified, including lack of initiation of MVRs when variances were identified in the auditing process, and incomplete or inaccurate auditing practices. Training was provided to address identified contributing factors. The trainings (completed in March 2011) led to initiation of efforts to develop an electronic version of the MVR form to increase accuracy, thoroughness, timeliness, simple tracking, follow-up and confidentiality (addressing staff's concern of peer pressure). 3. Nursing Policy and Procedure was aligned with the MVR Manual specifically regarding refinements of outcome categories and necessary training was completed. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue reporting of medication variances, including review and analysis of data and corrective actions as needed.</p>
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines,	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Same as in F.1.a through F.1.h.

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	<p>anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<ul style="list-style-type: none"> • Continue to provide above outcome data for the review period. <p>Findings: 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 (no significant change); 3. Any aggression to staff resulting in major injury (decrease); 4. Individuals having alleged abuse / neglect exploitation (mild decrease); 5. Individuals having confirmed abuse /neglect exploitation (increase, but number is limited); 6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons (modest increase); 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons (increase); 8. Unique count of individuals in restraint (increase); 9. Unique count of restraint events (mild decrease); 10. Unique count of individuals in seclusion (unchanged); 11. Unique count of seclusion events (essentially unchanged); 12. Individuals on benzodiazepines who are diagnosed with substance use (decrease); 13. Individuals on benzodiazepine diagnosed with cognitive disorder (unchanged); 14. Elderly on anticholinergic medications (age >65) (unchanged); 15. Individuals diagnosed with cognitive disorder on anticholinergics (decrease); 16. Individuals diagnosed with TD prescribed anticholinergics (increase but number is limited); 17. Count of severe ADRs (unchanged); and
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		<p>18. Count of severe medication variances (increase but number is limited).</p> <p>In addition, 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: 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> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to review and analyze outcome data. 2. Same as in Section I.2
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Same as in F.1.a through F.1.h.</p>

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		<p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 recommendations: Same as in F.1.a through F.1.h.</p>
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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>

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		<p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p>Compliance: Substantial.</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, January 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, January 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.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, January 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, January 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, January 2010: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendation: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who	<p>Current findings on previous recommendation:</p>

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	are prescribed new generation antipsychotic medications	<p>Recommendation, January 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, January 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>
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.	<p>This requirement applies exclusively to Metropolitan State Hospital.</p>

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2. Psychological Services		
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Alex Kettner, PhD, PBS Team Leader 2. Grace Moscoso, RN, Staff Nurse 3. Katie Cooper, PsyD, Mall Program Director 4. Michael Marco, RT, Supplemental Activity Coordinator 5. Tony Rabin, PhD, Acting Chief of Psychology <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The records of the following 50 individuals: AA, AG, AM, AW, BN, BO, BQ, CB, CC, CI, CS, DB, DC, DKB, DT, FM, FMC, GR, GS, JM, JRM, JTC, KB, KP, LCA, LK, LS, MD, MDW, MO, MOR, MP, MR, MW, MWP, NH, RAM, RJF, RKH, RM, RW, SAG, SG, SV, TDB, THS, TJM, TM, TR and VH 2. Behavioral guidelines implemented during this review period 3. Behavioral intervention fidelity data 4. By Choice procedure checklist 5. Completed By Choice satisfaction surveys 6. Completed PRS Mall Facilitator Observation Sheets 7. Dialectical Behavior Therapy Procedural Document 8. Functional assessments completed during this review period 9. List of exercise groups 10. List of individuals needing Neuropsychological assessment and services 11. List showing medical appointments scheduled and cancelled 12. Mall services procedure manual: Substance Recovery Provider Certification 13. NSHs Mall Services Procedure Manual 14. Outcome graphs for Positive Behavior Support Plans 15. PBS and DCAT Staff Development Training Roster 16. PBS plans implemented during this review period

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		<p>17. Procedures for Dialectical Behavior Therapy at NSH 18. PSSC meeting notes 19. PSSC procedure checklist 20. PSSC/ETRC attendance sheets 21. Psychosocial enrichment activity list 22. Structural assessments completed during this review period 23. Suicide Risk Screening Instrument</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, Unit T17) for monthly review of RP 2. WRPC (Program II, Unit T4) for 7-day review of TDB 3. WRPC (Program V, Unit Q8) for 60-day review of OM 4. PSSC Meeting
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to recruit additional PBS team members until all PBS teams are fully staffed.</p> <p>Findings: NSH has three full PBS teams. Two Psychiatric Technician positions were filled during this review period. The PBS service continued with monthly training on PBS and related topics. Documentation indicated that the following training topics had been covered during this review period:</p> <ul style="list-style-type: none"> • Wellness • Psychopathy -Unit Safety • Tourette's Syndrome • Traumatic Brain Injury • Autism Spectrum Disorders • Caregiver Self-Care versus Burnout • Team Building

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Data were not available for review.</p> <p>NSH continues to provide PBS training to all new employees during the New Employee Orientation period and to retrain all nursing staff during their Annual retraining schedules. PBS and DCAT staff receive ongoing training during PSSC meetings, scheduled lectures, and PBS/DCAT weekly meetings.</p> <p>All staff responsible for implementing behavioral intervention plans had been trained to competency and certified</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses</p>	<p>Current findings on previous recommendation:</p>

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	<p>self-determination and choice by the individuals served.</p>	<p>Recommendation, January 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 48% of the quarterly and annual WRPs due each month of this review period (December 2010 - May 2011):</p> <table border="1" data-bbox="993 524 1887 599"> <tr> <td data-bbox="993 524 1087 599">2.</td> <td data-bbox="1087 524 1793 599"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 524 1887 599">100%</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 16 individuals found that all 16 WRPs included documentation on By Choice. Eleven met full compliance (AG, CC, JTC, LCA, LK, MWP, RJF, RKH, RW, TDB and TR). Four met partial compliance (FMC, MDW, RAM and THS) in that the documentation was not comprehensive or the data was not updated (e.g., the documentation in MDWs May 3, 2011 WRP was "Mr. W likes the incentive By Choice program. His point allocation is currently individualized."). One was non-compliant (CS). Document for CS for the April 29, 2011 WRP was "June 2010 - No longer participates in By Choice. Reports he doesn't like what is at the store." There should have been ongoing discussion with the individual on the incentive system. He could have changed his mind. His lack of participation due the items at the store should have been evaluated to identify items he likes and communicated to the By Choice store for the By Choice staff to determine if it was feasible to accommodate his choices. WRPTs should remember to allocate the 50 points under their control to motivate the individual in areas of low performance. For example, MWP had difficulty with timely completion of morning activities. The team could have allocated the 50 points to see if</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	100%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	100%			

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		<p>that might help, even though the individual did not allocate his points.</p> <p>This monitor observed three WRPCs (OM, RP and TDB). All three of the WRPTs reviewed the By Choice point allocation process.</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 20% of the Level of Care staff:</p> <table border="1" data-bbox="991 522 1871 1313"> <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>99%</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>99%</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>98%</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>98%</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>98%</td> </tr> <tr> <td>8.</td> <td><i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Staff is able to state their unit or programs Incentive Store hours of operation.</i></td> <td>99%</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>	1.	<i>Staff understands the goal of the By Choice system</i>	99%	2.	<i>Staff can state the current point cycle</i>	99%	3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	99%	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>	98%	6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	98%	7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	98%	8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	99%	9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	99%	10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	99%
1.	<i>Staff understands the goal of the By Choice system</i>	99%																														
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		<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 12% of individuals in the facility:</p> <table border="1" data-bbox="991 414 1871 1128"> <tr> <td data-bbox="991 414 1066 488">1.</td> <td data-bbox="1066 414 1774 488"><i>The individual understands the goal of the By Choice system.</i></td> <td data-bbox="1774 414 1871 488">93%</td> </tr> <tr> <td data-bbox="991 488 1066 563">2.</td> <td data-bbox="1066 488 1774 563"><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td data-bbox="1774 488 1871 563">89%</td> </tr> <tr> <td data-bbox="991 563 1066 638">3.</td> <td data-bbox="1066 563 1774 638"><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td data-bbox="1774 563 1871 638">96%</td> </tr> <tr> <td data-bbox="991 638 1066 745">4.</td> <td data-bbox="1066 638 1774 745"><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td data-bbox="1774 638 1871 745">98%</td> </tr> <tr> <td data-bbox="991 745 1066 820">5.</td> <td data-bbox="1066 745 1774 820"><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td data-bbox="1774 745 1871 820">73%</td> </tr> <tr> <td data-bbox="991 820 1066 894">6.</td> <td data-bbox="1066 820 1774 894"><i>Individual can indicate how many points he or she may earn each day.</i></td> <td data-bbox="1774 820 1871 894">96%</td> </tr> <tr> <td data-bbox="991 894 1066 969">7.</td> <td data-bbox="1066 894 1774 969"><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td data-bbox="1774 894 1871 969">80%</td> </tr> <tr> <td data-bbox="991 969 1066 1044">8.</td> <td data-bbox="1066 969 1774 1044"><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td data-bbox="1774 969 1871 1044">83%</td> </tr> <tr> <td data-bbox="991 1044 1066 1128">9.</td> <td data-bbox="1066 1044 1774 1128"><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td data-bbox="1774 1044 1871 1128">97%</td> </tr> </table> <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>	1.	<i>The individual understands the goal of the By Choice system.</i>	93%	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>	96%	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>	73%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	96%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	80%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	83%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	97%
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		Previous period	Current period
Mean compliance rate			
2.		89%	89%
5.		88%	73%
7.		89%	80%
8.		87%	83%

Using the By Choice Monitoring Form: Satisfaction Check, NSH surveyed a mean sample of 13% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

		Previous period	Current period
1.	<i>By Choice motivates me to participate in treatment</i>	94%	93%
2.	<i>The point system motivates me to improve my behavior</i>	90%	86%
3.	<i>The point system motivates me to learn new skills</i>	89%	83%
4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	85%	79%
5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	87%	81%
6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	88%	81%
7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	90%	86%
8.	<i>My WRPT uses By Choice to help me learn new skills</i>	89%	83%

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		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	90%	86%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	89%	83%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	92%	88%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	91%	84%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	89%	83%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	88%	83%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	94%	92%
		<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%	
		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%	

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		<table border="1"> <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>	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%	
7.	<i>The incentive store staff has completed incentive store training.</i>	100%																
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11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%																
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports	<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 20% of the Level of Care Staff, 12% 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>99%</td> </tr> <tr> <td>Individuals</td> <td>91%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>100%</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendation:</p>	Level of Care Staff	99%	Individuals	91%	By Choice Program Staff	100%										
Level of Care Staff	99%																	
Individuals	91%																	
By Choice Program Staff	100%																	

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	Team and the By CHOICE incentive program.	<p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The Acting Chief of Psychology confirmed that he has clinical and administrative authority for the PBS Teams and the By Choice incentive program.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>						
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>						
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1227 1887 1414"> <tr> <td data-bbox="991 1227 1087 1341">1.</td> <td data-bbox="1087 1227 1793 1341"><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 1227 1887 1341">100%</td> </tr> <tr> <td data-bbox="991 1341 1087 1414">2.</td> <td data-bbox="1087 1341 1793 1414"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 1341 1887 1414">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%
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%						

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		3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%
		4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%
		5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%
		6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%
		7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%
		8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%
		9.	<i>A functional assessment rating scale was completed.</i>	100%
		10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%
		11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</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>A review of 10 behavioral intervention plans (AW, BQ, FM, GR, JM, KB, MP, MW, RM and RW) found that the plans had been developed and implemented based on data derived from structural and functional assessments.</p>		

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="993 711 1887 786"> <tr> <td data-bbox="993 711 1087 786">5</td> <td data-bbox="1087 711 1793 786"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1793 711 1887 786">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 10 behavioral intervention plans (AW, BQ, FM, GR, JM, KB, MP, MW, RM and RW) found that the hypotheses in the plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments. Psychologists should continue to collect and analyze data on settings/locations in which the behaviors are low or not exhibited. Not all behavioral assessments carried out this analysis. Such analysis will assist psychologists in forming a better understanding of the setting events, antecedents, and triggers for the problem behaviors. Many of the plans had entered "precursors" as antecedents. This needs correction. Antecedent manipulation would be utilized under prevention strategies whereas precursors would be attended to defuse the behavior at the earliest sign of onset as part of the reactive strategy.</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>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, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="993 748 1887 862"> <tr> <td data-bbox="993 748 1087 862">5</td> <td data-bbox="1087 748 1793 862"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 748 1887 862">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 seven structural and functional assessments for behavioral intervention plans in effect during this review period (BO, DKB, FM, JM, MP, RM and RW) found that the plans had, where available, documented previous behavioral interventions and their effects, often as part of the section under previous history. Psychologists should be as thorough as possible in reviewing previous interventions related to the maladaptive behaviors in order to benefit from previous interventions or not use the same if they have been ineffective.</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, January 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 (December 2010 - May 2011):</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 16 behavioral intervention plans (AA, AG, AM, AW, DB, JRM, LCA, MOR, MWP, RAM, RKH, RM, RW, SAG, TJM, and TR) found that all behavioral interventions were based on a positive behavioral support model without any use of aversive or punishment contingencies. Reactive strategies in most plans indicate what the staff should be doing when the individual exhibits precursor or target behaviors (for example, in one case the staff is to take the individual to search for the shift lead responsible for attending to the individual's requests/needs. This procedure might not work always. The staff and/or the shift lead might be dealing with other individuals; besides this is unrealistic in community settings). Psychologists should also consider empowering individuals with coping skills, self-monitoring, and self-management skills (relaxation, mindfulness, journaling, waiting for a time, etc.) that they can utilize during those times.</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.2.c.v	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 (December 2010 - May 2011) 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 21 individuals (AA, BN, BQ, CB, CI, DC, DT, FM, GR, GS, JM, KB, LS, MO, MR, MW, NH, SV, TM, TR and VH) developed and implemented or revised during this review period found that NSH had conducted fidelity checks for all of the behavioral intervention plans. Documentation also showed that the staff responsible for implementing the plans were trained and certified.</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, January 2010: Continue to monitor this requirement.</p>

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Findings:

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

DMH Psychology Services Monitoring Form							
2010/2011	Dec	Jan	Feb	Mar	Apr	May	Mean
Restraint	15	7	4	9	3	7	7
%C	100	100	100	100	100	100	100
Seclusion	2	4	4	4	2	1	3
%C	100	100	100	100	100	100	100
1:1	26	25	25	37	25	19	27
%C	100	100	100	100	100	100	100
Aggression to peers	3	2	4	6	3	1	3
%C	100	100	100	100	100	100	100
Aggression to staff	6	7	11	12	7	5	8
%C	100	100	100	100	100	100	100
Aggression to self	0	3	4	2	0	2	2
%C	100	100	100	100	100	100	100

As shown in the table above, the PSSC had reviewed all cases that had met the triggers for the key indicators involved.

According to the Acting Chief of Psychology, who is also the PSSC Coordinator, PBS and DCAT teams consulted on 147 individuals who triggered for excessive use of seclusion or restraint, physical assaults to others or self-harm between December 1, 2010 and May 31, 2011. The Acting Chief of Psychology has restructured the PSSC to ensure that triggered cases receive full attention and reviews. Triggered cases that result in assessments and behavioral intervention plans are reviewed during PSSC meetings to ensure that technical and clinical qualities are

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		<p>met. The PSSC and PBS/DCAT teams should emphasize using data from the Integrated Assessment: Psychology Section to target individuals with a history of maladaptive behaviors to implement milieu interventions or behavior guidelines in a proactive manner. This will potentially reduce the number of individuals meeting trigger thresholds.</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, January 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 (December 2010 - May 2011) 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>Review of 10 structural and functional assessments (progress notes, reports) conducted to develop and implement behavioral intervention plans (AW, BQ, FM, GR, JM, KB, MP, MW, RM and RW) found that the psychologists had reviewed the individual's background and psychiatric and psychosocial history, consulted WRPT psychiatrists, and consulted psychiatrists during ETRC/PSSC meetings to better assess and address the individual's behaviors of concern. Furthermore, PBS staff meets WRPTs to discuss plans, review progress, and assist with documentation.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="991 597 1887 711"> <tr> <td data-bbox="991 597 1087 711">19.</td> <td data-bbox="1087 597 1793 711"><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 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 the records of 16 individuals with PBS plans and Behavior Guidelines found that 12 met full compliance (AA, AG, AM, AW, DB, JRM, LCA, MO, RAM, RW, TJM and TR). The documentation for these plans was comprehensive with appropriate objectives and interventions. Three met partial compliance (MWP, RM and SAG). The documentation for these four was brief and/or was not updated. One met non-compliance (RKH); documentation in the WRP dated 6/22/11 was, "As of 12/1/10 he has a PBS plan and is working as well as can be expected, will be reviewed and updated as necessary."</p> <p>Current recommendation: Continue to monitor this requirement.</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	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%			
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at	<p>Current findings on previous recommendation:</p>			

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	<p>least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Recommendation, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="993 524 1887 602"> <tr> <td data-bbox="993 524 1087 602">24.</td> <td data-bbox="1087 524 1793 602"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 524 1887 602">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 13 individuals with behavioral intervention plans showed that nine records contained proper documentation with appropriate updates in the Present Status section of the individual's WRP on at least a quarterly basis (AA, DB, JRM, LCA, LK, MO, MWP, TJM and TR). Documentation was not updated, not comprehensive, or did not include appropriate objectives and interventions in the remaining four cases (AG, LCA, RM and RW).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			
F.2.c.x	<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, January 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, NSH assessed its</p>			

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		<p>compliance based on a 100% sample of behavior guidelines developed or revised during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 302 1887 415"> <tr> <td data-bbox="991 302 1087 415">20.</td> <td data-bbox="1087 302 1793 415"><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 302 1887 415">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>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 (December 2010 - May 2011):</p> <table border="1" data-bbox="991 711 1887 789"> <tr> <td data-bbox="991 711 1087 789">21.</td> <td data-bbox="1087 711 1793 789"><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 711 1887 789">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 10 PBS plans and related assessment and staff training data (AA, DB, KP, MO, MR, MW, RM, RW, SG and VH) found that the staff responsible for implementing the PBS plans had been trained to competency in all 10 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</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%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
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%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue to monitor this requirement.</p>						

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		<p>Findings: The facility reported that all PBS team members are primarily responsible for the provision of behavioral interventions. PBS staff are asked to perform other duties outside of their PBS work time, which does not hamper or interfere with their PBS duties.</p> <p>Current recommendation: Continue current practice.</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, January 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 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	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH has a full Developmental and Cognitive Abilities Team (DCAT). The DCAT members participate in PBS staff development training to maintain their competency. They also conduct behavioral assessments and write behavioral intervention plans, assist SW staff with discharge planning assessments, and facilitate Mall groups.</p>

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	<p>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>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: NSH maintains a Psychology Specialty Services Committee (PSSC). The PSSC continues to support the facility by collaborating with the ETRC to review and analyze cases referred to the PSSC/ETRC. The PSSC addresses the needs of PBS/DCAT team members and unit staff in dealing with challenging behaviors of individuals in the facility. Review of PSSC meeting minutes found that the meetings were held regularly and attendance of core members was high. This monitor attended one of the PSSC/ETRC meetings held during this review period. The meeting was well conducted, attendance was high; and case reviews with discussion, feedback, and action plans were appropriate.</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</p>	<p>Current findings on previous recommendation:</p>

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	<p>assessment of individuals with persistent mental illness.</p>	<p>Recommendation, January 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="991 488 1892 899"> <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. I</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>4</td> <td>9</td> <td>7</td> <td>5</td> <td>4</td> <td>9</td> <td>6</td> </tr> <tr> <td>18.a. Ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>5</td> <td>5</td> <td>8</td> <td>6</td> <td>5</td> <td>7</td> <td>6</td> </tr> <tr> <td>18.a. Iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>35 days</td> </tr> </tbody> </table> <p>As the table above shows, the Neuropsychology Service continues to address referrals (the mean number of referrals remains the same as during the previous review period). NSH has four neuropsychologists who support the facility with assessments, consultations, and Mall groups (including cognitive remediation groups).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			Jun	Jul	Aug	Sep	Oct	Nov	Mean	18.a. I	<i>Number of neuropsychological assessments due for completion in the review month</i>	4	9	7	5	4	9	6	18.a. Ii	<i>Of those in 18.a.i, number completed</i>	5	5	8	6	5	7	6	18.a. Iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							35 days
		Jun	Jul	Aug	Sep	Oct	Nov	Mean																														
18.a. I	<i>Number of neuropsychological assessments due for completion in the review month</i>	4	9	7	5	4	9	6																														
18.a. Ii	<i>Of those in 18.a.i, number completed</i>	5	5	8	6	5	7	6																														
18.a. Iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							35 days																														

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F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>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>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Michelle Patterson, RN, ACNS 2. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Nursing Services Monitoring PRN Audit summary data, December 2010 - May 2011 2. NSH Nursing Services Monitoring Stat Audit summary data, December 2010 - May 2011 3. NSH Nursing Staff Familiarity Monitoring Audit summary data, December 2010 - May 2011 4. NSH Medical Transfer Audit summary data, December 2010 - May 2011 5. NSH Nursing Services Audit summary data, December 2010 - May 2011 6. NSH Medication Administration Monitoring Audit summary data, December 2010 - May 2011 7. DMH Nursing Services Monitoring-Bed Bound Audit summary data, December 2010 - May 2011 8. NSH training rosters 9. Medication Variance forms for the review period 10. Centers for Medicare & Medicaid Services survey dated 4/14/2011 11. Medical records for the following 93 individuals: AB, ADA, AJL, AJL, AKS, APF, AR, AS, BAS, BB, BCP, BHF, BJC, BT, BW, CCS, CD, CMR, CS, CWS, DC, DES, DJC, DJM, DNA, DRM, DT, DTP, ERC, ERM, ETR, FC, FKL, GFU, GLL, GVC, GW, HJV, HS, JA, JB, JBC, JC, JD, JEA, JH, JKM, JL, JLA, JM, JMU, JRB, JS, JSH, JV, KEP, KFH, LCA, LJ, LRJ, LRM, MD, ML, MR, MRG, MW, PCM, PEM, RA, RAM, RB, RBD, RDY, RJ, RKH, RM, RR, RT, RW, SAE, SDB, SH, SMH, SMR, TEB, TGP, TM, TO, TOM, WLB, WQ, YH and YW

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program II, unit Q11) for annual review of IFI 2. WRPC (Program I, unit Q3) for monthly review of MMD 3. WRPC (Program II, unit T2) for monthly review of DMR 4. Shift report on Program II, unit Q11 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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 13% mean sample of PRNs administered each month during the review period (December 2010 - May 2011) 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 16% mean sample of Stat medications administered each month during the review period (December 2010 - May 2011) and reported a mean compliance rate of 97%. Comparative data</p>

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		<p>indicated that NSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 227 PRN and Stat orders (151 PRN and 76 Stat) for 80 individuals (AB, ADA, AJL, AKS, APF, AR, AS, BAS, BB, BCP, BHF, BJC, BT, BW, CCS, CMR, CS, CWS, DC, DES, DJC, DJM, DNA, DRM, DT, DTP, ERC, ERM, ETR, FC, FKL, GFU, GLL, GVC, HS, JA, JB, JBC, JC, JD, JEA, JH, JKM, JLA, JMU, JRB, JSH, KEP, KFH, LCA, LRJ, LRM, MD, ML, MR, MRG, PCM, PEM, RA, RAM, RB, RBD, RDY, RJ, RKH, RR, RT, SAE, SDB, SH, SMH, SMR, TEB, TGP, TM, TO, TOM, WLB and YH) 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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 13% mean sample of PRNs administered each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1192 1887 1341"> <tr> <td data-bbox="991 1192 1087 1341">3.</td> <td data-bbox="1087 1192 1793 1341"><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 1192 1887 1341">99</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</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>at least 90% from the previous review period.</p> <p>A review of 151 incidents of PRN medications for 27 individuals (AJL, AKS, APF, BW, CWS, DJC, DJM, DNA, DT, ERC, ERM, GFU, GLL, GVC, JA, JC, JMU, KEP, ML, MR, PEM, RBD, RDY, SMH, TEB, TM and WLB) found adequate documentation in the IDNs of the circumstances requiring the PRN in 149 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH also assessed its compliance based on a 16% mean sample of Stat medications administered each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 672 1887 821"> <tr> <td data-bbox="991 672 1087 821">4.</td> <td data-bbox="1087 672 1793 821"><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 672 1887 821">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 76 incidents of Stat medications for 53 individuals (AB, ADA, AJL, AR, AS, BAS, BB, BCP, BHF, BJC, BT, CCS, CMR, CS, DC, DES, DRM, DTP, ETR, FC, FKL, HS, JB, JBC, JD, JEA, JH, JKM, JLA, JRB, JSH, KFH, LCA, LRJ, LRM, MD, MRG, PCM, RA, RAM, RB, RJ, RKH, RR, RT, SAE, SDB, SH, SMR, TGP, TO, TOM and YH) 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%			

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<p>F.3.a.iii</p>	<p>documentation of the individual's response to PRN and Stat medication.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, NSH assessed its compliance based on a 13% mean sample of PRNs administered each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 565 1885 673"> <tr> <td data-bbox="991 565 1087 673">5.</td> <td data-bbox="1087 565 1793 673"><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 565 1885 673">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 151 incidents of PRN medications for 27 individuals (AJL, AKS, APF, BW, CWS, DJC, DJM, DNA, DT, ERC, ERM, GFU, GLL, GVC, JA, JC, JMU, KEP, ML, MR, PEM, RBD, RDY, SMH, TEB, TM and WLB) found a timely comprehensive assessment in the IDNs of the individual's response in 148 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, NSH also assessed its compliance based on a 16% mean sample of Stat medications administered each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1230 1885 1339"> <tr> <td data-bbox="991 1230 1087 1339">6.</td> <td data-bbox="1087 1230 1793 1339"><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 1230 1885 1339">98%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</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>	98%
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>	98%						

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		<p>at least 90% from the previous review period.</p> <p>A review of 76 incidents of Stat medications for 53 individuals (AB, ADA, AJL, AR, AS, BAS, BB, BCP, BHF, BJC, BT, CCS, CMR, CS, DC, DES, DRM, DTP, ETR, FC, FKL, HS, JB, JBC, JD, JEA, JH, JKM, JLA, JRB, JSH, KFH, LCA, LRJ, LRM, MD, MRG, PCM, RA, RAM, RB, RJ, RKH, RR, RT, SAE, SDB, SH, SMR, TGP, TO, TOM and YH) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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, January 2011: 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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p>

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	<p>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>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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 12% of the nursing staff:</p> <table border="1" data-bbox="991 971 1887 1118"> <tr> <td data-bbox="991 971 1087 1118">8.</td> <td data-bbox="1087 971 1793 1118"><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 971 1887 1118">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>	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%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.e	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2011:</p> <ul style="list-style-type: none"> • 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. • Continue training focused on mentoring and improve nursing competency regarding assessments and documentation addressing changes in status. <p>Findings: NSH indicated that in December 2010, the Utilization Review Nurse initiated a stringent auditing process addressing changes in status with an increased emphasis on the quality and legibility of the nursing documentation for outside hospitalization/ER visits. In addition, the current auditing process included a review of the nursing documentation two weeks prior and after the hospitalization. In March, the CNS Change of Condition/Transfer Out audit instrument was revised and implemented to formally address the quality of the nursing assessment documentation. The findings for each outside hospitalization audit are sent to Program management and Program HSSs for necessary corrective actions and mentoring. The HSSs will monitor and follow up on reassessments each shift for any physical status changes. Also, the Nursing Education Department continues to provide the annual Physical Assessment training to RNs. In May 2011, the revised assessment module regarding the</p>

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		<p>Neuro System Assessment was provided.</p> <p>Recommendation 3, January 2011: 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.</p> <p>Findings: The Shift Report on Unit T6 was videotaped and copies were provided to each unit and other state facilities to improve the shift report process.</p> <p>Recommendation 4, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Transfer Audit, NSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 930 1887 1156"> <tr> <td data-bbox="991 930 1087 1044">1.</td> <td data-bbox="1087 930 1793 1044"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 930 1887 1044">75%</td> </tr> <tr> <td data-bbox="991 1044 1087 1156">7.</td> <td data-bbox="1087 1044 1793 1156"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 1044 1887 1156">87%</td> </tr> </table> <p>Compliance rates for items 1 and 7 were 91% and 93% respectively in the previous review period.</p> <p>The findings of the monitoring team did not comport with NSH's findings. A review of the records of 14 individuals who were transferred to a community hospital/emergency room (BT, CD, GW, JC, JL, JM, JS, JV,</p>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	75%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	87%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	75%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	87%						

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		<p>LJ, MW, RM, RW, WQ and YW) found problematic issues similar to those found in past reviews in the nursing documentation in 13 of the records. Identified issues included:</p> <p><u>Nursing Assessments</u></p> <ul style="list-style-type: none"> • No regular nursing assessments conducted for an individual noted to have episodes of abdominal pain. • No adequate nursing assessments and teaching for an individual who received an ileostomy. • No nursing assessment or vital signs found for complaints of pain. • No nursing assessment documented prior to giving medication for complaints of pain or after to assess effectiveness. • Inadequate nursing assessment prior to transfer to hospital. • No nursing assessment or vital signs found in response to an individual unable to void. • No nursing assessments found for individuals' complaints of constipation. • No nursing assessments for individual noted to have diminished lung sounds and non-productive cough. • Inadequate nursing assessment for an individual with an elevated temperature. • Inadequate nursing assessment found for complaints of muscle rigidity. • The IDNs noted an individual was experiencing significant cognitive and behavior changes; no nursing assessment found. • No nursing assessment found for individual experiencing episodes of vomiting. • No nursing assessment for an individual noted to have "very unstable gait." • No neuro checks assessed for an individual found with cognitive changes. • No nursing assessment conducted for an individual complaining of abdominal pain and "blackouts" when getting up from a lying position.
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		<ul style="list-style-type: none"> • No regular nursing assessment for an individual with fractured ribs. • No regular nursing assessment of surgical site post-hospitalization. • Significant gaps in time between nursing assessments when changes in status were identified. • Lack of a complete nursing assessment upon return to the facility specifically addressing the symptoms that precipitated the hospitalization. • Missing nursing assessment on Change of Transfer forms marked as completed. <p><u>Documentation</u></p> <ul style="list-style-type: none"> • No nursing notes found after a hospitalization. • Change of status form indicated individual experiencing symptoms for past few days; no documentation of this found in the IDNs. • Lack of consistent documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline. • Medical PRNs consistently not documented according to policy and nursing standards. • Several nursing notes illegible. • RN Transfer note frequently not completed. • Significant lost and missing documents not initially found at the time of the document request. <p><u>Process</u></p> <ul style="list-style-type: none"> • No evidence that nurses are using the RANs or nursing protocols. <p>Although the facility had implemented the interventions listed above addressing some of the problematic issues in this area at the time of the review, little improvement in compliance with this requirement was noted. The facility needs to develop and implement a system for documentation, such as the use of the RANs and/or Nursing Protocols, so that nurses have a structure guiding their documentation to ensure completeness and</p>
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		<p>consistency. At the time of the review, the Nursing Department was aware that it had considerable additional work to do in this area.</p> <p>Using the DMH Nursing Services Audit, NSH assessed its compliance based on a 48% sample of Change of Shift Reports observed during in the review months (December 2010 - May 2011):</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">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>Observation of shift report on Program II, unit Q11 found that the quality of the content of this shift report had declined since the last review in that it was basically generic and lacked individualized, clinically relevant information regarding the individuals' status. These findings do not comport with NSH's data. The facility needs to continue its efforts in mentoring appropriate shift reports.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The facility needs to develop and implement a system for practice and documentation, in alignment with Nursing Standards of Practice, that includes the use of RANs and/or Nursing Protocols. 2. Continue training and mentoring focused on building and improving nursing competency regarding assessments and documentation addressing changes in status. 3. Further review of the monitoring tool and instructions addressing Medical Transfers regarding nursing documentation should be 	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>	95%
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>	95%			

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		<p>conducted to ensure it is representative of the requirements for this area and includes qualitative standards for nursing such as RANs and/or Nursing protocols for evaluating the compliance of the nursing documentation.</p> <ol style="list-style-type: none"> 4. Increase efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses. 5. Continue to monitor these requirements.
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 recommendations:</p> <p>Recommendation 1, January 2011: Ensure that individuals with compromised health issues are safely administered medications and that specific positioning and instructions are followed consistently.</p> <p>Findings: NSH did not address this recommendation.</p> <p>Recommendation 2, January 2011: 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 13% 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. Compliance rates for other items in this audit are reported in the following cells.</p>

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		<p>A number of problematic issues were observed during medication administration on unit A4. Specifically, the RN administering the medications did not:</p> <ul style="list-style-type: none"> • Check the Physical and Nutritional Plan for the proper positioning to safely administer medications; • Know the reason why an individual took nothing by mouth (NPO) and took all nourishment and medications via tube (individual was at risk for aspiration); • Know if the individual had a J or G tube; • Know the differences between a J and a G tube; • Conduct an assessment when the individual began coughing during medication administration. <p>In addition, a second RN who was in the individual's room could not answer any of the questions noted above. At that time, this reviewer had a discussion with the shift lead and unit supervisor regarding the immediate need for training addressing risk of aspiration, PMNPs, and G/J tubes. By the end of the review, the facility had provided the monitoring team with documentation that the appropriate training had been provided to all nurses on the unit.</p> <p>These findings are particular concerning since they are similar to the findings for the past two reviews regarding medication administration on Unit A4. In addition, the Centers for Medicare & Medicaid Services survey dated 4/14/2011 indicated problematic findings regarding positioning and medication administration.</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 consistently being followed.
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		2. Continue to monitor this requirement.
F.3.f.ii	education is provided to individuals during medication administration;	The facility 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. See F.3.f.i for reviewer's findings.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	The facility 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. See F.3.f.i for reviewer's findings.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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 13% of level of care nursing staff who are licensed and medication-certified, 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>NSH was able to produce MVRs for the blanks that were found and reported on the MTRs and Narcotic Logs during the review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</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 (one individual) who were bed bound during the review period and reported a mean compliance rate of 100%.</p> <p>A review of the record of one individual who was bed-bound during the review period (HJV) found that the physicians' orders and WRP included the clinical justification for the 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, January 2011: Continue current practice.</p> <p>Findings: NSH's training rosters indicated that all 17 newly hired nursing staff completed the training for Psych Nursing 101. In addition, a new class, Therapeutic Approaches to Working with Individuals, was initiated and 46 staff have taken this class thus far. Also, 121 RNs have completed the Physical Assessment training. In May 2011, the Neuro System</p>

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		<p>Assessment class was initiated, and 38 RNs have received the initial training. This class will be mandated for all new RNs effective June 2011 and will be added to annual required training for all RNs beginning in January 2012.</p> <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, January 2011: Continue current practice.</p> <p>Findings: NSH's training rosters verified that the required staff received and passed competency-based training addressing Therapeutic Strategy Interventions (TSI) and Positive Behavior Support Principles.</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, January 2011: Continue current practice.</p> <p>Findings: See F.3.h.ii.</p> <p>Current recommendation: Continue current practice.</p>

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F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: NSH's training rosters verified that out of 411 licensed nursing staff that were due for annual training, 405 completed competency-based training on Medication Administration: Theory and Skills and/or Med Challenge. The remaining staff were scheduled for training by August 2011.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Camille Gentry-Kajankoski, Acting Chief of Rehabilitation Therapy Services 2. Jennie Gilmore, Acting Senior Rehabilitation Therapist 3. Jennifer Deterville, Acting Senior Rehabilitation Therapist 4. Phyllis Moore, Acting Senior Rehabilitation Therapist 5. Susan Jette, Acting Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for December 2010 - May 2011 2. NSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 21 individuals participating in observed PSR Mall groups: AP, AS, AW, DAF, DAL, FP, FSP, HC, HQV, JJB, JRB, JTT, LKM, MAF, MB, MC, MSS, RA, TM, TRB and ZJP 4. List of individuals who received direct physical therapy services from December 2010 - May 2011 5. List of individuals who received direct speech therapy services from December 2010 - May 2011 6. List of individuals who received direct occupational therapy services from December 2010 - May 2011 7. Records of the following 10 individuals who received direct physical, occupational and/or speech therapy services from December 2010 - May 2011: JDK, KZ, MDP, MER, MMP, MP, PA, RJR, RWS and ZCP 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following six individuals with 24-Hour Rehabilitation Support Plans: JDK, JJR, JWS, MER, MMP and RJR 10. List of individuals with INPOP plans 11. Records for the following two individuals with INPOP plans: BMS and DKB

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		<p>11. Records for the following two individuals at high risk for falls: RDF and RG</p> <p>12. Records for the following four individuals who had three or more falls in 30 days or a fall with a major injury during the review period: BVT, EWT, GLH and JSC</p> <p>13. Records for the following two individuals at high risk for impaired skin integrity: VC</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Relaxation through Art PSR Mall group 2. Leisure Skills through Dance PSR Mall group 3. Life Skills PSR Mall group 4. Competency through Music PSR Mall group 5. Mindfulness Strategies PSR Mall group 6. Enhancing Motivation through Music PSR Mall group 7. Reality Orientation through Music 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:	Please see sub-cells for compliance.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</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 May 2-6:</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>108</td> <td>83</td> </tr> <tr> <td>OT</td> <td>25</td> <td>19</td> </tr> <tr> <td>SLP</td> <td>18</td> <td>16</td> </tr> </tbody> </table> <p>Other findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 13% of individuals receiving occupational, physical, and/or speech therapy direct treatment during the review period December 2010 - May 2011 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 10 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 nine out of 10 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes (progress for one individual could not be determined due to just starting treatment).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Scheduled	Provided	PT	108	83	OT	25	19	SLP	18	16
	Scheduled	Provided												
PT	108	83												
OT	25	19												
SLP	18	16												
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, January 2011: Continue to monitor this requirement.</p>												

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		<p>Findings: Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 56% of plans completed during the review period December 2010 - May 2011, and reported a mean compliance rate of 84%.</p> <p>A review of the records of two individuals with INPOP plans to assess compliance with F.4.a.ii criteria found both records in substantial compliance.</p> <p>Compliance: Substantial.</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, January 2011: Continue to monitor this requirement.</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 1151 1873 1421"> <thead> <tr> <th>Training Type</th> <th>Date(s)</th> <th>Training Subject</th> <th># Trained</th> </tr> </thead> <tbody> <tr> <td rowspan="3">Adaptive Equipment</td> <td>12/13/10</td> <td>Soft helmet use</td> <td>1</td> </tr> <tr> <td>12/17/10</td> <td>Adaptive cup</td> <td>3</td> </tr> <tr> <td>2/11/11</td> <td>Adaptive cup</td> <td>7</td> </tr> <tr> <td rowspan="3">24 Hour Support Plan training</td> <td>12/14/10</td> <td>24-Hour Support Plan</td> <td>1</td> </tr> <tr> <td>12/30/10</td> <td>24-Hour Support Plan</td> <td>1</td> </tr> <tr> <td>4/6/11</td> <td>24-Hour Support Plan</td> <td>5</td> </tr> </tbody> </table>	Training Type	Date(s)	Training Subject	# Trained	Adaptive Equipment	12/13/10	Soft helmet use	1	12/17/10	Adaptive cup	3	2/11/11	Adaptive cup	7	24 Hour Support Plan training	12/14/10	24-Hour Support Plan	1	12/30/10	24-Hour Support Plan	1	4/6/11	24-Hour Support Plan	5
Training Type	Date(s)	Training Subject	# Trained																							
Adaptive Equipment	12/13/10	Soft helmet use	1																							
	12/17/10	Adaptive cup	3																							
	2/11/11	Adaptive cup	7																							
24 Hour Support Plan training	12/14/10	24-Hour Support Plan	1																							
	12/30/10	24-Hour Support Plan	1																							
	4/6/11	24-Hour Support Plan	5																							

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			4/15/11	24-Hour Support Plan	2
			4/19/11	24-Hour Support Plan	1
			4/20/11	24-Hour Support Plan	3
			4/25/11	24-Hour Support Plan	3
			4/27/11	24-Hour Support Plan	1
			5/12/11	24-Hour Support Plan	1
			5/20/11	24-Hour Support Plan	2
		Positioning/Mobility	8/18/10	Transfer training and cognition	2
			12/1/10	Wheelchair use	1
			12/7/10	Wheelchair use	1
			12/8/10	Wheelchair use	1
			12/29/10	Wheelchair use	1
			1/5/11	ORIF protocol	2
			5/25/11	Wheelchair use	2
		Promote Individuals' Independence	12/13/10	Helmet use	
		Exercise programs	12/7/10	Home exercise program	1
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p>			

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		<p>Findings:</p> <p>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 December 2010 - May 2011 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 records of six individuals with 24-hour support plans to assess compliance with F.4.c criteria found five records in substantial compliance and one record in partial compliance (JDK). The 24-hour support plan for JDK did not contain strategies to address fall risk during mobility and ADL tasks.</p> <p>Using the DMH F.4 Monitoring Tool, NSH assessed its compliance based on an average sample of 10% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period December 2010 - May 2011, 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 20 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 16 records in substantial compliance (AP, AS, AW, DAL, FP, HQV, JRB, JTT, LKM, MAF, MB, MSS, RA, TM, TRB and ZJP) and four records in partial compliance (DAF, FSP, HC and JJB).</p> <p>In terms of individualized outcomes, record review found that 13 out of 18 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</p>
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		<p>documentation for three individuals due to recently starting group.</p> <p>Observation of seven PSR Mall groups found that in all 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> <p>Information on scheduled versus provided PSR Mall hours was not provided; this information is contained in Section C.2.</p> <p>Other findings: Record reviews of four individuals who had three or more falls in 30 days and/or fall with major injury found that two individuals (GLH and JSC) were referred for and received physical and/or occupational therapy assessment and treatment (direct treatment and/or 24-hour support plan) to address fall risk. One individual (EWT) was referred for physical therapy assessment following fall incidents but refused five times. One individual (BVT) was not referred for PT or OT assessment following fall trigger but had nursing objectives in place to address fall risk. A review of the records of two individuals who were at high risk for falls found evidence that one individual (RG) was receiving occupational therapy services to improve safety with functional mobility and ADLs due to fall risk, and one individual (RDF) was not referred for POST services.</p> <p>The record for one individual at high risk for impaired skin integrity was reviewed, and it did not appear that a PT or OT assessment was clinically indicated to address potential decubitus risk.</p> <p>Compliance: Substantial.</p>
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		<p>Current recommendation: Continue to monitor this requirement.</p>															
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</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 December 2010 - May 2011:</p> <table border="1" data-bbox="989 711 1887 1088"> <tr> <td data-bbox="989 711 1087 784">e.</td> <td data-bbox="1087 711 1776 784"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1776 711 1887 784">100%</td> </tr> <tr> <td data-bbox="989 784 1087 862">f.</td> <td data-bbox="1087 784 1776 862"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1776 784 1887 862">100%</td> </tr> <tr> <td data-bbox="989 862 1087 938">g.</td> <td data-bbox="1087 862 1776 938"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1776 862 1887 938">100%</td> </tr> <tr> <td data-bbox="989 938 1087 1015">h.</td> <td data-bbox="1087 938 1776 1015"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1776 938 1887 1015">100%</td> </tr> <tr> <td data-bbox="989 1015 1087 1088">i.</td> <td data-bbox="1087 1015 1776 1088"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1776 1015 1887 1088">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate greater than 90% from the previous review period.</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>	100%
e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%															
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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>	100%															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christen Adams, Clinical Dietitian 2. Deena Rosen, Assistant Director of Dietetics 3. Jessica Tuttle, Clinical Dietitian 4. Joanne Merrill, MA, Clinical Dietitian 5. Kumiko Kato, MPH, Clinical Dietitian 6. Laufey Gunnarsdottir, Clinical Dietitian 7. Linderpal Dhillon, Clinical Dietitian 8. Lynn Wurzel, Clinical Dietitian 9. Lynne Fredricksen, Assistant Director of Dietetics 10. Wen Pao, Director of Dietetics <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from December 2010 - May 2011 for each assessment type 2. Records of the following 15 individuals with types a-j.ii assessments from December 2010 - May 2011: BS, EG, GG, GT, JK, JS, KB, KK, MM, MT, PB, RDR, RJ, RSS and SC 3. Meal Accuracy Report audit data from December 2010 - May 2011 4. Nutrition Care Monitoring Tool audit data from December 2010 - May 2011 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. Records for the following two individuals at risk for choking or aspiration: CEF and JHH 7. List of individuals with an incident of choking during the review period 8. Records for the following individuals with a choking incident during the review period: BMH, DDC and MR 9. List of individuals with an incident of aspiration pneumonia during the

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		<p>review period</p> <ol style="list-style-type: none"> 10. Records for the following two individuals with an incident of aspiration pneumonia during the review period: JWS and MAW 11. List of individuals with a new diabetes diagnosis during the review period 12. Records for the following five individuals with a new diabetes diagnosis during the review period: AKL, DHF, KMB, MP and RP 13. List of individuals at risk for metabolic syndrome 14. Records for the following four individuals at high risk for metabolic syndrome: CS, JT, RGK and RS 15. Enteral Feeding Review Committee meeting minutes 16. Records for the following four individuals receiving enteral nutrition: CR, JAH, NJ and SS <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Nutrition and Wellness PSR Mall group 2. A4 Dining room 						
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, January 2011: 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 32% of Nutrition Assessments (all types) due each month from December 2010 - May 2011 (total of 523 out of 1610):</p> <table border="1" data-bbox="989 1263 1885 1414"> <tr> <td data-bbox="989 1263 1087 1304">7.</td> <td data-bbox="1087 1263 1776 1304"><i>Nutrition education is documented.</i></td> <td data-bbox="1776 1263 1885 1304">100%</td> </tr> <tr> <td data-bbox="989 1304 1087 1414">8</td> <td data-bbox="1087 1304 1776 1414"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1776 1304 1885 1414">100%</td> </tr> </table>	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>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 15 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>Other findings: A review of records for four individuals at high risk for metabolic syndrome and for five individuals with a new diagnosis of diabetes found that all nine 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>NSH assessed its compliance based on an average sample of 15% of trays served (modified and regular diets) to assess compliance with meal accuracy, and reported the following data:</p> <table border="1" data-bbox="989 967 1887 1122"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>Meal accuracy</td> <td>94%</td> <td>93%</td> </tr> </tbody> </table> <p>The facility reported that all food service technicians and cooks are provided training on therapeutic diet textures upon New Employee Orientation, with updates provided as clinically indicated. An observation in the A4 dining room revealed that the RN was present at the tray line to verify that diet texture and liquid consistency were accurate.</p>		Previous period	Current period	Mean compliance rate			Meal accuracy	94%	93%
	Previous period	Current period									
Mean compliance rate											
Meal accuracy	94%	93%									

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		<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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, NSH assessed its compliance with WRP integration based on an average sample of 32% of Nutrition Assessments (all types) due each month from December 2010 - May 2011 (523 out of 1610):</p> <table border="1" data-bbox="989 821 1885 1010"> <tr> <td data-bbox="989 821 1087 898">19.</td> <td data-bbox="1087 821 1776 898"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1776 821 1885 898">100%</td> </tr> <tr> <td data-bbox="989 898 1087 1010">20.</td> <td data-bbox="1087 898 1776 1010"><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="1776 898 1885 1010">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 15 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>	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%						

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.5.c	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: 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 records of two individuals with an incident of aspiration pneumonia, and three individuals with choking incidents found that four individuals (BMH, DDC, MAW and MR) were referred for and received speech therapy assessment and/or services (direct treatment and/or 24-hour support plans) to address risk and prevent future occurrence, and one individual (JWS) was not. The individual JWS did receive a 24-hour support plan to address positioning during enteral nutrition subsequent to PEG tube placement, but the plan did not address positioning for bed, bathing, and dressing. Review of the records for two individuals at high risk for aspiration and choking found that both 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, one of the two individuals had an individualized 24-hour support plan to promote optimal safety due to identified risk.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: The facility reported that the following trainings were provided to nurses by POST staff:</p> <table border="1" data-bbox="989 784 1705 976"> <thead> <tr> <th>Date(s)</th> <th>Training Subject</th> <th>Staff Trained</th> </tr> </thead> <tbody> <tr> <td>12/20/10</td> <td>Swallow precautions</td> <td>4</td> </tr> <tr> <td>12/27/10</td> <td>PO trials training</td> <td>1</td> </tr> <tr> <td>2/03/11</td> <td>Dysphagia Daily Risk</td> <td>5</td> </tr> <tr> <td>5/25/11</td> <td>Swallow precautions</td> <td>2</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Date(s)	Training Subject	Staff Trained	12/20/10	Swallow precautions	4	12/27/10	PO trials training	1	2/03/11	Dysphagia Daily Risk	5	5/25/11	Swallow precautions	2
Date(s)	Training Subject	Staff Trained															
12/20/10	Swallow precautions	4															
12/27/10	PO trials training	1															
2/03/11	Dysphagia Daily Risk	5															
5/25/11	Swallow precautions	2															
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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p>															

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	<p>the feasibility of returning them to oral intake status.</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. One individual (NJ) has received direct speech therapy for PO trials; one individual (SS) has a supplemental PEG tube and thus eats by mouth; one individual (JAH) was referred for possible PO trials but refused speech therapy treatment; and one individual (CR) does not appear to be a candidate for PO trials and possible return to oral intake due to the severity 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 December 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.	

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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Abishai Rumano, MD, Physician and Surgeon, Chief of Medical Ancillary Services 2. David Perts, MD, Physician and Surgeon 3. Hong-Shen Yeh, MD, Physician and Surgeon 4. Jaskaran Momi, MD, Physician and Surgeon 5. Joseph Ritsick, MD, Physician and Surgeon 6. Lane Melgarejo, MD, Physician and Surgeon 7. Macaria Villalobos, MD, Physician and Surgeon 8. Mandeep Singh, MD, Physician and Surgeon 9. Manveen Sekhon, MD, Physician and Surgeon 10. Marleen Salvador, MD, Physician and Surgeon 11. Rajeev Sachdev, MD, Physician and Surgeon 12. Rodolfo Pineda, MD, Physician and Surgeon 13. Shahid Rehman, MD, Staff Neurologist 14. William Kocsis, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 12 individuals who were transferred to an outside medical facility during this reporting period: BT, CD, GW, JC, JL, JM, JS, JV, LJ, MW, WQ and YW 2. Physician's Quarterly Progress note for the following 12 individuals: BAM, DPA, EH, HA, JA, JRB, KFR, MB, NJ, NSF, PA and SB 3. NSH Neurological Assessment Flow Sheet 4. Nursing Policy and Procedure 1203, Neurological Status: Basic Monitoring and Assessment, revised 5. NSH Medical-Surgical Progress Note Auditing summary data (December 2010 - May 2011) 6. NSH Integration of Medical Conditions into the WRP Auditing summary data (December 2010 - May 2011)

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		<ol style="list-style-type: none"> 7. NSH Medical Transfer Auditing summary data (December 2010 - May 2011) 8. NSH Audit of Timeliness of Consultations & Referrals to off-site Medical Consultants/Services (December 2010 - May 2011) 9. NSH Diabetes Mellitus Auditing summary data (December 2010 - May 2011) 10. NSH Hypertension Auditing summary data (December 2010 - May 2011) 11. NSH Dyslipidemia Auditing summary data (December 2010 - May 2011) 12. NSH Cardiac Disease Monitoring summary data (December 2010 - May 2011) 13. NSH Preventive Care Monitoring data (December 2010 - May 2011) 14. 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	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2010: Ensure proper implementation of a procedure of timely neurological checks for individuals following head injury.</p> <p>Findings: The facility implemented a revised Neurological Assessment Flow Sheet</p>

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	<p>monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>to ensure timely and adequate neurological checks for individuals with head injury (effective July 1, 2011).</p> <p>Recommendation 2, January 2010: 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.</p> <p>Findings: The facility reported the following actions:</p> <ol style="list-style-type: none"> 1. Beginning in May 2011, the facility provided training that focused on Neuro System Assessment. 2. Nursing Policy and Procedure 1203, Neurological Status: Basic Monitoring and Assessment has been revised to reflect the modification of the Neurological Assessment Flow Sheet. 3. The Nursing Education department continued to provide the annual Physical Assessment training to RNs. <p>Recommendation 3, January 2010: Address the issue of inadequate staff coverage during off-hours as mentioned in finding #5 [in this cell in the previous report].</p> <p>Findings: NSH has implemented double coverage during identified peak off-hours effective May 1, 2011.</p> <p>Recommendation 4, January 2010: Continue to provide summary of any changes in current medical policies, procedures, ADs or protocols/guidelines during this review period.</p> <p>Findings: The facility updated its Diabetes Mellitus Practice Guidelines to align</p>
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		<p>with the 2011 American Diabetes Association guidelines. The updates addressed the following:</p> <ol style="list-style-type: none"> 1. The target preprandial blood glucose level; 2. Parameters for use of aspirin/antiplatelet therapy for primary cardiovascular disease protection; and 3. Hemoglobin A1C criteria for the diagnosis of diabetes mellitus and prediabetes. <p>In addition, new standardized procedures and guidelines for Nurse Practitioners' expanded practice were presented and approved (April 5, 2011).</p> <p>Other findings: This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility on 15 occasions during this review period. The monitor also interviewed the physicians and surgeons involved in the care of these individuals. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 993 1896 1412"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>12/4/10</td> <td>Seizure</td> </tr> <tr> <td>2</td> <td>12/15/10</td> <td>Seizure and Aspiration Pneumonia</td> </tr> <tr> <td>3</td> <td>12/22/10</td> <td>Abdominal Pain</td> </tr> <tr> <td>4</td> <td>1/1/11</td> <td>Ingested Foreign Body</td> </tr> <tr> <td>5</td> <td>1/17/11</td> <td>Abdominal Pain</td> </tr> <tr> <td>6</td> <td>1/18/11</td> <td>Possible Diverticulitis</td> </tr> <tr> <td>7</td> <td>1/24/11</td> <td>Delirium</td> </tr> <tr> <td>8</td> <td>1/29/11</td> <td>Central Nervous System Lymphoma</td> </tr> <tr> <td>6</td> <td>2/5/11</td> <td>Seizure</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1	12/4/10	Seizure	2	12/15/10	Seizure and Aspiration Pneumonia	3	12/22/10	Abdominal Pain	4	1/1/11	Ingested Foreign Body	5	1/17/11	Abdominal Pain	6	1/18/11	Possible Diverticulitis	7	1/24/11	Delirium	8	1/29/11	Central Nervous System Lymphoma	6	2/5/11	Seizure
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		9	2/7/11	Abdominal Pain
		9	3/5/11	Hypotension and Acute Renal Failure
		10	3/21/11	Altered Level of Consciousness
		11	3/22/11	Unresponsiveness
		10	3/22/11	Urosepsis
		12	4/15/11	Possible Neuroleptic Malignant Syndrome
		<p>The review found general evidence of timely and adequate medical attention to the individuals. The following process deficiencies were identified:</p> <ol style="list-style-type: none"> 1. There was evidence of a delay in the response by the MOD Physician and Surgeon to several notifications by nursing during the period of 12/20-21/2010 regarding the status of an individual who was experiencing acute persistent abdominal pain. Since then, the facility has improved staffing of its medical coverage off-hours. 2. The seizure tracking record was not completed for an individual who reportedly suffered status epilepticus during hospitalization. 3. The nursing assessments (2/5-2/6, 2011) of an individual who developed acute and persistent abdominal pain were inadequate. <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure timely and adequate medical care with proper attention to all the previously mentioned deficiencies in the CM reports. 2. Continue to update medical policies and procedures and guidelines and ensure alignment with current standards. 3. Continue to monitor the timeliness and quality of medical and nursing assessments of changes in the physical status of the individuals. 		

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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, January 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 11% of all individuals with at least one diagnosis on Axis III during the review period (December 2010 - May 2011). The facility reported 100% compliance with the following indicators that are relevant to this requirement:</p> <ol style="list-style-type: none"> 1. There is a quarterly note that documents reassessment of the individual medical status. 2. There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated. 3. If applicable, the on-call (after-hours) physician documents in the PPN necessary communication with the regular medical physician regarding changes in the individual's physical condition. 4. 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).

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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>Other findings: This monitor reviewed Physician's Quarterly Progress notes for the following 12 individuals: BAM, DPA, EH, HA, JA, JRB, KFR, MB, NJ, NSF, PA and SB. The notes were selected to represent different providers at the facility. There was general evidence of adequate compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>								
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1, January 2010: Continue to monitor this requirement, including medical transfers, integration of medical conditions into WRPs and refusal by individuals of medical treatment/laboratory testing.</p> <p>Findings: Using the DMH Medical Transfer Auditing Form, NSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1227 1860 1412"> <thead> <tr> <th data-bbox="991 1227 1062 1304"></th> <th data-bbox="1062 1227 1587 1304"></th> <th data-bbox="1587 1227 1724 1304">Previous period</th> <th data-bbox="1724 1227 1860 1304">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1304 1062 1412">1.</td> <td data-bbox="1062 1304 1587 1412"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the</i></td> <td data-bbox="1587 1304 1724 1412">91%</td> <td data-bbox="1724 1304 1860 1412">75%</td> </tr> </tbody> </table>			Previous period	Current period	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the</i>	91%	75%
		Previous period	Current period							
1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the</i>	91%	75%							

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			<i>physician.</i>		
		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%	97%
		3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	85%	77%
		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%	97%
		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%	100%
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	100%	100%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	93%	87%
		<p>The facility reported the following corrective actions to address the declines in compliance for items 1, 3 and 7:</p>			

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		<ol style="list-style-type: none"> 1. In December 2010, the Utilization Review Nurse (URN) initiated self-auditing with increased emphasis on the quality of each nursing assessment of a change in status requiring outside hospitalization/ER visit. In addition to the previous auditing process, the URN incorporated the review of nursing assessments two weeks prior to and after the outside hospitalization. 2. The Nursing Change of Condition/Transfer Out audit tool was revised and implemented in March 2011 to address the quality of the nursing assessment documentation. Findings from this audit were sent to Program management and Program Health Services Specialists (HSSs) for necessary corrective actions and mentoring. 3. HSSs have been directed to follow up on the reassessments each shift post any physical status change by incorporating these into their HSS logs. 4. The Nursing Education department continued to provide the annual Physical Assessment training to RNs. Beginning in May 2011, the first revised assessment module was focused on Neuro System Assessment. <p>NSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 11% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (December 2010 - May 2011). The following is a summary of the data:</p> <table border="1" data-bbox="991 1117 1890 1416"> <tr> <td>1.</td> <td><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition listed on the Medical Conditions form</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td>99%</td> </tr> </table>	1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	96%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	98%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	98%	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	99%
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		<table border="1"> <tr> <td data-bbox="976 186 1094 267">5.</td> <td data-bbox="1094 186 1793 267"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1793 186 1923 267">98%</td> </tr> </table>	5.	<i>There are appropriate intervention(s) for each objective</i>	98%
5.	<i>There are appropriate intervention(s) for each objective</i>	98%			
<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>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"> <tr> <td data-bbox="976 597 1094 711">6.</td> <td data-bbox="1094 597 1793 711"><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 597 1923 711">76%</td> </tr> </table>			6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	76%
6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	76%			
<p>NSH reported that the low compliance rate for refusals (item 6) was due to the lack of appropriate auditing, resources, and unit/program follow-up. A March 2011 change in the auditing process, which emphasized the quality of WRP documentation in Focus 6 and/or Present Status section, resulted in an improvement in the compliance data using the Medical Procedures Refusal audit tool.</p> <p>A review of records of 16 individuals who refused medical treatments/appointments (AMC, BAM, DER, EAS, EJS, GDM, GJ, HLA, JAO, JDK, JRC, MSB, NHB, PDR, PLZ and RA) found that all had appropriate focus statements addressing refusals, objectives, and interventions included in the WRPs. The efforts that NSH had expended since the last review addressing this requirement produced positive outcomes.</p> <p>The facility reported the following corrective actions to improve individuals' adherence to necessary treatment/procedures:</p> <ol style="list-style-type: none"> <li data-bbox="976 1380 1923 1416">1. A process for referral to the Positive Behavior Support (PBS) Teams 					

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		<p>was developed to address issues of repeated refusals after the WRPT has exhausted all interventions to address non-compliance.</p> <p>2. The Quality Council has chartered a Quality Improvement Team to address treatment non-adherence as a hospital-wide problem impacting multiple systems.</p> <p>Recommendations 2, January 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 20% of the referrals for external consultations, the facility reported the following:</p> <ol style="list-style-type: none"> 1. Referrals were appropriate and seen in a timely manner per diagnostic category reviewed. 2. Referral patterns continued to adequately reflect the population served. 3. There was delay noted in the average number of days from referral to appointment compared to previous review period (19 days versus 15). This was due to a change to a new set of sub-specialists effective September 20, 2010. The delay in payment for services rendered also negatively impacted the waiting time. <p>Recommendations 2, January 2010: 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> <p>Findings: NSH reported 35 actual medical emergency response incidents for this</p>
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		<p>reporting period with four code blue events requiring CPR. The emergency drills were reportedly increased from 113 during the last review period to 188 during this review period.</p> <p>NSH reportedly reviewed the code blue events and identified several issues for performance improvement. The areas of concern were focused on the following:</p> <ol style="list-style-type: none"> 1. Administration of oxygen; 2. Utilization of AED; 3. RN role in emergency situation including RN assessment, RN to RN communication, using emergency cart from the nearest location and proper MERS documentation in the chart; and 4. Use of prone containment and restraint <p>The following areas of concern were identified during the reviews of the emergency drills:</p> <ol style="list-style-type: none"> 1. Slow and delayed dialing "7" (six occurrences); 2. Use of equipment (AED, ambu bag, vital machine, alarm system, suction machine (seven occurrences); 3. Response to MERS drill: delayed response due to unit activities or staff escort from neighboring units and minimum participation from ancillary staff and MDs (14 occurrence); 4. Incomplete documentation (two occurrences); 5. Off-site issues including availability of equipment (five occurrences); and 6. Staff competency: proper placement of hand in assessing pulse (one occurrence). <p>The facility's corrective actions included the following:</p> <ol style="list-style-type: none"> 1. Training and handouts were provided regarding the delivery of
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		<p>oxygen;</p> <ol style="list-style-type: none"> 2. The AED Nursing Policy and Procedure was updated; 3. Training was provided regarding the role of nursing during MERS; 4. Training was provided regarding containment safety; 5. Nursing Policy 1506, Behavior Seclusion and Restraints was updated to address containment safety; 6. The areas of concern identified during code blue events were emphasized during medical emergency drills; 7. An MERS review group was established in June 2011 to provide a multi-disciplinary review of events and develop systemic corrective actions. The group included representatives from the Fire Department, Medical Ancillary Services, Medical Director's Office and Nursing Services. 8. Code blue events and emergency drills forms (MH-C 9128, DMH Medical Emergency Flow Sheet and MH-C 9129, DMH Medical Emergency Response Evaluation) were reviewed by Nursing Services. In addition, the facility began to utilize a form (MH-C 9131 DMH Medical Emergency Response Improvement Plan) to track issues of concern and facilitate review during HSS meetings and improve communications across departments. The information gathered in these processes was provided to the MERS review group to facilitate communication across departments. <p>The facility presented data based on the current DMH monitoring tools regarding the Medical Emergency Response. However, the monitor found this auditing process to be inadequate at NSH. The above information regarding identified areas of concern and corresponding corrective actions were sufficient to address this area.</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, including medical transfers, integration of medical conditions into WRPs, refusal by individuals of medical treatment/laboratory testing and consultation services. 2. Continue to review medical emergency response events (actual and drills) and identify areas of concern and develop and implement appropriate corrective actions.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: The facility has maintained its practice. The physicians' duty statements are aligned with current administrative directives, policies and procedures, and 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	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>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, January 2010:</p> <ul style="list-style-type: none"> • Continue current practice. • Same as in Recommendation 3 in F.7.a.

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		<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 F.7.a.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2010: Continue current practice.</p> <p>Findings: All physicians and surgeons at NSH continue to have privileges for continuous access to the hospital records of their individuals during outside hospitalization.</p> <p>Other findings: This monitor's chart reviews (see F.7.a) found that necessary outside hospital records were in all the charts reviewed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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<p>F.7.c</p>	<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, January 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 and asthma/COPD. The average samples were 13% of individuals diagnosed with these disorders. The facility also used NSH tools to assess compliance with the management of cardiac disease and with preventive care based on samples of 100% of the individuals diagnosed with cardiac disease and 100% of individuals receiving annual medical history and physical examination (regarding preventive care).</p> <p>The facility reported compliance rates that ranged from 93% to 100% for all the indicators that were outlined in the previous reports with the exception of the following indicators that had compliance rates less than 90%:</p> <ol style="list-style-type: none"> 1. Is dyslipidemia addressed in focus 6 of the WRP (89%); 2. Is asthma and COPD addressed in focus 6 of the WRP? (85%); and 3. Does the patient have a LDL-C <100mg/dl? (85%). <p>With the exception of the above-noted indicators, comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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<p>F.7.d</p>	<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, January 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 reprivileging.</p> <p>Findings: NSH reported that Physician and Surgeons who were scheduled for reprivileging (#2) were reprivileged during this review period using adequate performance indicators as previously described.</p> <p>Recommendation 2, January 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: The facility reviewed its practice guidelines. No changes were indicated except for the guideline regarding diabetes mellitus as noted in F.7.a above.</p> <p>Recommendation 3, January 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 no educational/corrective actions in this context.</p> <p>Recommendation 4, January 2010: Provide data regarding clinical and process outcomes of medical care and data analysis of significant trends/patterns.</p>
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		<p>Findings: The facility provided process and clinical outcome data based on indicators addressing the following areas:</p> <ul style="list-style-type: none">❖ Process outcomes:<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 3 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➤ 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
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		<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 recommendation: Continue to monitor process and clinical outcomes of medical care, modify these outcomes as indicators and utilize data to optimize services.</p>
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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. Michelle Patterson, RN, ACNS 3. Robert Kolker, RN, PHN II 4. Steve Athens, NC, CNS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH IC Admission PPD summary data, December 2010 - May 2011 2. NSH IC Annual PPD Audit summary data, December 2010 - May 2011 3. NSH IC Hepatitis C Audit summary data, December 2010 - May 2011 4. NSH IC HIV Positive Audit summary data, December 2010 - May 2011 5. NSH IC Immunization Audit summary data, December 2010 - May 2011 6. NSH IC Immunization Refusal Audit summary data, December 2010 - May 2011 7. NSH IC MRSA Audit summary data, December 2010 - May 2011 8. NSH IC Positive PPD Audit summary data, December 2010 - May 2011 9. NSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, December 2010 - May 2011 10. NSH IC Sexually Transmitted Disease (STD) Audit summary data, December 2010 - May 2011 11. NSH's Key Indicator data 12. Infection Control Audit Report dated 6/21/2011 13. Infection Control Committee meeting minutes dated 1/18/11 and 4/19/11 14. Department of Mental Health Public Health Committee meeting minutes dated 2/16/11 15. Medical records for the following 85 individuals: AA, AAC, AB, AH, AJM, AMP, AVR, BAM, BEA-1, BEA-2, BES, BX, CB, CCR, CEB, CEG, CMC, CMS, DAM, DBE, DFH, DIB, DJS, DLR, DSH, DV, EN, FC, GA,

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		GAH, GIG, GRP, HSP, IEJ, ILL, JAF, JB, JCP, JCS, JJJ, JM, JO, JRK, JRS, JW, JWM, KJK, KK, KKG, KMB, KNT, KRB, KWC, LAS, LCA, LJ, LRJ, MAA, MAM, MEB, MG, MID, MJC, MJP, MMP, NRG, OAP, ODB, RDA, RDS, RJH, RLS, ROK, RRB, SC, SH, SJR, SWH, TLB, TLB, WLB, WML, YVW and YW															
	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, January 2011: 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 47% of individuals admitted to the hospital with a negative PPD in the review months (December 2010 - May 2011):</p> <table border="1"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>100%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>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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5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</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>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 admitted during the review period (AAC, AB, AJM, BX, CCR, DAM, DJS, EN, JW, KMB, KRB, KWC, MJP, SJR and WML) 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 30% of individuals needing an annual PPD during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1149 1890 1416"> <tr> <td data-bbox="991 1149 1087 1226">1.</td> <td data-bbox="1087 1149 1795 1226"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1795 1149 1890 1226">100%</td> </tr> <tr> <td data-bbox="991 1226 1087 1302">2.</td> <td data-bbox="1087 1226 1795 1302"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1795 1226 1890 1302">100%</td> </tr> <tr> <td data-bbox="991 1302 1087 1378">3.</td> <td data-bbox="1087 1302 1795 1378"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1795 1302 1890 1378">100%</td> </tr> <tr> <td data-bbox="991 1378 1087 1416">4.</td> <td data-bbox="1087 1378 1795 1416"><i>PPDs were read by the nurse within 48-72 hours of</i></td> <td data-bbox="1795 1378 1890 1416">100%</td> </tr> </table>	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</i>	100%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
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		<table border="1"> <tr> <td data-bbox="978 186 1081 228"></td> <td data-bbox="1081 186 1793 228"><i>administration.</i></td> <td data-bbox="1793 186 1923 228"></td> </tr> <tr> <td colspan="3" data-bbox="978 228 1923 342"> <p>Comparative data indicated that NSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 342 1923 456"> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 456 1923 570"> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 570 1923 683"> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 683 1923 797"> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> NSH will continue to monitor this requirement.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 797 1923 976"> <p>A review of the records of 12 individuals requiring an annual PPD during the review period (AH, BAM, BEA-1, BEA-2, CEG, CMS, DFH, ILL, JJJ, LCA, ODB and SWH) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> </td> </tr> <tr> <td colspan="3" data-bbox="978 976 1923 1219"> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, NSH assessed its compliance based on an average sample of 83% of individuals admitted to the hospital in the review months (December 2010 - May 2011) who were positive for Hepatitis C:</p> </td> </tr> <tr> <td data-bbox="978 1219 1081 1333">1.</td> <td data-bbox="1081 1219 1793 1333"><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 1219 1923 1333">100%</td> </tr> <tr> <td data-bbox="978 1333 1081 1414">2.</td> <td data-bbox="1081 1333 1793 1414"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C</i></td> <td data-bbox="1793 1333 1923 1414">100%</td> </tr> </table>		<i>administration.</i>		<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 12 individuals requiring an annual PPD during the review period (AH, BAM, BEA-1, BEA-2, CEG, CMS, DFH, ILL, JJJ, LCA, ODB and SWH) 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 83% of individuals admitted to the hospital in the review months (December 2010 - May 2011) who were positive for Hepatitis C:</p>			1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C</i>	100%
	<i>administration.</i>																															
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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</i>	100%																														

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			<i>Antibody test.</i>	
		3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%
		4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	100%
		5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%
		6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%
		7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	95%
		<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 14 individuals who were admitted Hepatitis C positive during the review period (BES, FC, GAH, GRP, JCP, JCS, JO, LAS, MJC, RJH, TLB, YVW, RLS and MAM) 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</p>		

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		<p>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 (five individuals) of individuals who were positive for HIV antibody in the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 451 1885 1201"> <tr> <td data-bbox="991 451 1087 565">1.</td> <td data-bbox="1087 451 1793 565"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 451 1885 565">100%</td> </tr> <tr> <td data-bbox="991 565 1087 678">2.</td> <td data-bbox="1087 565 1793 678"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 565 1885 678">100%</td> </tr> <tr> <td data-bbox="991 678 1087 792">3.</td> <td data-bbox="1087 678 1793 792"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 678 1885 792">100%</td> </tr> <tr> <td data-bbox="991 792 1087 906">4.</td> <td data-bbox="1087 792 1793 906"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 792 1885 906">N/A</td> </tr> <tr> <td data-bbox="991 906 1087 1052">5.</td> <td data-bbox="1087 906 1793 1052"><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></td> <td data-bbox="1793 906 1885 1052">100%</td> </tr> <tr> <td data-bbox="991 1052 1087 1092">6.</td> <td data-bbox="1087 1052 1793 1092"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 1052 1885 1092">100%</td> </tr> <tr> <td data-bbox="991 1092 1087 1166">7.</td> <td data-bbox="1087 1092 1793 1166"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 1092 1885 1166">100%</td> </tr> <tr> <td data-bbox="991 1166 1087 1201">8.</td> <td data-bbox="1087 1166 1793 1201"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 1166 1885 1201">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 4 was N/A in the previous period).</p>	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%
1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%																								
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> 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 five individuals who were admitted during the review period with HIV (JB, JRK, KK, NRG and WLB) found that all were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, NSH assessed its compliance based on an average sample of 29% of individuals admitted to the hospital during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1003 1887 1344"> <tr> <td data-bbox="991 1003 1087 1079">1.</td> <td data-bbox="1087 1003 1793 1079"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 1003 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1156">2.</td> <td data-bbox="1087 1079 1793 1156"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 1079 1887 1156">100%</td> </tr> <tr> <td data-bbox="991 1156 1087 1232">3.</td> <td data-bbox="1087 1156 1793 1232"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 1156 1887 1232">95%</td> </tr> <tr> <td data-bbox="991 1232 1087 1344">4.</td> <td data-bbox="1087 1232 1793 1344"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 1232 1887 1344">95%</td> </tr> </table> <p>Comparative data indicated that NSH has maintained a compliance rate of</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>	95%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	95%
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%												
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4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	95%												

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		<p>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 12 individuals (CB, CEB, DLR, DSH, GA, JAF, JM, KJK, KKG, MEB, RDS and YW) 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 92% sample (21 individuals) of individuals in the hospital who refused to take their immunizations during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1149 1887 1416"> <tr> <td data-bbox="991 1149 1087 1263">1.</td> <td data-bbox="1087 1149 1793 1263"><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 1149 1887 1263">100%</td> </tr> <tr> <td data-bbox="991 1263 1087 1338">2.</td> <td data-bbox="1087 1263 1793 1338"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 1263 1887 1338">97%</td> </tr> <tr> <td data-bbox="991 1338 1087 1416">3.</td> <td data-bbox="1087 1338 1793 1416"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1338 1887 1416">97%</td> </tr> </table>	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>	97%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	97%
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>	97%									
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	97%									

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		4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	97%
		5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	N/A
<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 records of six individuals who refused immunizations during the review period (FC, IEJ, KNT, LRJ, MG and MMP) 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 a 100% sample (two individuals) of individuals in the hospital who tested positive for MRSA during the review months (December 2010 - May 2011):</p>				

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		<table border="1"> <tr> <td data-bbox="989 228 1087 337">1.</td> <td data-bbox="1087 228 1793 337"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 228 1887 337">100%</td> </tr> <tr> <td data-bbox="989 337 1087 446">2.</td> <td data-bbox="1087 337 1793 446"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 337 1887 446">100%</td> </tr> <tr> <td data-bbox="989 446 1087 555">3.</td> <td data-bbox="1087 446 1793 555"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 446 1887 555">100%</td> </tr> <tr> <td data-bbox="989 555 1087 664">4.</td> <td data-bbox="1087 555 1793 664"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 555 1887 664">100%</td> </tr> <tr> <td data-bbox="989 664 1087 773">5.</td> <td data-bbox="1087 664 1793 773"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1793 664 1887 773">100%</td> </tr> <tr> <td data-bbox="989 773 1087 881">6.</td> <td data-bbox="1087 773 1793 881"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 773 1887 881">100%</td> </tr> <tr> <td data-bbox="989 881 1087 990">7.</td> <td data-bbox="1087 881 1793 990"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 881 1887 990">100%</td> </tr> <tr> <td data-bbox="989 990 1087 1099">8.</td> <td data-bbox="1087 990 1793 1099"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 990 1887 1099">100%</td> </tr> </table> <p data-bbox="989 948 1917 1015">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 1058 1482 1125"><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p data-bbox="989 1169 1692 1235"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p data-bbox="989 1279 1575 1346"><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%																								
2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%																								
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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><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 with MRSA (MAA and OAP) found that both individuals were placed on contact precautions; both individuals were placed on the appropriate antibiotic; and both WRPs contained appropriate objectives and interventions.</p> <p>Positive PPD Using the DMH IC Positive PPD Audit, NSH assessed its compliance based on an average sample of 89% of individuals in the hospital who had a positive PPD test during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 711 1890 1274"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</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 4 was N/A in the previous period).</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>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%
1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%																					
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> 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 10 individuals who had a positive PPD (AMP, AVR, DBE, DJS, DV, GIG, HSP, RDA, SC and SH) 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 94% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1149 1890 1414"> <tr> <td data-bbox="991 1149 1087 1300">1.</td> <td data-bbox="1087 1149 1793 1300"><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 1149 1890 1300">100%</td> </tr> <tr> <td data-bbox="991 1300 1087 1377">2.</td> <td data-bbox="1087 1300 1793 1377"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 1300 1890 1377">92%</td> </tr> <tr> <td data-bbox="991 1377 1087 1414">3.</td> <td data-bbox="1087 1377 1793 1414"><i>There are appropriate objectives written for the lab</i></td> <td data-bbox="1793 1377 1890 1414">92%</td> </tr> </table>	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>	92%	3.	<i>There are appropriate objectives written for the lab</i>	92%
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>	92%									
3.	<i>There are appropriate objectives written for the lab</i>	92%									

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		<table border="1"> <tr> <td data-bbox="989 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>work or PPD refusal.</i></td> <td data-bbox="1793 188 1892 228"></td> </tr> <tr> <td data-bbox="989 228 1087 305">4.</td> <td data-bbox="1087 228 1793 305"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 228 1892 305">91%</td> </tr> </table>		<i>work or PPD refusal.</i>		4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	91%
	<i>work or PPD refusal.</i>							
4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	91%						
<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 10 individuals who refused admitting or annual labs/diagnostics (AA, CMC, DIB, JRS, JWM, LJ, MID, ROK, RRB and TLB) found that all refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> NSH reported no cases of STDs during the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>								

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F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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, January 2011: 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, January 2011: 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, January 2011: 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, January 2011: Continue current practice.</p> <p>Findings: Review of the minutes of NSH's Infection Control Committee meetings verified that IC data are discussed at the meetings, integrated into other discipline committee meetings, and are included in the facility's Key</p>

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		<p>Indicator data.</p> <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. Michelle Patterson, RN, ACNS 2. Randall Boyd, DDS 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, December 2010 - May 2011 2. NSH's Dental Department staffing 3. NSH's appointment log 4. NSH's Refusal List 5. Medical records for the following 98 individuals: AJ, AMW, ARD, ATE, AW, BA, BAT, CCS, CGJ, CHS, CLW, DAB, DAM, DAT, DC, DDL, DLS, DMP, DO, DOO, DTR, EEH, EG, EIB, ERC, ERM, ETA, FBT, FK, FL, GBB, GJN, HPA, HT, JAD, JAL, JAP, JEJ, JHP, JKP, JKS, JOC, JT, KO, KRO, KSQ, LAB, LAS, LBR, LER, LH, LIE, LSB, LSE, LWW, MAB, MAS, MDC, MDW, MEP, MRW, MUG, NF, NNB, PAF, PRM, RAD, RC, RDB, RHB, RIK, RIS, RMS, ROG, ROS, RTH, RW, RYH, RZ, SAJ, SEG, SHE, SHV, SJS, SLG, SOS, STC, SYC, TAE, TC, THE, TIK, TSS, TT, TUN, VAK, WB and ZP
<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, January 2011: Continue current practice.</p> <p>Findings: The number of full-time staff for the Dental Department remained unchanged from the last review period. Current staffing has been</p>

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		<p>adequate to provide timely and appropriate dental care and treatment.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.bth	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, January 2011: 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="991 971 1890 1011"> <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 15 individuals (AMW, BAT, JAD, JAL, LAS, LER, MEP, RAD, RIK, SEG, SHV, STC, TAE, TIK and WB) 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% mean sample of individuals who have been in the hospital for 90 days or less during the review period (December 2010 - May 2011):</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

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		<table border="1" data-bbox="991 224 1885 266"> <tr> <td data-bbox="991 224 1087 266">1.b</td> <td data-bbox="1087 224 1793 266"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 224 1885 266">98%</td> </tr> </table> <p data-bbox="991 310 1898 375">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 418 1898 524">A review of the records of 15 individuals (AMW, BAT, JAD, JAL, LAS, LER, MEP, RAD, RIK, SEG, SHV, STC, TAE, TIK and WB) found that 14 individuals were timely seen for their admission exams.</p> <p data-bbox="991 568 1898 673">Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals due for annual routine dental examinations during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 711 1885 786"> <tr> <td data-bbox="991 711 1087 786">1.c</td> <td data-bbox="1087 711 1793 786"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 711 1885 786">96%</td> </tr> </table> <p data-bbox="991 829 1898 894">Comparative data indicated that NSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 938 1898 1044">A review of the records of 15 individuals (ARD, BA, CHS, DOO, FK, JAP, JEJ, LH, MAS, NNB, PAF, ROS, SYC, TUN and VAK) found that all annual exams were timely completed.</p> <p data-bbox="991 1088 1898 1230">Using the DMH Dental Services Audit, NSH assessed its compliance based on a 100% mean sample of individuals with dental problems identified on admission or annual examination during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 1268 1885 1378"> <tr> <td data-bbox="991 1268 1087 1378">1.d</td> <td data-bbox="1087 1268 1793 1378"><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 1268 1885 1378">100%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</i>	98%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	96%	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>	98%									
1.c	<i>Annual date of examination was within anniversary month of admission</i>	96%									
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 30 individuals (AMW, ARD, BA, BAT, CHS, DOO, FK, JAD, JAL, JAP, JEJ, LAS, LER, LH, MAS, MEP, NNB, PAF, RAD, RIK, ROS, SEG, SHV, STC, SYC, TAE, TIK, TUN, VAK and WB) 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% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="993 673 1890 824"> <tr> <td data-bbox="993 673 1087 824">1.e</td> <td data-bbox="1087 673 1795 824"><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="1795 673 1890 824">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 17 individuals (CLW, DAB, DAT, DO, EG, EIB, ERC, JOC, JT, LAB, MRW, RC, RHB, RIS, ROG, SHE and THE) 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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p>			

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		<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 (December 2010 - May 2011) 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 30 individuals (AMW, ARD, BA, BAT, CHS, DOO, FK, JAD, JAL, JAP, JEJ, LAS, LER, LH, MAS, MEP, NNB, PAF, RAD, RIK, ROS, SEG, SHV, STC, SYC, TAE, TIK, TUN, VAK and WB) 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, January 2011: 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 due for annual routine dental examinations during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="993 1192 1887 1305"> <tr> <td data-bbox="993 1192 1087 1305">3.a</td> <td data-bbox="1087 1192 1793 1305"><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 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>	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>A review of the records of 18 individuals (AJ, ATE, AW, CCS, ERM, FL, GJN, HT, JHP, JKS, KRO, LIE, LWW, RTH, SAJ, TC, TT and ZP) 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 (December 2010 - May 2011):</p> <table border="1" data-bbox="993 524 1887 602"> <tr> <td data-bbox="993 524 1087 602">3.c</td> <td data-bbox="1087 524 1793 602"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 524 1887 602">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 16 individuals (CGJ, DAM, EEH, ETA, GBB, JKP, KO, LSE, MUG, NF, PRM, RDB, RYH, RZ, SLG and SOS) 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, January 2011: 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 who had tooth extractions during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="993 1378 1887 1416"> <tr> <td data-bbox="993 1378 1087 1416">4.</td> <td data-bbox="1087 1378 1793 1416"><i>Tooth extractions be used as a treatment of last</i></td> <td data-bbox="1793 1378 1887 1416">100%</td> </tr> </table>	4.	<i>Tooth extractions be used as a treatment of last</i>	100%
4.	<i>Tooth extractions be used as a treatment of last</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></p> <p>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 (CLW, DAB, DAT, DO, EG, EIB, ERC, JOC, JT, LAB, MRW, RC, RHB, RIS, ROG, SHE and THE) found that all records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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, January 2011: 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 who received comprehensive dental examinations or follow-up dental care during the review months (December 2010 - May 2011) 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 30 individuals (AMW, ARD, BA, BAT, CHS, DOO, FK, JAD, JAL, JAP, JEJ, LAS, LER, LH, MAS, MEP, NNB, PAF, RAD, RIK, ROS, SEG, SHV, STC, SYC, TAE, TIK, TUN, VAK and WB)</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>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, January 2011: 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 dental appointments during the review months (December 2010 - May 2011):</p> <table border="1" data-bbox="991 894 1887 933"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>65%</td> </tr> </table> <p>Comparative data indicated a decrease in attendance at dental appointments from 70% in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="991 1156 1860 1421"> <thead> <tr> <th>Month</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>Dec 2010</td> <td>15</td> <td>10</td> <td>0</td> </tr> <tr> <td>Jan 2011</td> <td>15</td> <td>9</td> <td>0</td> </tr> <tr> <td>Feb 2011</td> <td>15</td> <td>11</td> <td>0</td> </tr> <tr> <td>March 2011</td> <td>15</td> <td>8</td> <td>0</td> </tr> </tbody> </table>	6.a	<i>The individual attended the scheduled appointment</i>	65%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	Dec 2010	15	10	0	Jan 2011	15	9	0	Feb 2011	15	11	0	March 2011	15	8	0
6.a	<i>The individual attended the scheduled appointment</i>	65%																							
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>April 2011</td> <td>20</td> <td>6</td> <td>0</td> </tr> <tr> <td>May 2011</td> <td>16</td> <td>10</td> <td>0</td> </tr> </table>	April 2011	20	6	0	May 2011	16	10	0				
April 2011	20	6	0											
May 2011	16	10	0											
F.9.e	<p>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, January 2011: Continue implementing strategies addressing dental refusals.</p> <p>Findings: NSH reported that a total of 213 licensed nursing staff received follow-up training addressing the quality of the WRPs for Dental Refusals in February and April 2011. The PBS Referral form was developed and implemented in April 2011 to address the issue of repeated refusals when the WRPT had exhausted all interventions. In addition, the review of systematic issues related to Dental Refusals is a standing agenda in the Nursing Coordinators' meetings, HSS meetings, and NC/PD/NA meetings. The Dental Refusal audit instrument was initiated, and increased resources for auditing this area were initiated in March 2011.</p> <p>Recommendation 2, January 2011: Continue to monitor this requirement.</p>												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Using the DMH Dental Services Audit, NSH assessed its compliance based on an 89% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (December 2010 - May 2011) and reported a mean compliance rate of 70%. The mean compliance rate was 77% in the previous review period.</p> <p>A review of the records of 17 individuals (DC, DDL, DLS, DMP, DTR, FBT, HPA, KSQ, LBR, LSB, MAB, MDC, MDW, RMS, RW, SJS and TSS) found improvements in the WRPs addressing dental refusals; all had an open focus with interventions addressing refusals included in their WRPs.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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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: Clearly, NSH has made solid progress in decreasing the use of restraint and seclusion. Although overall practice has been in alignment with the EP for the past three tours, the significant problematic issues found during this review regarding two cases of prone containment preclude a finding of substantial compliance in this section. The facility should review current systems to ensure that practices are in alignment with State and facility policies, and ensure that the use of any prohibited practice is critically reviewed and analyzed and that recommendations generated from these processes are specific, appropriate, and implemented in a timely manner.</p>
H	<p>Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Dana Kormanik, RN, Standards Compliance 2. Dean Gardiner, Acting Standards Compliance Coordinator 3. Dolly Matteucci, Executive Director 4. Gary Walters, Acting Nurse Administrator 5. James Young, DO, Acting Assistant Medical Director 6. Kuldip Dhaliwal, Assistant Coordinator of Nursing Services 7. Linda Howard, Program Director, Program III 8. Michelle Patterson, RN, ACNS 9. Natalie Allen, Acting Training Officer III, Psychiatric Nurse Education Director 10. Norm Kramer, Acting Clinical Administrator 11. Renee Lafayette, Psychiatric Technician Instructor 12. Steve Athens, NC, CNS 13. Steve Weule, SRN, Risk Manager

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

		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH Seclusion/Restraint Audit summary data, December 2010 - May 2011 2. NSH's training rosters 3. Significant Injury During TSI In-Depth Analysis Report (Draft Final Report, not dated) 4. Nursing Procedure SAFE 1501 "Assaultive Individuals: Guidelines for Interventions" 5. Medical Death Summary dated 4/21/11 6. NSH Nursing Mortality Review dated 4/15/11 7. Mortality Interdisciplinary Review Committee (MIRC) meeting minutes dated 4/25/11 8. Medical records for the following 28 individuals: AJL, AMP, BJC, BT, BW, CC, CCS, CDB, CH, DTB, EGC, IAD, JA, JW, KEP, KS, MJM, ML, RGZ, RT, TEH, TJM, TLB, TM, TMM, TOM, TRF and WR
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: NSH reported that since the last review, there were two significant incidents that occurred during responses to behavioral emergencies and the actions taken by the facility. Initially, the facility was aware of only one incident of the use of prone containment until the monitoring team found a second incident of prone containment during the review of the investigations onsite.</p> <p>In the case of one individual, the facility progress report indicated that on 1/10/11, the individual was on 1:1 observation and requested a PRN medication for agitation. While staff was in the process of obtaining a physician's order for the medication, the individual became assaultive to</p>

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

		<p>his 1:1 staff. A Unit Office Assistant intervened to assist the 1:1 staff and indicated during an interview with an investigator that the take-down was "harder than it should be." In addition, the staff member who was calling the physician to obtain an order for the PRN indicated in an interview that the individual was "face-down on the floor and staff members [names] were laying over his back and legs." However, a review of the IDNs found that they did not mention that the individual was contained in a prone position; rather, the notes indicated that "proper TSI techniques" were used. After the individual was placed in five-point restraints, he complained of pain to his left shoulder and elbow. He was sent to the hospital and found to have an acute fractured of the proximal left humerus. On 1/14/11, in response to complaints of left knee pain, he was again sent to the hospital and found to have an acute tibia fracture. The IDNs for that day indicated no fall or event precipitating the tibia fracture.</p> <p>The conclusions from the Significant Injury During TSI In-Depth Analysis Report (Draft Final Report-not dated) included the following:</p> <ul style="list-style-type: none">• Fracture of arm probably occurred during containment;• Unable to determine when fracture of leg occurred;• Assessment was attempted but initially refused, no complaint of pain;• Policies do not explicitly outline methods of containment; expectations are taught in annual training, but teaching materials are not available on units. <p>The recommendations included:</p> <ul style="list-style-type: none">• Review and update of Nursing Procedure SAFE 1501 "Assaultive Individuals: Guidelines for Interventions" with a focus on use of TSI (not MAB); how many staff should be available for TSI, or what to do when you are alone;• Review and update of specific JCAHO Standards identified for up-to-
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>date information; and</p> <ul style="list-style-type: none"> • Development of TSI manual for use by all staff <p>Although no minutes were provided as requested, the facility provided the following summary of the recommendations from the IRC and SI Investigation:</p> <ul style="list-style-type: none"> • Follow up with bone density exam (IRC) • Training in Dependent Elder Abuse for specific staff (SI Investigation) <p>From review of the IDNs from 1/10/11 through 1/15/11, the description of the episode on 1/10/11 reflected that the use of prone containment was unwarranted and inappropriate. In view of the fact that there was no awareness or mention in the documentation provided of the review by the facility that prone containment was used in this incident, the facility did not conduct a thorough review of the incident. Consequently, there were no recommendations addressing the prohibition of the use of prone restraints, prone containment and prone transportation. No discussion was found addressing why a Unit Office Assistant was the only staff available to immediately intervene in the situation and how this could have contributed to the use of a prohibited procedure.</p> <p>Also, at the time of the tour, there was no one staff person assigned to ensure that all recommendations generated from this incident were implemented. Although a Dexa [bone density] scan was attempted in March 2011, from review of the individual's WRP for June 2011, there was no indication that it was actually completed, and there was no indication that a TSI manual for use by all staff was developed for an incident that had taken place in early January 2011. NSH's system for review of seclusion and restraint episodes for prone containment did not timely and appropriately identified the incident; critically review the incident and associated documentation; and implement corrective actions to avoid</p>
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>incidents of reoccurrence.</p> <p>In the tragic case of another individual, the facility's summary indicated that on April 11, 2011 the individual expired due to cardiac arrest while being physically contained in a prone position on the floor due to uncharacteristically aggressive behavior. His diagnoses as listed on the Monthly Psychiatric Progress Note dated 3/30/11 included:</p> <ul style="list-style-type: none"> • Schizophrenia, Undifferentiated Type; • Borderline Intellectual Functioning; • Congenital hydrocephalus; diabetes mellitus, Type 2; hyperlipidemia; obesity; constipation; and extrapyramidal symptoms. <p>Review of the documentation indicated that the individual had been hospitalized for most of his adult life, beginning when he was 15 years old. According to his WRP dated 3/23/11, he did not warrant a behavior plan or guidelines and there was no mention of restraint or seclusion use recently or in the past. Also, the WRP noted that he became overwhelmed by teasing from peers and daily stressors and responded with verbal or physical aggression. A number of incidents from past years were noted in the WRP regarding verbal and physical altercations when teased about his intellect. The individual had been transferred to a different unit on 3/9/11 following an incident in which he became angry with staff and banged his fist on the nursing station window and insisted on being transferred to another unit. The Physician Inter-Unit Transfer Summary dated 3/9/11 indicated that he was a moderate violence risk and responded well to supportive interventions. In addition, the Summary noted "Would be careful about peer provoking him." Problematic issues found in the documentation included:</p> <ul style="list-style-type: none"> • In the only IDN found for 4/11/11, the Medical Death Summary dated 4/21/11, NSH Nursing Mortality Review dated 4/15/11, and the Mortality Interdisciplinary Review Committee (MIRC) meeting minutes
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>dated 4/25/11, there is no mention that prone containment was used during the incident.</p> <ul style="list-style-type: none">• There was no indication from review of all reports addressing this incident that staff was aware of the individual's repeated reactions to being teased by peers and how to address this reaction. The only IDN addressing this incident noted that "peer was smiling and also swinging his arms towards individual as if taunting him."• There were no IDNs found from staff directly involved in the incident, aside from a brief summary note from nursing.• The NSH Nursing Mortality Review dated 4/15/11 did not address the lack of documentation in the IDNs adequately describing the incident including the measures staff took to defuse the situation; the delay in applying the AED until Fire Rescue arrived at the scene; and the incomplete documentation found on the Medical Emergency Flow Sheet. In fact, the NSH Nursing Mortality Review report stated that "Nursing Staff responded quickly and appropriately to the emergency, dialing 7 as soon as the individual stopped breathing. Documentation was well done."• There was no indication from any of the documentation provided by the facility, including the minutes of the MIRC meeting, that there was actually a critical review of the incident itself, including the appropriateness of staff reaction to the situation related to the individual's history and WRP interventions, the use of prone containment, and what actions could have prevented the situation. Consequently, there were no recommendations found addressing these critical issues.• There was no risk assessment completed addressing the individual's health status/risk factors and the use of restrictive measures; restraint and seclusion.• Most of the recommendations found in the MIRC meeting minutes were generically written to include interventions that stated "should assure," "should discuss," and "advise the staff." Thus, there was no supporting documentation indicating that most of the recommenda-
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>tions were actually implemented.</p> <p>From review of this incident, NSH did not critically and completely review the incident and associated documentation and implement adequate corrective actions to prevent incidents of reoccurrence.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The facility needs to develop a methodology to critically review incidents of prohibited procedures, specifically prone containment, prone restraint, and prone transportation in the event they are utilized, with the focus aimed at the prevention of reoccurrences. 2. Structure recommendations to ensure that they are specifically defined in order to be adequately implemented. 3. Continue to monitor this requirement. 						
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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 73% mean sample of initial seclusion orders each month during the review period (December 2010 - May 2011):</p> <table border="1"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an</i></td> <td>100%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	99%	2.	<i>Seclusion is used only when the individual posed an</i>	100%
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2.	<i>Seclusion is used only when the individual posed an</i>	100%						

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

		<table border="1" data-bbox="991 191 1915 344"> <tr> <td></td> <td><i>imminent danger to self or others.</i></td> <td></td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>99%</td> </tr> </table> <p data-bbox="991 386 1915 457">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="991 500 1915 782">A review of 24 episodes of seclusion for 15 individuals (AJL, AMP, BJC, BT, BW, DTB, EGC, IAD, JA, KEP, KS, TEH, TJM, TMM and TRF) found that the documentation for 23 episodes supported the decision to place the individual in seclusion. In the remaining one episode, there was no documentation of specific circumstances that would justify placement of 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="991 831 1915 928">Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on an 84% mean sample of initial restraint orders each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 971 1915 1198"> <tr> <td>1.</td> <td><i>Restraint is used in a documented manner.</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>97%</td> </tr> </table> <p data-bbox="991 1247 1915 1318">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 1360 1915 1416">A review of 19 episodes of restraint for 11 individuals (CC, CCS, CDB, CH, JW, MJM, ML, RGZ, RT, TLB and TM) found that the documentation for</p>		<i>imminent danger to self or others.</i>		3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%	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>	97%
	<i>imminent danger to self or others.</i>																
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>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> <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, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 73% mean sample of initial seclusion orders each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 821 1887 1344"> <tr> <td data-bbox="991 821 1087 896">4.</td> <td data-bbox="1087 821 1793 896"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 821 1887 896">94%</td> </tr> <tr> <td data-bbox="991 896 1087 1122">5.</td> <td data-bbox="1087 896 1793 1122"><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 896 1887 1122">100%</td> </tr> <tr> <td data-bbox="991 1122 1087 1344">6.</td> <td data-bbox="1087 1122 1793 1344"><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 1122 1887 1344">100%</td> </tr> </table> <p>Comparative data indicated that NSH maintained a compliance rate of at</p>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	94%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (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%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>least 90% from the previous review period for all items.</p> <p>A review of 24 episodes of seclusion for 15 individuals (AJL, AMP, BJC, BT, BW, DTB, EGC, IAD, JA, KEP, KS, TEH, TJM, TMM and TRF) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on an 84% mean sample of initial restraint orders each month during the review period (December 2010 - May 2011):</p> <table border="1" data-bbox="991 636 1890 1157"> <tr> <td data-bbox="991 636 1087 711">4.</td> <td data-bbox="1087 636 1793 711"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 636 1890 711">98%</td> </tr> <tr> <td data-bbox="991 711 1087 935">5.</td> <td data-bbox="1087 711 1793 935"><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 711 1890 935">99%</td> </tr> <tr> <td data-bbox="991 935 1087 1157">6.</td> <td data-bbox="1087 935 1793 1157"><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 935 1890 1157">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 19 episodes of restraint for 11 individuals (CC, CCS, CDB, CH, JW, MJM, ML, RGZ, RT, TLB and TM) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all</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%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>episodes indicated that the individual was released when calm</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.2.c	<p>are not used as part of a behavioral intervention; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on a 73% mean sample of episodes of seclusion each month during the review period (December 2010 - May 2011) 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. See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH assessed its compliance based on an 84% mean sample of episodes of restraint each month during the review period (December 2010 - May 2011) and reported a mean compliance rate of 100%. Comparative data indicated that NSH</p>

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		<p>maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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 73% mean sample of initial seclusion orders each month during the review period (December 2010 - May 2011) 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 24 episodes of seclusion for 15 individuals (AJL, AMP, BJC, BT, BW, DTB, EGC, IAD, JA, KEP, KS, TEH, TJM, TMM and TRF) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in 22 episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, NSH also assessed its compliance with the one-hour requirement based on an 84% mean sample of initial restraint orders each month during the review period (December 2010 - May 2011) 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 19 episodes of restraint for 11 individuals (CC, CCS, CDB, CH, JW, MJM, ML, RGZ, RT, TLB and TM) found that the RN conducted a</p>

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		<p>timely assessment in all episodes and that the individual was timely seen by a psychiatrist in 18 episodes.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: NSH continues to use the same procedures to ensure the accuracy of the data for the use of restraint, seclusion, psychiatric PRN medication, and Stat medications. A review of the PRN/Stat medications and seclusion and restraint lists provided found no incidents that were not included in the NSH 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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to monitor this requirement.</p>

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	<p>period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Findings:</p> <p>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 (December 2010 - May 2011) 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 five individuals who were in seclusion more than three times in 30 days during the review period (BJC, BT, DTB, KEP 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 (December 2010 - May 2011) 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 restraint more than three times in 30 days during the review period (CH, JW, RT and TM) found that all WRPs included documentation within three business days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	Compliance: Substantial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	Current findings on previous recommendation: Recommendation, January 2011: See F.1.b. Findings: See F.1.b. Current recommendation: See F.1.b.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	Current findings on previous recommendation: Recommendation, January 2011: See F.1.b. Findings: See F.1.b. Current recommendation: See F.1.b.
H.6.c	PRN medications are appropriately time limited.	Current findings on previous recommendation: Recommendation, January 2011: See F.1.b.

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		<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, January 2011: 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 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>Current findings on previous recommendation:</p> <p>Recommendation, January 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	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p>

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	implementation of all such policies and the use of less restrictive interventions.	<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 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>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendation: Not applicable.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ul style="list-style-type: none"> • DMH provided a status report on the implementation of Aggression Reduction Strategies forthcoming from the March Strategic Planning Conference. Completed actions include, but are not limited to: <ul style="list-style-type: none"> • The Medical Directors' committee has initiated aggressive pharmacotherapeutic protocols for management of aggression at the facilities and approved the use of a protocol (STOP-A Algorithm) at PSH. • The Medical Directors' Committee has approved a report with recommendation for implementing routine, random drug testing for all forensic patients and formulary restrictions for commonly abused/diverted prescription medications. Implementation plan is due by mid-September. • DMH formalized a process whereby Forensic Chiefs will provide written recommendations to DMH on proposed legislation. • The Therapeutic Strategies and Interventions (TSI) Statewide task force is changing the curriculum to focus on aggression types, prison culture and enhanced aggression reduction techniques. • Executive Directors' Council subgroup on aggression is working on coordination of statewide violence data. • ASH plans to open its Specialty/Enhanced Staffing Unit in August. • Draft revisions have been completed to the MOU that will improve the 7301 transfer mechanism by shortening the process, clarifying criteria and simplifying the application. • HSH has reorganized and improved the operations of the Quality Council (QC), and each meeting now includes a review of Key Indicator data. The QC also receives scheduled status reports from various workgroups, which provide aggression data beyond that related to the Key Indicators. • NSH has taken several constructive steps to improve safety, including but not limited to the following:

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		<ul style="list-style-type: none">• Some individuals who require a level of custodial security that cannot be provided at the facility were identified and recently transferred to more appropriate settings within DMH (one individual was transferred to CDCR under legislation 7301). These individuals were selected based on a review and analysis of aggression data and risk assessment methods consistent with currently generally accepted standards.• Senior psychiatrists completed four Drug Utilization Evaluations dealing with medications used to treat aggression or that are associated with problematic behaviors. This resulted in the recategorization of a medication (bupropion), which is reportedly often abused in prisons and can induce a stimulant effect leading to impulsive or psychotic aggression when snorted, from formulary status to non-formulary status.• In response to analysis of aggression patterns, the facility developed interim guidelines and a consulting contract to improve pain management using opiate analgesics. These are the forerunners of revised Administrative Directives on this topic.• Resources have been allocated to establish an integrated campus-wide personal alarm system and to enhance the hospital's Grounds Security and Grounds Presence teams as measures to improve safety on hospital grounds.• The facility designated space for a planned specialty (enhanced staffing) unit and developed entry and exit criteria for the individuals requiring this level of care.• The review of data on aggression on Program IV led the hospital to increase staffing on several units in that program.• The facility initiated a Morning Management Meeting (Monday-Friday) to review the events of the previous day. The re-evaluation of all individuals for grounds privileges and escort level, training with help from Department of Corrections on gang affiliation and activities, and changes to the outdoor environment are some of outcomes of these meetings.
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		<ul style="list-style-type: none">• NSH's review of the Risk Management Committee Review system found that the thresholds were too low, resulting in a great many individuals being referred. This sometimes resulted in cursory reviews and recommendations that were not helpful in changing individuals' behaviors. Among the changes made were revisions in review criteria. The monitor found evidence of improved performance in the implementation of the risk management procedures, including progress on the areas of deficiency that were identified in the previous report.• Key Indicator data on aggression for the review period indicate a reduction of 5% in peer-to-peer aggression resulting in major injury and a 36% reduction in aggression to self resulting in major injury in the first six months of the year as compared to the last six months of 2010. RM Committee recommendations were addressed in most of the WRPs of the individuals sampled. Similarly, the vast majority of WRPs sampled addressed high risk behaviors of individuals on high risk lists. <p><u>Areas of need include:</u></p> <ol style="list-style-type: none">1. <i>Ensure full and proper implementation of the DMH Strategic Plan to Reduce Aggression.</i>2. <i>Ensure adequate implementation of other planned actions that were initiated and/or recommended per the facility's most recent Court Monitor Safety and Security Monthly Action Report.</i>3. <i>The death of an individual while in prone containment and the prone containment of another individual that resulted in his sustaining an arm and a leg fracture should be clear signals of the dangers inherent in this position. The EP prohibits the use of this method and these dangers have been addressed by The Joint Commission, SAMHSA and accrediting and review bodies as well as in professional literature. The hospital should take all means necessary to discourage staff from restraining individuals face down on the floor.</i>4. <i>NSH must improve the medical leadership's participation in the sentinel event reviews and analyses in order to assess the performance of medical and/or psychiatric systems, as indicated.</i>
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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. Cindy Black, Standards Compliance Director 2. Dolly Matteucci, Executive Director 3. Dominique Hauscarriague, Supervising Special Investigator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 11 OSI investigations, including two death investigations 2. Aggression data 3. Seven completed Allegations Checklist forms 4. Documents related to five unexpected deaths 5. Incident Review Committee minutes and reports 6. Quality Council minutes 7. Selected HR information for 14 staff members 8. Signed Statement of Rights for 14 individuals 9. Four Headquarters Reportable Briefs 10. OSI Recommendations Task Tracking form <p><u>Attended:</u></p> <p>Quality Council meeting</p>
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:</p> <p>Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of	<p>Current findings on previous recommendation:</p>

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	<p>individuals;</p>	<p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: As has been the case in earlier reports, the OSI continues to investigate all allegations of abuse and neglect and to identify instances of staff members' failure to report A/N/E incidents. Facility policies and DMH Special Orders define abuse and neglect and address the reporting responsibilities of staff members.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.a.ii</p>	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: In a June report to the Quality Council, the Standards Compliance Director stated that because staff members are directly reporting incidents electronically, the number of incident reports has increased, and timely e-mail notification of incidents to Unit Supervisors and Program Management is occurring. This real-time entry of incidents facilitates communication at the daily Morning Management Meeting where events and issues occurring in the last 24 hours are reviewed.</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</p>	<p>Current findings on previous recommendation:</p>

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	<p>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>Recommendation, January 2011: Follow DMH guidance on standard procedure for removing staff named in A/N/E investigations.</p> <p>Findings: The facility does not follow the directive in SO 263 to remove a staff member alleged to have physically abused an individual when the allegation is plausible, as evidenced by the failure to remove the staff members named in the allegation of physical abuse of TM. TM sustained a fractured arm and fractured leg in a prone containment during which he alleged he was thrown onto the floor prone and restrained. The decision to not remove the named staff members, despite evidence of injury to TM's arm and his complaints of rib pain, was made by the Program Director. This decision was based on the Program Director's belief that the injuries were caused accidentally, per the investigation.</p> <p>The facility does not use the Allegation Checklist as prescribed in the Special Order for making a decision to return a staff member to duties providing services to individuals prior to the close of the investigation. Rather, the facility uses its own version of the checklist to make the decision whether to remove the staff member when the initial allegation is made. The Allegation Checklist form used by the facility does not require the approval of the Executive Director or designee as does the form that is part of the Special Order. Thus, staff members who direct the supervision of the named staff member are making the decision to remove or not remove with no documented contribution from hospital leadership.</p> <p>An IRC report to the Quality Council in June 2011 noted that in seven of the 10 cases in which A/N/E was sustained during the review period, one or more staff members had been reassigned. The report concluded that it appears that Program Management is properly assessing the necessity of staff reassignment.</p>
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		<p>Other findings: Review of seven Allegation Checklists associated with several of the investigations reviewed found nine errors in the checklists. Question #6 asking about the presence of physical evidence was most often the source of the errors and demonstrated that the staff members completing the checklist misunderstand the meaning of the phrase "physical evidence."</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement SO 263 related to the removal and return of staff members. Ensure that a designee of the Executive Director approves the decision made regarding removal as evidenced by his/her signature on the Allegation Checklist form included in the Special Order. 2. Provide instruction to Program Directors and others completing the Allegation Checklist about question #6 and the definition of "physical evidence."
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practices.</p> <p>Findings: In the sustained allegation of the physical abuse of TM during a physical restraint, the investigator found that the named staff member completed TSI at orientation but had not attended any of his mandatory trainings in 2010.</p> <p>Other findings: As shown in the table below, three of the 14 sampled staff members had not participated in annual A/N training in the last year. One of these staff members, an RN, last attended six years ago, according to information supplied by HR Department.</p>

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr><td>_B</td><td>4/3/00</td><td>2/23/00</td><td>4/3/00</td><td>6/3/05</td></tr> <tr><td>_J</td><td>9/11/00</td><td>7/11/09</td><td>9/11/00</td><td>2/16/11</td></tr> <tr><td>_J</td><td>1/9/03</td><td>1/9/08</td><td>1/9/03</td><td>8/26/10</td></tr> <tr><td>_N</td><td>7/31/03</td><td>6/25/03</td><td>7/31/03</td><td>2/18/11</td></tr> <tr><td>_S</td><td>10/1/04</td><td>4/22/04</td><td>10/1/04</td><td>4/12/11</td></tr> <tr><td>_C</td><td>3/9/05</td><td>11/17/04</td><td>3/9/05</td><td>7/6/10</td></tr> <tr><td>_W</td><td>6/1/05</td><td>2/28/05</td><td>6/1/05</td><td>1/11/11</td></tr> <tr><td>_R</td><td>7/11/06</td><td>5/24/06</td><td>7/11/06</td><td>9/18/09</td></tr> <tr><td>_S</td><td>8/31/07</td><td>12/5/06</td><td>8/31/07</td><td>10/11/10</td></tr> <tr><td>_L</td><td>1/16/09</td><td>11/12/08</td><td>1/16/09</td><td>4/12/11</td></tr> <tr><td>_F</td><td>1/30/09</td><td>11/14/08</td><td>1/30/09</td><td>12/9/10</td></tr> <tr><td>_M</td><td>3/2/09</td><td>12/23/08</td><td>3/2/09</td><td>3/3/09</td></tr> <tr><td>_K</td><td>5/18/09</td><td>4/21/09</td><td>5/18/09</td><td>4/28/11</td></tr> <tr><td>_H</td><td>6/16/09</td><td>5/15/09</td><td>6/16/09</td><td>1/11/11</td></tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p> <p>Current recommendation: If not already the practice, include attendance in mandatory training as part of staff members' performance evaluations.</p>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_B	4/3/00	2/23/00	4/3/00	6/3/05	_J	9/11/00	7/11/09	9/11/00	2/16/11	_J	1/9/03	1/9/08	1/9/03	8/26/10	_N	7/31/03	6/25/03	7/31/03	2/18/11	_S	10/1/04	4/22/04	10/1/04	4/12/11	_C	3/9/05	11/17/04	3/9/05	7/6/10	_W	6/1/05	2/28/05	6/1/05	1/11/11	_R	7/11/06	5/24/06	7/11/06	9/18/09	_S	8/31/07	12/5/06	8/31/07	10/11/10	_L	1/16/09	11/12/08	1/16/09	4/12/11	_F	1/30/09	11/14/08	1/30/09	12/9/10	_M	3/2/09	12/23/08	3/2/09	3/3/09	_K	5/18/09	4/21/09	5/18/09	4/28/11	_H	6/16/09	5/15/09	6/16/09	1/11/11
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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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: As noted in the table above, all of the staff members sampled signed the Mandatory Reporter statement on the date they were hired.</p>																																																																															

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	<p>recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</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, January 2011: Continue current practice.</p> <p>Findings: As shown in the table below, all of the individuals in this sample (randomly selected from the individuals on the units toured) were provided the opportunity to sign the statement of rights in the last year.</p> <table border="1" data-bbox="961 711 1451 1323"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>JB</td> <td>11/10/10 - refused</td> </tr> <tr> <td>TB</td> <td>12/4/10</td> </tr> <tr> <td>JL</td> <td>1/27/11</td> </tr> <tr> <td>TZ</td> <td>2/28/11 - refused</td> </tr> <tr> <td>CS</td> <td>3/24/11</td> </tr> <tr> <td>AM</td> <td>4/1/11</td> </tr> <tr> <td>LG</td> <td>4/30/11</td> </tr> <tr> <td>KH</td> <td>6/12/11</td> </tr> <tr> <td>DS</td> <td>6/12/11 - refused</td> </tr> <tr> <td>MR</td> <td>6/21/11</td> </tr> <tr> <td>CR</td> <td>7/12/11</td> </tr> <tr> <td>MM</td> <td>7/12/11</td> </tr> <tr> <td>CL</td> <td>7/18/11</td> </tr> <tr> <td>CP</td> <td>7/21/11 - refused</td> </tr> </tbody> </table>	Individual	Date of most recent signing	JB	11/10/10 - refused	TB	12/4/10	JL	1/27/11	TZ	2/28/11 - refused	CS	3/24/11	AM	4/1/11	LG	4/30/11	KH	6/12/11	DS	6/12/11 - refused	MR	6/21/11	CR	7/12/11	MM	7/12/11	CL	7/18/11	CP	7/21/11 - refused
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		<p>Current recommendation: Continue current practice.</p>
I.1.a. vii	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Each unit toured had the rights poster affixed to a wall in a common area.</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, January 2011: Continue current practice.</p> <p>Findings: The Napa County sheriff's office is investigating the containment death of WR on 4/11/11. The findings of this investigation were not yet available at the time of the tour.</p> <p>The Headquarters Brief for the incident (4/2/11) in which PM attacked a peer with a heavy wooden chair documents that PM was arrested on a felony warrant obtained by the Napa County District Attorney's Office and was charged with Assault with a Deadly Weapon.</p> <p>Current recommendation: Continue current practice.</p>

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<p>I.1.a.ix</p>	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice of being alert to and investigating allegations of retaliation or fear of retaliation.</p> <p>Findings: While not a direct statement of fear of retaliation, during the investigation of psychological abuse of RB et al, a staff member who was identified as a witness stated in an interview with the investigator that he did not report the incident because he was a new employee and wanted to get along with everyone.</p> <p>During the investigation of the alleged neglect of SE, the named staff member was interviewed a second time. In that interview, he charged that the Unit Supervisor in the past had given him permission on numerous occasions to leave CIO (Constant In-Sight Observation) of SE when SE was sleeping in order to engage in other duties. He added further that he did not report these instances or question these instructions because he was "afraid action would be taken against him." The investigator conducted a second interview of the Unit Supervisor pursuing this allegation, and the Unit Supervisor denied the allegation.</p> <p>Current recommendation: Questions staff members further when they state or imply in an interview that they have reason to not report incidents or to delay reporting incidents or conduct that they know violates hospital policy.</p>
<p>I.1.b</p>	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of</p>	<p>Compliance: Substantial.</p>

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	<p>care. Such policies and procedures shall:</p>	
<p>I.1.b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice of implementing performance improvement actions identified as a result of the review of deaths.</p> <p>Findings: There were 10 deaths during the review period. Five were unexpected deaths:</p> <ul style="list-style-type: none"> • BN died at age 26 on 1/11/11 at Queen of the Valley Medical Center. The cause of death was septic shock with multiple organ failure and endocarditis. In his report, the Independent External Reviewer made 18 recommendations related to issues raised by this death. Several recommendations related to the use of pain medication and psychostimulant medications and others related to staff actions when individuals refuse treatment under certain circumstances. It also raised questions regarding what appeared to be the lack of attention by MODs to calls on several occasions. All of the recommendations are being tracked in the 3/6/11 MIRC tracking form. • RA died on 1/12/11 at age 49 at Sonoma Valley Hospital after a lengthy hospital stay. The cause of death was respiratory failure secondary to aspiration pneumonia. This death also raised questions regarding appropriate responses to individuals who continuously refuse their psychotropic medications and when individuals refuse emergency medical care that the physician believes is necessary. As in the MIRC review of BN's death, all recommendations related to the death of RA are being tracked in the 5/19/11 MIRC tracking form. • CS died at age 53 in a board and care home three weeks after his discharge from NSH. The autopsy listed the cause of death as dilated cardiomyopathy, coronary arteriosclerotic disease and class III obesity. • LL, 27 years old, died at Santa Rosa Hospital on 4/12/11 as a result of

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		<p>head and neck injuries he sustained when he jumped/fell from a second-story balcony onto the A7 courtyard on 2/26/11. Environmental changes were immediately made in the courtyard: loose chairs were removed, metal picnic tables were secured, metal mesh was placed over the chain link fence, a metal shield was put in place to block the window ledge and the telephone was made functional.</p> <ul style="list-style-type: none">• WR at age 47 died of cardiac arrest while in a prone containment on the floor. The autopsy revealed WR had hypertensive and atherosclerotic cardiovascular disease. The Internal Discipline Services Review stated: "...it is by no means a coincidence that the confrontation preceded a heart attack in an individual with a significant but silent coronary stenosis." Further information about this death is provided in I.1.b.iv. <p>The NSH Acting Medical Director presented a report on these five unexpected deaths to the Quality Council. This analysis states that two of these lives were lost because individuals "refused to comply with reasonable requests for evaluation of medical complaints." Noting that there were similar cases last year, the report states that DMH has been asked for clarification of the circumstances in which an individual should be allowed to refuse medical treatment. Training addressing this matter has been requested of DMH as well. A Refusal Workgroup has been established.</p> <p>The report acknowledges the increased awareness and documentation of cardiac and metabolic risk factors, while noting that the vending machines in the facility continue to supply "unhealthy, calorie-dense snacks high in sugar and fat" and the regular hospital diet has high salt and fat content. The author recommends that consideration be given to replacing the regular diet with the Heart Association prudent diet plan.</p> <p>Although Zoll defibrillators are available on each unit, these deaths saw instances in which staff continue to wait for the paramedic crews to use a defibrillator. The report acknowledges that defibrillation as part of BCLS as opposed to ACLS is new and unfamiliar to staff. Training is being</p>
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		<p>provided, according to the report.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue full implementation of the DMH process for the review of deaths and the report to the QC of unexpected deaths that require review by an independent external physician. 2. Continue to track the implementation of death review recommendations.
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Preliminary investigations are done by HPOs who qualify for patrol duty. Generally, experienced HPOs are assigned to patrol duty according to information received via phone from the office of the Chief of Hospital Police. Present staffing in the Office of Special Investigations consists of the Supervising Special Investigator, four full-time Special Investigators and one retired annuitant.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Several investigations reviewed included photos that were preserved as evidence. Critical interviews are recorded and preserved as well. The April 25 MIRC review of the containment death of WR states that the body was</p>

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		<p>covered and left on the floor in the unit hallway for seven hours. It was guarded by a hospital police officer at all times. The delay in removing the body was attributed to the need for a sheriff's investigation, since this was a containment death.</p> <p>Current recommendation: Continue to safeguard evidence. Conduct death investigations in a manner that respects the dignity of deceased persons.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Reviews of the containment death of WR on 4/11/11 have resulted in several systemic recommendations and completed actions that include, but are not limited to:</p> <ul style="list-style-type: none"> • Flagging the records of individuals for whom restraints or seclusion are counter-indicated because of their medical condition. AD 761 was revised to require the assessment of individuals who may have medical contraindications for the use of restraints. • AD 761: Behavioral Restraint and Seclusion was revised to include a prohibition against prone restraints, prone containment and prone transportation. In those instances when it is unavoidable, the policy requires that a clinical staff member not participating in the containment process do continuous assessment and monitoring for respiratory distress and physical well-being of the individual. • Review of training provided to staff in the use of the AED. • The TSI training manual was put on the NSH intranet and printed copies were distributed to Programs for quick reference for staff. • A new process was initiated to ensure that individuals on clozapine have

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		<p>an initial and annual EKG.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the investigation of incidents that involve the use of restraints address the questions of imminent risk and de-escalation methods undertaken, and the number and position of the staff members involved in the containment. 2. In investigations of the use of prone containment, address the presence of the uninvolved observer monitoring the individual and removal of the individual from the prone position as quickly as safely possible.
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: In all of the A/N/E investigations reviewed, hospital police began the preliminary investigation in a very timely manner after notification of the incident.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: As shown below, seven of the 11 investigations reviewed were completed within 30 business days or within a few days of that timeline.</p>

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		<table border="1"> <thead> <tr> <th data-bbox="953 228 1371 342">Incident type</th> <th data-bbox="1371 228 1541 342">Date incident reported</th> <th data-bbox="1541 228 1715 342">To OSI</th> <th data-bbox="1715 228 1885 342">Date investigation closed</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 342 1371 378">Neglect</td> <td data-bbox="1371 342 1541 378">10/29/10</td> <td data-bbox="1541 342 1715 378">11/15/10</td> <td data-bbox="1715 342 1885 378">12/2/10</td> </tr> <tr> <td data-bbox="953 378 1371 414">Sexual Abuse</td> <td data-bbox="1371 378 1541 414">11/5/10</td> <td data-bbox="1541 378 1715 414">11/15/10</td> <td data-bbox="1715 378 1885 414">12/20/10</td> </tr> <tr> <td data-bbox="953 414 1371 449">Physical Abuse</td> <td data-bbox="1371 414 1541 449">11/14/10</td> <td data-bbox="1541 414 1715 449">11/16/10</td> <td data-bbox="1715 414 1885 449">12/29/10</td> </tr> <tr> <td data-bbox="953 449 1371 531">Suicide Attempts-Neglect</td> <td data-bbox="1371 449 1541 531">11/9 and 11/18/10</td> <td data-bbox="1541 449 1715 531">11/18/10</td> <td data-bbox="1715 449 1885 531">1/6/11</td> </tr> <tr> <td data-bbox="953 531 1371 566">Neglect</td> <td data-bbox="1371 531 1541 566">12/28/10</td> <td data-bbox="1541 531 1715 566">12/30/10</td> <td data-bbox="1715 531 1885 566">1/19/11</td> </tr> <tr> <td data-bbox="953 566 1371 602">Physical Abuse</td> <td data-bbox="1371 566 1541 602">12/29/10</td> <td data-bbox="1541 566 1715 602">1/4/11</td> <td data-bbox="1715 566 1885 602">2/10/11</td> </tr> <tr> <td data-bbox="953 602 1371 638">Physical Abuse</td> <td data-bbox="1371 602 1541 638">1/10/11</td> <td data-bbox="1541 602 1715 638">1/20/11</td> <td data-bbox="1715 602 1885 638">2/28/11</td> </tr> <tr> <td data-bbox="953 638 1371 760">Suicide Date of suicide action: 2/26/11 Date of death: 4/12/11</td> <td data-bbox="1371 638 1541 760">2/26/11</td> <td data-bbox="1541 638 1715 760">4/12/11</td> <td data-bbox="1715 638 1885 760">4/14/11</td> </tr> <tr> <td data-bbox="953 760 1371 795">Psychological Abuse</td> <td data-bbox="1371 760 1541 795">3/6/11</td> <td data-bbox="1541 760 1715 795">3/8/11</td> <td data-bbox="1715 760 1885 795">4/18/11</td> </tr> <tr> <td data-bbox="953 795 1371 831">Neglect Abandonment</td> <td data-bbox="1371 795 1541 831">3/30/11</td> <td data-bbox="1541 795 1715 831">4/4/11</td> <td data-bbox="1715 795 1885 831">5/26/11</td> </tr> <tr> <td data-bbox="953 831 1371 867">Containment Death</td> <td data-bbox="1371 831 1541 867">4/11/11</td> <td data-bbox="1541 831 1715 867">4/12/11</td> <td data-bbox="1715 831 1885 867">4/21/11</td> </tr> </tbody> </table> <p data-bbox="953 915 1152 946">Other findings:</p> <p data-bbox="953 953 1856 1057">Review of the OSI Case Log finds that 24 (65%) of the 37 listed investigations for the period December 2010—May 2011 were completed within 30 business days or very shortly thereafter.</p> <p data-bbox="953 1102 1274 1133">Current recommendation:</p> <p data-bbox="953 1140 1766 1203">Continue current efforts to complete investigations within the EP timeframe.</p>	Incident type	Date incident reported	To OSI	Date investigation closed	Neglect	10/29/10	11/15/10	12/2/10	Sexual Abuse	11/5/10	11/15/10	12/20/10	Physical Abuse	11/14/10	11/16/10	12/29/10	Suicide Attempts-Neglect	11/9 and 11/18/10	11/18/10	1/6/11	Neglect	12/28/10	12/30/10	1/19/11	Physical Abuse	12/29/10	1/4/11	2/10/11	Physical Abuse	1/10/11	1/20/11	2/28/11	Suicide Date of suicide action: 2/26/11 Date of death: 4/12/11	2/26/11	4/12/11	4/14/11	Psychological Abuse	3/6/11	3/8/11	4/18/11	Neglect Abandonment	3/30/11	4/4/11	5/26/11	Containment Death	4/11/11	4/12/11	4/21/11
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I.1.b. iv.3	each investigation results in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to	<p data-bbox="953 1252 1541 1282">Current findings on previous recommendation:</p> <p data-bbox="953 1325 1373 1356">Recommendation, January 2011:</p> <p data-bbox="953 1362 1281 1393">Continue current practice.</p>																																																

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	<p>provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Findings: All of the investigation reports reviewed provided a comprehensive description of the process and findings of the investigation.</p> <p>Other findings: See I.1.b.iv.3 (viii) for a description of an investigation that did not provide sufficient information to support one of the determinations.</p> <p>Current recommendation: Conclude investigations with a clear rationale for the determinations made.</p>
<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: In all of the investigations reviewed, the initially identified allegations were investigated. See I.1.a.ix for description of an investigation in which an allegation of misconduct was made against a supervising staff member during the course of an investigation. In that instance the investigator conducted a second interview of the accused supervisor to address the new allegation.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: The investigation reports reviewed identified the names of all witnesses. In</p>

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		<p>the investigation of the suicide, investigators, keeping in mind the well-being of individuals who witnessed the act, did not interview them as part of the investigation. There were sufficient staff witnesses to meet the investigation's requirements. This was a commendable decision.</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, January 2011: Continue current practice.</p> <p>Findings: All investigations reviewed clearly identified the alleged victim and the alleged perpetrator (if known) on the investigation face sheet.</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, January 2011: Continue current practice.</p> <p>Findings: In the investigation of the allegation of sexual abuse of DH, DH in his first interview described being sexually abused by a female staff member and acknowledged he had thoughts of raping her in retaliation. The investigator, following standard investigation practice, conducted a second interview of DH after a staff member reported that DH had recanted the allegation to him (staff member). In the second interview, the investigator questioned DH about the recantation and thoughts of retaliation. DH apologized for</p>

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		<p>lying in the first place and confirmed that he had no thoughts of raping or otherwise harming the named female staff member.</p> <p>Similarly, as reported in I.1.a.ix, the investigator conducted a second interview of a supervising staff member when an allegation of misconduct was made against him by the named staff member during an investigation.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(v)</p>	<p>a summary of each interview;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Each investigation report included summaries of all persons interviewed that included the date and the location of the interview.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: All A/N/E investigation reports reviewed contained a listing of the documents reviewed. The investigation report of the alleged neglect of SE included not only a listing of the documents reviewed but a short synopsis of the relevant content.</p>

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		<p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: Each of the investigation reports reviewed included documentation of a review of the prior contacts with OSI of the alleged victim and the named staff member. In each case in which prior contact had occurred, the type of contact was identified. For example, for the named staff member, the investigation report might document "one unfounded neglect case in 2009."</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: The investigation of the alleged physical abuse of TM leaves a central question unanswered and therein raises questions about the final determination.</p> <p>In an interview, TM, the victim of alleged physical abuse perpetrated during a containment on 1/10/11, said two staff members threw him to the floor and restrained him. During the prone containment he sustained bruised ribs and fractured his left arm and left leg, although at the time he was not aware of the leg injury. Named staff member #1 described the containment as "not pretty" and "harder than it should be" to the Unit Supervisor. In an</p>

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		<p>interview, staff member #2 said TM was about to hit him when named staff #1 grabbed TM from behind and both "twirled" or fell to the floor. Named staff #2 then said he (#2) "straddled and sat on" TM's back. The report notes that named staff #2 weighs 275 pounds. In his investigation interview, named staff #1 said he pinned TM down as you would "in a wrestling match." He said he did not believe he used excessive force and that the amount of force used was appropriate to the situation. The physician who examined TM after the fractures were confirmed was of the opinion that the amount of force was excessive.</p> <p>The investigation sustained the allegation of physical abuse against named staff member #1. Physical abuse was not sustained for named staff member #2, but he was determined not to have used proper TSI techniques. The investigation does not clarify an essential element of the incident, i.e., whether staff #2 actually sat on the victim's back. If this were the case, then clearly this represents not only use of an unauthorized restraining technique but the use of excessive force as well. Use of excessive force is a specifically identified component of physical abuse.</p> <p>The IRC discussed this case in April and addressed whether staff should have viewed the incident as possible abuse and reported it. The minutes report that the consensus among the IRC members was that no, staff members' views in not recognizing and reporting the actions as abuse were not faulty. The minutes noted that the facility "did not want to discourage other staff/witnesses from stepping forward and helping with assaultive individuals."</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that investigations clarify issues that have a critical bearing on the outcome of the investigation. This would include, but not be limited to, issues that directly relate to an element in the definition of the incident type under investigation.2. Clarify that it is the facility's expectation that staff report in good
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		<p>faith any incident when there is reason to believe the event may constitute A/N. Subsequent investigation will make this determination.</p>
I.1.b. iv.3(ix)	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: The accounts by several staff witnesses of the wall containment of KB that resulted in an allegation of physical abuse varied on several important issues. Witnesses agreed that KB complained that her arm was hurting as she was being restrained. The named staff member said he left the scene of the containment to wash his face because KB spit at him. No witnesses mentioned seeing any spitting. Three staff witnesses saw the psychologist motion to the named staff to lower his voice and/or leave the scene. The named staff member said he did not hear the psychologist's instruction because he has a hearing impairment. The victim was not able to provide an account of the incident. The investigation did not address the conflicting evidence about the psychologist's attempt to calm down or have the named staff member remove himself from the scene.</p> <p>The investigation did not sustain the allegation of physical abuse but found that the named staff member had failed to use proper TSI procedures in the way he held KB's arm behind her back and this constituted a violation of policy.</p> <p>Current recommendation: Address conflicting evidence that directly relates to the alleged misconduct under investigation.</p>
I.1.b. iv.4	<p>staff supervising investigations review the written report, together with any other</p>	<p>Current findings on previous recommendation:</p>

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	<p>relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: All of the investigations reviewed were signed by the Supervising Special Investigator, indicating his approval. The IRC minutes of March 15, 2011 indicate that the review of two incidents led the committee to ask the Supervising Special Investigator to remind investigators to document requests for additional witnesses.</p> <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, January 2011: Continue current practice.</p> <p>Findings: The IRC report to the Quality Council (June 14, 2011) presented areas of potential concern that the Committee identified through its review of incidents. These included:</p> <ul style="list-style-type: none"> • Individuals possessing contraband including shanks, cell phones, tobacco and drugs. • Gang influence/membership contributing to criminal activity, including drug/contraband trade. • Individuals' fears of retaliation by peers and staff for reporting misconduct and alleged criminal activity. • Violations of staff/individual boundaries. • Multiple cases of staff inattention or sleeping while on duty. • Staff non-participation in response to behavior emergency events.

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		<ul style="list-style-type: none"> • Inconsistency in applying the policies and procedures related to granting grounds access and concern that nursing input into these decisions was not sought and utilized. <p>This same report tracked actions planned and in process to address these concerns. These include:</p> <ul style="list-style-type: none"> • Enhanced professional boundary training is being provided at new employee orientation and annually. This initiative began in January 2011. • All individuals were evaluated for the appropriateness and/or level of grounds access. • Initial Gang Training for hospital police, Unit Supervisors and Program Directors was provided with assistance from staff of the Department of Corrections. Annual training and new employee orientation will include a Gang Training component. • The Clinical Administrator and Program Management are working to establish guidelines for the identification, reporting, and addressing of sleeping/alertness issues. <p>Other findings: Recommendations for training/retraining and review of specific policies and procedures as well as referral to Human Resources for disciplinary action were made in the investigations reviewed. As shown below, follow-up as documented in the OSI Recommendations Task Tracking form and information supplied by HR indicated that recommended trainings were completed as was the review of policies. The absence of disciplinary action in the sustained case of physical abuse (1/10/11) raises questions.</p> <table border="1" data-bbox="953 1227 1911 1302"> <thead> <tr> <th data-bbox="953 1227 1312 1263">Incident type/ Policy violation (date)</th> <th data-bbox="1312 1227 1629 1263">Recommendation</th> <th colspan="2" data-bbox="1629 1227 1911 1263">Follow-up</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1263 1312 1302"></td> <td data-bbox="1312 1263 1629 1302"></td> <td data-bbox="1629 1263 1766 1302"></td> <td data-bbox="1766 1263 1911 1302"></td> </tr> </tbody> </table>			Incident type/ Policy violation (date)	Recommendation	Follow-up					
Incident type/ Policy violation (date)	Recommendation	Follow-up										

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		Sustained: Neglect failure to follow policy/ failure to report/ insubordination (3/30/11)	Referral to HR	Employee dismissed
		Sustained Physical abuse (1/10/11)	Repeat A/N training and TSI training	Completed 2/25/11
		Sustained Psychological abuse (3/6/11)	Attend training in employee ethics, professional boundaries and A/N	Training completed and verified 2/15/11 Employee demoted
		Not sustained Physical abuse Sustained: Failure to follow TSI procedure (12/29/10)	Attend TSI refresher course	Training completed 3/31/11 Employee counseled
		Sustained: Neglect failure to follow policy (11/18/10)	Review policies and attend training on A/N, Suicide Prevention and Safety/Security Searches	Training and policy reviews completed on 3/31/11
		<p>Compliance: Substantial.</p> <p>Current recommendation: Ensure the even-handed application of penalties for sustained cases of abuse and neglect.</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	<p>Compliance: Substantial.</p>		

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	categories:	
I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue the presentation of data in a form that makes trends apparent.</p> <p>Findings: The facility presented considerable data on violence in table and graph form. This data showed March 2011 as having an unusually high number of aggressive acts (physical and verbal) to staff (approximately 130) and physical acts of aggression toward peers (nearly 100). Taking a longer view, from December 2010 -May 2011, there has been a slightly downward slope in the rate of aggression to staff per 1000 patient days. During the same period, peer aggression per 1000 patient days remained largely unchanged, with a dip occurring in May. For the same study period, the count of unique aggressors (not incidents) ranged from approximately 250 in December, March and April to approximately 210 in May.</p> <p>Other findings: The IRC presented an analysis of behavioral triggers to the Quality Council. This report stated:</p> <ul style="list-style-type: none"> • Peer-to-peer aggression with major injury has remained little changed over the last 12 months. • There was an 18% decrease from a mean of 11 acts of aggression to staff resulting in major injury for June-November 2010 to nine acts this review period. Two of the top three aggressors were transferred to other state hospitals. • There was a 22% decrease from a mean of 27 (June-November 2010) for two or more aggressive acts in seven days to a mean of 21 for the review period. Ninety unique individuals accounted for 128 of these triggers in the review period. • Individuals with four or more aggressive acts in 30 days saw a 40%

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		<p>decrease from a mean of 15 (June-November 2010) to a mean of nine in the current review period.</p> <p>Reported incidents of alleged abuse and neglect declined by 51% during the current review period as well.</p> <table border="1" data-bbox="963 415 1703 797"> <thead> <tr> <th>Abuse type</th> <th>June-November 2010</th> <th>December 2010 - May 2011</th> </tr> </thead> <tbody> <tr> <td>Physical</td> <td>18</td> <td>7</td> </tr> <tr> <td>Verbal</td> <td>8</td> <td>2</td> </tr> <tr> <td>Psychological</td> <td>2</td> <td>2</td> </tr> <tr> <td>Sexual</td> <td>8</td> <td>3</td> </tr> <tr> <td>Neglect</td> <td>17</td> <td>11</td> </tr> <tr> <td>Exploitation</td> <td>0</td> <td>1</td> </tr> <tr> <td>Other</td> <td>0</td> <td>0</td> </tr> <tr> <td>Total</td> <td>53</td> <td>26</td> </tr> </tbody> </table> <p>Current recommendation: Continue current practice.</p>	Abuse type	June-November 2010	December 2010 - May 2011	Physical	18	7	Verbal	8	2	Psychological	2	2	Sexual	8	3	Neglect	17	11	Exploitation	0	1	Other	0	0	Total	53	26
Abuse type	June-November 2010	December 2010 - May 2011																											
Physical	18	7																											
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Neglect	17	11																											
Exploitation	0	1																											
Other	0	0																											
Total	53	26																											
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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> <p>Findings: The facility did not provide a listing of staff members named in A/N/E incidents for a specific period of time, but provided the listing below of the number of staff involved in A/N/E incidents during the review period.</p> <table border="1" data-bbox="953 1354 1591 1429"> <thead> <tr> <th>Incident type- Allegation of:</th> <th># staff involved</th> </tr> </thead> <tbody> <tr> <td>Physical abuse</td> <td>9</td> </tr> </tbody> </table>	Incident type- Allegation of:	# staff involved	Physical abuse	9																							
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		<table border="1" data-bbox="955 190 1591 386"> <tr> <td>Neglect</td> <td>17</td> </tr> <tr> <td>Verbal abuse</td> <td>2</td> </tr> <tr> <td>Psychological abuse</td> <td>2</td> </tr> <tr> <td>Exploitation</td> <td>1</td> </tr> <tr> <td>Sexual abuse</td> <td>3</td> </tr> </table> <p data-bbox="955 430 1917 532">Other findings: All of the investigations reviewed documented the history of the named staff member(s) in prior A/N/E incidents.</p> <p data-bbox="955 576 1917 678">Current recommendation: Provide a listing of staff members named in A/N/E incidents to the IRC on a periodic basis with sufficient information to enable discernment of patterns.</p>	Neglect	17	Verbal abuse	2	Psychological abuse	2	Exploitation	1	Sexual abuse	3											
Neglect	17																						
Verbal abuse	2																						
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Sexual abuse	3																						
I.1.d.iii	individuals directly and indirectly involved;	<p data-bbox="955 727 1543 755">Current findings on previous recommendation:</p> <p data-bbox="955 799 1917 901">Recommendation, January 2011: Continue the production and analysis of useful aggression data and enact corrective measures accordingly.</p> <p data-bbox="955 945 1917 1084">Findings: An IRC report to the Quality Council provides a count of the individuals who were victims in sustained allegations of abuse in the period June-December in 2009 and 2010. 2010 figures showed a decrease of 47%.</p> <table border="1" data-bbox="961 1123 1392 1391"> <thead> <tr> <th></th> <th>2009</th> <th>2010</th> </tr> </thead> <tbody> <tr> <td>June</td> <td>1</td> <td>4</td> </tr> <tr> <td>July</td> <td>1</td> <td>1</td> </tr> <tr> <td>August</td> <td>2</td> <td>1</td> </tr> <tr> <td>September</td> <td>0</td> <td>0</td> </tr> <tr> <td>October</td> <td>4</td> <td>2</td> </tr> <tr> <td>November</td> <td>2</td> <td>0</td> </tr> </tbody> </table>		2009	2010	June	1	4	July	1	1	August	2	1	September	0	0	October	4	2	November	2	0
	2009	2010																					
June	1	4																					
July	1	1																					
August	2	1																					
September	0	0																					
October	4	2																					
November	2	0																					

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		<table border="1"> <tr> <td>December</td> <td>7</td> <td>7</td> </tr> <tr> <td>Total</td> <td>17</td> <td>9</td> </tr> </table>	December	7	7	Total	17	9
December	7	7						
Total	17	9						
I.1.d.iv	location of incident;	<p>Also see I.1.d.i.</p> <p>Other findings: Graphed data presented to the QC in the July Safety and Security Monthly Report showed a slight downward trend in the number of unique aggressors for the period December 2010-May 2011. The counts ranged from approximately 260 in March to 200 in May.</p> <p>Current recommendation: Continue current practice and monitoring.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: The facility reported that five units saw sizeable reductions in incidents of peer aggression from the last review period:</p> <ul style="list-style-type: none"> • A8 down 31 incidents • A7 down 35 incidents • Q4 and Q5 each down 18 incidents • Q9 down 22 incidents <p>In contrast, two units saw sizeable increases in peer aggression incidents in the current review period as compared to the prior period: A2 increased by 22 incidents and T14 increased by 18 incidents.</p> <p>(Both units A7 and A8 have completed team building training and A2 is</p>						

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		<p>scheduled for team building.)</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, January 2011: Continue current practice.</p> <p>Findings: No data was provided to fulfill this requirement of the EP.</p> <p>Current recommendation: Provide data on day and time of incidents.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to use aggression data to guide the allocation of resources.</p> <p>Findings: The facility reported measures taken to curb aggression that included, but were not limited to:</p> <ul style="list-style-type: none"> • Forty-one individuals were identified as appropriate for a more secure facility or for one with a treatment program that meets their needs. Seven individuals were transferred to Patton and five to Metro to meet their security and treatment needs. The transfers of 13 additional individuals to Patton are pending and seven transfers are pending to Metro. • NSH has submitted to DMH budget proposals for safety and security measures that include a campus-wide personal alarm system,

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		<p>establishment of a Specialty Unit and increased police presence within the Secure Treatment Area, including the establishment of a permanent satellite station near the Specialty Unit.</p> <ul style="list-style-type: none"> • Staffing of a Grounds Presence Team to assist with monitoring of activities on the grounds. • Upgraded outdoor lighting and removal of obstacles that provide hiding spaces outside. • Implementation of a fast-track referral of individuals who present an imminent danger to self or others to the Facility Review Committee by Program Review Committees. • All individuals require an escort when on grounds. The ratio of individuals to escort is determined by the individuals' grounds access status. <p>See also I.2.c for additional initiatives.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.d. vii</p>	<p>outcome of investigation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to maintain the OSI Case Log and make it available to the IRC.</p> <p>Findings: The OSI Case Log lists investigations of 10 deaths, 26 allegations of A/N/E and one attempted suicide. Allegations of A/N/E were sustained against nine staff members.</p> <p>Current recommendation: Continue to maintain the OSI Case Log, making it available to the IRC and appearing in the IRC reports to the Quality Council.</p>

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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, January 2011: As planned, follow DMH guidance on procedures for reassigning staff named in A/N/E allegations.</p> <p>Findings: The facility does not follow the guidance in Special Order 263 for removing or reassigning staff members named in A/N/E allegations. See I.1.a.iii for a further explanation.</p> <p>Other findings: As shown in the table in I.1.a.iv, a criminal history investigation was completed by the date of hire for all staff members sampled.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice in providing timely criminal background checks.</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. Dolly Matteucci, Executive Director 2. Norm Kramer, Interim Clinical Administrator 3. K. Cooper, Program Director 4. D. Kormanik, RN, Standards Compliance 5. <u>Quality Council Interview:</u> <ul style="list-style-type: none"> • Dolly Matteucci, Executive Director, Chair Quality Council • Cindy Black, LCSW, Director, Standards Compliance, member Quality Council • Anish Shah, MD, Acting Medical Director, member Quality Council • James Young, DO, Acting Assistant Medical Director, member Quality Council • Mike McQueeney, Acting Hospital Administrator, member Quality Council • Steve Weule, RN, Senior Registered Nurse, Risk Manager, member Quality Council • Abishai Rumano, MD, Chief Physician and Surgeon, member Quality Council • Tony Rabin, PhD, Acting Chief of Psychology Services, member Quality Council • Gary Walters, RN, Acting Nurse Administrator, member Quality Council • Barbara, McDermott, PhD, Research Director, member Quality Council • Norm Kramer, Interim Clinical Administrator, member Quality Council • Dana Kormanik, RN, Standards Compliance, recorder Quality Council 6. <u>Sentinel Event Interview:</u> <ul style="list-style-type: none"> • Dolly Matteucci, Executive Director • Norm Kramer, Interim Clinical Administrator

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		<ul style="list-style-type: none"> • Jonathan Berry, MD, Acting Senior Psychiatrist • Dean Gardiner, RN, Standards Compliance Coordinator <p>7. <u>Mortality Review Interview:</u></p> <ul style="list-style-type: none"> • Anish Shah, MD, Acting Medical Director (Mortality Review cases) • James Young, DO, Acting Assistant Medical Director • Jonathan Berry, MD, Acting Senior Psychiatrist (Mortality Review cases) • Patrick Nolan, MD, Acting Chief of Psychiatry (Mortality Review cases) <p>8. WRP Team Risk Management Trigger Event case review for RT, Unit A1 <u>Team Members:</u></p> <ul style="list-style-type: none"> • William Gardner, PsyD, Staff Psychologist • Christina Patino, LCSW, Licensed Clinical Social Worker • Michael Fedderson, DO, Staff Psychiatrist • Alice Rivera, RN, Shift Lead • Elsa Nunez, PT, Psychiatric Technician • Linda Birney, RN-BC, Registered Nurse, PBS • Steve Weule, RN, Supervising Registered Nurse • Jennifer Marshall, RT, Rehabilitation Therapist <p>9. WRP Team Risk Management Trigger Event case review for SV, Unit A2 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Jocelyn Ricafort, RN, Registered Nurse • Greg Burnside, PT, Psychiatric Technician • Kobita Rikhye, PsyD, Staff Psychologist • Chandandeep Chahal, MD, Staff Psychiatrist • Cynthia Guilford, LCSW, Licensed Clinical Social Worker <p>10. WRP Team Risk Management Trigger Event case review for DP, Unit A7 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Harold Collins, PT, Senior Psychiatric Technician • Todd Finnemore, PsyD, Staff Psychologist • Saeed Elmi, PT, Psychiatric Technician, PBS • Alex Lapinski, LCSW, Licensed Clinical Social Worker • Sharon Sanguinetti, RN, Registered Nurse, PBS
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		<ul style="list-style-type: none"> • Javed Iqbal, MD, Staff Psychiatrist • Kathy Mattheis, RT, Rehabilitation Therapist <p>11. WRP Team Risk Management Trigger Event case review for CR, Unit Q3 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Beverly Lynn, RT, Rehabilitation Therapist • Leizel Fajardo, RN, Registered Nurse • Merritt Kollen, PT, Psychiatric Technician • Ben Levin, PsyD, Staff Psychologist • Fouad Saddik, MD, Staff Psychiatrist • Anthony Bowers, Clinical Social Worker <p>12. WRP Team Risk Management Trigger Event case review for SL, Unit T8 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Kamaljeet Boora, MD, Staff Psychiatrist • Shannah Ziatz, LCSW, Licensed Clinical Social Worker • Aysha Joseph, RN, Registered Nurse • Todd Schirmer, PhD, Staff Psychologist • Bimbo Lavares, PT, Psychiatric Technician <p>13. WRP Team Risk Management Trigger Event case review for JT, Unit T2 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Nicholas Kammerer, MD, Staff Psychiatrist • Chris Echols, PhD ABPP, Staff Psychologist • Chrysler Villanueva, LCSW, Licensed Clinical Social Worker • Gary Val Silagan, RN, Registered Nurse • Ingrid Lacey, MA BC-DMT, Rehabilitation Therapist (Dance) <p>14. WRP Team Risk Management Trigger Event case review for RK, Unit Q7 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Andrew O'Neill, PsyD, Staff Psychologist • Farhad Numan, MD, Staff Psychiatrist • Holly Bloom, LCSW, Licensed Clinical Social Worker • Menchor Cuizon, RN, Incident/Risk Management Specialist <p>15. WRP Team Risk Management Trigger Event case review for MO, Unit Q8 <u>Team Members:</u></p> <ul style="list-style-type: none"> • Xavier Maldonado, Clinical Social Worker
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		<ul style="list-style-type: none"> • Miyoung Kim, DT, Rehabilitation Therapist • Robin Hemenway, PsyD, Staff Psychologist • Michael Cosgrove, MD, Staff Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. NSH July Safety and Security Monthly Action Report 2. Quality Council minutes 3. Key Indicator Data 4. Individual-specific Key Indicator data 5. DMH Strategic Planning Conference: Statewide Aggression Reduction March 28, 2011, revised July 25, 2011 6. May 2011 PRC meeting minutes for Programs I, II, III, IV and V 7. WRPs of 13 individuals for Risk Management Committee recommendations 8. WRPs of 29 individuals on behavioral High Risk Lists 9. WRPs of 23 individuals on medical High Risk Lists (reviewed by M. Jackman) 10. Sentinel event case for TM on January 10, 2011 11. Nursing procedure 1506, Behavioral Seclusion and Restraints, revised, June 24, 2011 12. NSH 6-month Incident report (February 2011-present) 13. Risk Management Trigger list (December 2010-present) 14. The closed chart documents of individual LL described below for mortality review 15. Mortality Review documents for individual LL: <ul style="list-style-type: none"> • Special Investigator report • Nursing Death Summary • Medical Death Summary • Initial MIRC minutes • Internal Services/Discipline review • Independent External review • Final MIRC minutes • Task Tracking log 16. Mortality Review documents for individual WR:
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		<ul style="list-style-type: none">• Special Investigator report• Nursing Death Summary• Medical Death Summary• Initial MIRC minutes• Internal Services/Discipline review• Independent External review• Final MIRC minutes• Task Tracking log <p>17. Mortality Review documents for individual RA:</p> <ul style="list-style-type: none">• Special Investigator report• Nursing Death summary• Medical Death summary• Initial MIRC minutes• Internal Services/Discipline review• Independent External review• Final MIRC minutes• Task Tracking log <p>18. Mortality Review documents for individual CS:</p> <ul style="list-style-type: none">• Special Investigator report• Nursing Death summary• Medical Death summary• Initial MIRC minutes• Internal Services/Discipline review• Independent External review• Final MIRC minutes• Task Tracking log <p>19. Mortality Review documents for individual BN:</p> <ul style="list-style-type: none">• Special Investigator report• Nursing Death summary• Medical Death summary• Initial MIRC minutes• Internal Services/Discipline review• Independent External review
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		<ul style="list-style-type: none"> • Final MIRC minutes • Task Tracking log
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	Compliance: Substantial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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> <p>Findings: The July Safety and Security Monthly Report describes several actions taken to reduce violence in Program IV:</p> <ul style="list-style-type: none"> • Team building meetings were conducted on three units, are in progress in one unit and are planned for four units. • Increased staffing was provided: <ul style="list-style-type: none"> ○ For unit A9 (Acute Admissions) one additional staff was added per shift and any 1:1 observation generates another staff member. ○ On units A2 (Intermediate Care) and A4 (Skilled Nursing), one additional staff per unit for clinical care issues and any 1:1 generates another staff member. <p>See also I.1.d.iv for data related to the reduction of aggression on specific units in Program IV.</p> <p>Other findings: Behavioral Key Indicators showed a decrease in aggression during the</p>

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		current review period.			
			July-December 2010	January-June 2011	% change
		Aggression to self resulting in major injury	22	14	36% decrease
		Individuals with two or more aggressive acts to self in seven days	35	25	29% decrease
		Individuals with four or more aggressive acts to self in 30 days	21	15	29% decrease
		Peer-to-peer aggression resulting in major injury	19	18	5% decrease
		Aggression to staff resulting in major injury	70	52	26% decrease
		Individuals with two or more aggressive acts to others in seven days	153	131	14% decrease
		Individuals with four or more aggressive acts to others in 30 days	87	56	36% decrease
<p>Data for this review period indicate an increase in four measures of violence in March, followed by decreases in April and May. These four measures were peer-to-peer aggression resulting in major injury, aggression to staff resulting in major injury, individuals with two or more aggressive acts to others in seven consecutive days and individuals with four or more aggressive acts to others in 30 consecutive days.</p>					
<p>Current recommendation: Continue current practice of presenting and analyzing data and addressing violence-related issues.</p>					

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<p>I.2.a.ii</p>	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue implementation of plans to make outside consultations and specialized training available.</p> <p>Findings: The NSH Monthly Safety and Security Report for July states that IN an effort to assist individuals in reducing impulsive aggression, the hospital is working to expand the availability of DBT services. The Chairs were identified of a committee that would recommend a training plan, create a treatment proposal and conduct a needs assessment to determine which individuals would benefit from DBT. The Committee will report its progress to the Quality Council in August.</p> <p>Other findings: The hospital's evaluation of the Risk Management system found that it cast too wide a net as the trigger thresholds were too low and resulted in a very large number of individuals to be reviewed, which in turn encouraged cursory reviews and recommendations that were of little assistance in changing individuals' behavior. Consequently, the hospital made changes and documented these in a Status Report dated March 15, 2011: Process and Structural Changes to the Incident and Risk Management Programs. A short synopsis of the changes is provided below:</p> <ul style="list-style-type: none"> • Changes implemented on the PRC level include collaboration between the Senior Psychiatrist, Senior Psychologist and Program Director on who will be reviewed. Review criteria revised to include any major injury, repetitive assaults or self injury, any individual exhibiting predatory aggression, individuals at high risk for suicide, individuals on admission with a past history of serious self harm with consideration of results from the COVR and/or High Risk Admission Checklist, and individuals on enhanced observation for more than 10 consecutive days.
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		<ul style="list-style-type: none"> • ETRC changes include criteria for review—individuals who triggered twice or more for major injury, aggression to self or others subsequent to a PRC review, cases recommended by the PRC where interventions have not been effective and where the potential for a negative outcome is greatest. • FRC changes include criteria for review—cases recommended by ETRC/PSSC where interventions are not successful or where treatment services are not available at NSH, individuals who continue to trigger for major injury from any cause four or more times and/or are instrumental in the occurrence of an incident resulting in major disability, and individuals on enhanced observation for more than 30 days. • A pre-meeting is held prior to the ETRC and FRC meetings at which the Chair identifies two cases for review and notifies the committee members. The Chairs of the PRCs hold a pre-meeting and identify 3-4 cases per week for review. <p>Current recommendation: Continue implementation and evaluation of the revised Risk Management Committee Process and Structure.</p>
I.2.a. iii	identification of systemic trends and patterns of high risk situations.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to identify those individuals whose multiple and serious acts of aggression indicate a need for further consultation and treatment recommendations.</p> <p>Findings: Review of individuals reaching triggers related to aggression to self found that several individuals reached these triggers on three or more occasions during the six-month review period as shown:</p> <ul style="list-style-type: none"> • Aggression to self resulting in major injury: RW met this trigger five

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		<p>times.</p> <ul style="list-style-type: none"> Two or more aggressive acts to self in seven days: RW (same individual as named above) and AW each met this trigger four times. ET and RT each met this trigger three times. Four or more aggressive acts to self in 30 days: AW met this trigger five times and RW met this trigger four times. (Both of these individuals are mentioned above.) <p>Twenty-five individuals reached both the two aggressive acts in seven days and the four aggressive acts to others in 30 days triggers in a single month. Three of these individuals also reached the trigger for an aggressive act resulting in major injury in that same month.</p> <p>The individuals listed below reached the two aggressive acts in seven days and the four aggressive acts in 30 days triggers in two or more months and three also reached the trigger for aggression resulting in major injury in one of those same months:</p> <table border="1" data-bbox="953 857 1875 1360"> <thead> <tr> <th>Individual</th> <th>Reached triggers for two in seven <u>and</u> four in 30 in these months</th> <th>Reached trigger for aggression resulting in major injury</th> </tr> </thead> <tbody> <tr> <td>AS</td> <td>Jan, Mar</td> <td></td> </tr> <tr> <td>CW</td> <td>Jan, May</td> <td></td> </tr> <tr> <td>JW</td> <td>Dec, Jan</td> <td>Dec</td> </tr> <tr> <td>KB-1</td> <td>Dec, Jan</td> <td></td> </tr> <tr> <td>KB-2</td> <td>April, May</td> <td></td> </tr> <tr> <td>MO</td> <td>Jan, Feb</td> <td></td> </tr> <tr> <td>MP</td> <td>Apr, May</td> <td></td> </tr> <tr> <td>RT</td> <td>Dec, Jan, Mar, Apr, May</td> <td>Apr</td> </tr> <tr> <td>SE</td> <td>Feb, March</td> <td>March</td> </tr> <tr> <td>TM</td> <td>Jan, Mar</td> <td></td> </tr> </tbody> </table>	Individual	Reached triggers for two in seven <u>and</u> four in 30 in these months	Reached trigger for aggression resulting in major injury	AS	Jan, Mar		CW	Jan, May		JW	Dec, Jan	Dec	KB-1	Dec, Jan		KB-2	April, May		MO	Jan, Feb		MP	Apr, May		RT	Dec, Jan, Mar, Apr, May	Apr	SE	Feb, March	March	TM	Jan, Mar	
Individual	Reached triggers for two in seven <u>and</u> four in 30 in these months	Reached trigger for aggression resulting in major injury																																	
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RT	Dec, Jan, Mar, Apr, May	Apr																																	
SE	Feb, March	March																																	
TM	Jan, Mar																																		

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		<p>Current recommendation: Continue efforts to identify those individuals whose behavior is most frequent and most severe and provide them clinical consultation and/or transfer as appropriate.</p>												
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Substantial.</p>												
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: 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> <p>Findings: The minutes of PRC meetings for May 2011 for Programs I, II, III, IV and V included documentation of the recent trigger and incident history of the individuals being reviewed. Some individuals cited above are among the 13 individuals reviewed (below) to determine whether their WRPs reflect consideration of the RM Committee recommendations. The findings were generally positive.</p> <table border="1"> <thead> <tr> <th></th> <th>PRC date</th> <th>PRC Recommendation</th> <th>WRP Implementation or Response</th> </tr> </thead> <tbody> <tr> <td>VC</td> <td>5/19/11</td> <td>Review medication management of PTSD, if indicated.</td> <td>Insufficient evidence for PTSD diagnosis. Med change under consideration pending lab results to obtain hepatic baseline.</td> </tr> <tr> <td>WF</td> <td>5/19/11</td> <td>Consider providing him</td> <td>WRP 8/24. Enrolled in a</td> </tr> </tbody> </table>		PRC date	PRC Recommendation	WRP Implementation or Response	VC	5/19/11	Review medication management of PTSD, if indicated.	Insufficient evidence for PTSD diagnosis. Med change under consideration pending lab results to obtain hepatic baseline.	WF	5/19/11	Consider providing him	WRP 8/24. Enrolled in a
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			with a Gardening Group	Nature Walk Group (best fit available).
	RB	5/26/11	PBS to revisit BGs. Get TRC consult for antipsy-chotic polypharmacy.	WRP 7/25/11. BGs updated on 6/23/11. TRC consult requested on 5/31 and report made on 6/2/11.
	DZ	5/5/11	Contact dietary and speech therapy as he does not have dentures. Review the use of Ativan and Wellbutrin. Taper Vicodin.	WRP 6/23/11. Currently being followed by the dentist. Denture molds not yet complete. Ativan was discontinued. Wellbutrin being tapered. Vicodin reduced from max of four doses daily to one dose daily.
	BW	5/12/11	Assess ongoing need for scheduled Cogentin.	WRP 8/4/11. No longer on scheduled Cogentin.
	KB	5/12/11	Individual does not trust unit psychologist. Refer to another for Cognitive Screening.	WRP 8/4/11. Refused testing with second psychologist in May. Still considering testing in July.
	RH	5/12/11	Consider Inderal for management of impulsivity.	WRP 8/17/11. Currently prescribed Inderal 10 mg bid.
	KB	5/19/11	Contact PBS to update the previous PBS plan.	WRP 7/7/11. BG plan updated to include additions to antecedents, clarify role of contact person and add steps for reinforcement of alternate behaviors.
	AS	5/19/11	Follow up on getting her started with her Individual Therapist.	WRP 7/14/11. No mention of Individual Therapist. Focus 3.1 addresses SIB, but there

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				is no mention of individual therapy time. If the recommendation is for an Individual Recreation Therapist, it is not addressed in Focus 10.	
		RT	5/19/11	Agree with plan to recheck CBC and consider clozapine. Revise PBS plan.	WRP 7/28/11. Clozapine now part of medication regimen. BGs reviewed and sticker program discontinued.
		DS	5/26/11	Refer to PBS for BGs. If not recently done, recheck valproic and clozapine levels.	WRPs 7/19 and 8/15. No mention of BGs. Valproic and clozapine levels ordered 5/26. No need to reorder.
		CW	5/5/11	Do AIMS. Refer to TRC to review medication regimen. Do EKG.	WRP 6/15/11. Neuro consult requested to assess abnormal movements on 5/5. TRC consult ordered on 5/5. EKG ordered on 5/5/11.
		RW	5/5/11	Consider Individual Therapy with a therapist who really understands how to approach.	WRP 9/6/11. "Will explore availability of individual therapy." [Not a timely response.]
		<p>Current recommendation: Continue current practice and monitoring.</p>			
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and	<p>Current findings on previous recommendation:</p>			

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	<p>patterns;</p>	<p>Recommendation, January 2011: Continue current practice and monitoring.</p> <p>Findings: As shown in the table below, the high-risk behaviors of the majority of the 29 sampled individuals (76%) were addressed in their WRP.</p> <table border="1" data-bbox="963 451 1724 1398"> <thead> <tr> <th></th> <th>Listed in Risk Factors</th> <th>WRP date /address</th> </tr> </thead> <tbody> <tr> <td colspan="3">Victimization</td> </tr> <tr> <td>MS</td> <td>Yes</td> <td>8/17/11 Focus 2.1</td> </tr> <tr> <td>JU</td> <td>Yes</td> <td>8/10/11 Not addressed</td> </tr> <tr> <td>JD</td> <td>Yes</td> <td>8/11/11 Focus 1.2</td> </tr> <tr> <td>RG</td> <td>Yes</td> <td>8/1/11 Not addressed</td> </tr> <tr> <td>AJ</td> <td>Yes</td> <td>7/20/11 Not addressed</td> </tr> <tr> <td>VS</td> <td>No</td> <td>8/2/11 Not addressed</td> </tr> <tr> <td>DC</td> <td>Yes</td> <td>7/22/11 Not addressed</td> </tr> <tr> <td>LT</td> <td>Yes</td> <td>8/9/11 Not addressed</td> </tr> <tr> <td>GL</td> <td>Yes</td> <td>8/18/11 Focus 3.1</td> </tr> <tr> <td>RT</td> <td>Yes</td> <td>7/28/11 Focus 3.1</td> </tr> <tr> <td colspan="3">Aggression</td> </tr> <tr> <td>JA</td> <td>Yes</td> <td>7/19/11 Focus 3.5</td> </tr> <tr> <td>JD</td> <td>No</td> <td>8/11/11 Focus 3.1</td> </tr> <tr> <td>BH</td> <td>Yes</td> <td>7/6/11 Focus 3.1</td> </tr> <tr> <td>NJ</td> <td>Yes</td> <td>7/21/11 Focus 3.1</td> </tr> <tr> <td>CR</td> <td>Yes</td> <td>7/28/11 Focus 3.1</td> </tr> <tr> <td>RJ</td> <td>Yes</td> <td>5/13/11 Focus 3.1</td> </tr> <tr> <td>RT</td> <td>Yes</td> <td>7/28/11 Focus 3.1</td> </tr> <tr> <td>RR</td> <td>Yes</td> <td>8/15/11 Focus 3.1</td> </tr> <tr> <td>LJ</td> <td>Yes</td> <td>8/12/11 Focus 3.1</td> </tr> <tr> <td>RH</td> <td>No</td> <td>7/6/11 Focus 3.2</td> </tr> <tr> <td>JP</td> <td>No</td> <td>7/27/11 Not addressed</td> </tr> </tbody> </table>		Listed in Risk Factors	WRP date /address	Victimization			MS	Yes	8/17/11 Focus 2.1	JU	Yes	8/10/11 Not addressed	JD	Yes	8/11/11 Focus 1.2	RG	Yes	8/1/11 Not addressed	AJ	Yes	7/20/11 Not addressed	VS	No	8/2/11 Not addressed	DC	Yes	7/22/11 Not addressed	LT	Yes	8/9/11 Not addressed	GL	Yes	8/18/11 Focus 3.1	RT	Yes	7/28/11 Focus 3.1	Aggression			JA	Yes	7/19/11 Focus 3.5	JD	No	8/11/11 Focus 3.1	BH	Yes	7/6/11 Focus 3.1	NJ	Yes	7/21/11 Focus 3.1	CR	Yes	7/28/11 Focus 3.1	RJ	Yes	5/13/11 Focus 3.1	RT	Yes	7/28/11 Focus 3.1	RR	Yes	8/15/11 Focus 3.1	LJ	Yes	8/12/11 Focus 3.1	RH	No	7/6/11 Focus 3.2	JP	No	7/27/11 Not addressed
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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="951 854 1541 886">Current findings on previous recommendation:</p> <p data-bbox="951 927 1906 1032">Recommendation, January 2011: Summarize RM committee recommendations at the close of the discussion to ensure they are recorded clearly and correctly.</p> <p data-bbox="951 1073 1812 1179">Findings: The minutes of the PRC minutes for May clearly identify the recommendations and the staff member making the recommendation.</p> <p data-bbox="951 1219 1906 1365">Other findings: As evidenced by the positive findings in the preceding cells, notifications are reaching teams as intended, identifying individuals with high-risk behaviors and forwarding RM committee recommendations.</p>																											

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		<p>Current recommendation: Continue current practice and monitoring.</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, January 2011: Continue current practice in addressing medical high risk conditions in WRPs.</p> <p>Findings:</p> <table border="1" data-bbox="953 561 1896 1416"> <thead> <tr> <th data-bbox="953 561 1062 602"></th> <th data-bbox="1062 561 1314 602">Issue</th> <th data-bbox="1314 561 1896 602">WRP documentation</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 602 1062 1344">GLH</td> <td data-bbox="1062 602 1314 1344">Met trigger 7.1 for fall with major injury on 5/16/11 and 5/26/11</td> <td data-bbox="1314 602 1896 1344">WRP following triggers dated 6/13/11 discussed fall triggers, referrals for follow-up EKG, podiatry, MRI and physical therapy. Open focus 6.21 for fall risk with objectives and interventions related to education (nursing) and demonstration of safe transfer techniques (physical therapy) noted. POST consultation for physical therapy assessment due to fall risk and neuropathy written 5/16/11 and PT assessment completed 6/2/11, with recommendations for wheelchair and direct PT treatment to improve static and dynamic balance and transfers. 24-hour support plan developed and implemented 5/11/11 includes fall risk strategies. <i>Progress:</i> Individual has not met PT or nursing objectives as of 6/30/11 WRP, but has had no further documentation of fall incidents in the review period.</td> </tr> <tr> <td data-bbox="953 1344 1062 1416">JSC</td> <td data-bbox="1062 1344 1314 1416">Met trigger 7.2 for three or</td> <td data-bbox="1314 1344 1896 1416">WRP dated 5/19/11 reviewed fall trigger, and individual had rover assigned to monitor</td> </tr> </tbody> </table>				Issue	WRP documentation	GLH	Met trigger 7.1 for fall with major injury on 5/16/11 and 5/26/11	WRP following triggers dated 6/13/11 discussed fall triggers, referrals for follow-up EKG, podiatry, MRI and physical therapy. Open focus 6.21 for fall risk with objectives and interventions related to education (nursing) and demonstration of safe transfer techniques (physical therapy) noted. POST consultation for physical therapy assessment due to fall risk and neuropathy written 5/16/11 and PT assessment completed 6/2/11, with recommendations for wheelchair and direct PT treatment to improve static and dynamic balance and transfers. 24-hour support plan developed and implemented 5/11/11 includes fall risk strategies. <i>Progress:</i> Individual has not met PT or nursing objectives as of 6/30/11 WRP, but has had no further documentation of fall incidents in the review period.	JSC	Met trigger 7.2 for three or	WRP dated 5/19/11 reviewed fall trigger, and individual had rover assigned to monitor
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JSC	Met trigger 7.2 for three or	WRP dated 5/19/11 reviewed fall trigger, and individual had rover assigned to monitor											

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			<p>more falls in 30 days on 3/12/11, fall with major injury with hospitalization on 3/22/11</p>	<p>symptoms of dizziness and referrals to ETRC and FRC; currently has CIO. Focus 6.32 open to address learning about fall risk. CIPRTA assessment completed 4/7/11 and individual enrolled in direct OT and PT treatment to address transfers, self-care skills and lower extremity strengthening. 24-hour support plan developed and implemented 5/11/11 includes fall risk strategies.</p> <p><i>Progress:</i> Individual has made progress toward PT and OT objectives but has had recurrent falls on 5/2/11, 5/1/11, and 6/12/11.</p>
		EWT	<p>Met trigger 7.2 for three or more falls in 30 days on 5/12/11</p>	<p>Fall trigger in WRP dated 2/16/11 and documentation that individual was reviewed in MRMC and PRC, with recommendations for follow-up neurological consultation, potential environmental modifications, and physical therapy consultation. Focus 6.9 open for fall risk with nursing objectives and interventions for education and environmental modification in place. Individual referred for gait assessment and physical therapy services but refused five times.</p> <p><i>Progress:</i> No further documented fall incidents in the remainder of the review period.</p>
		BVT	<p>Met trigger 7.1 for fall with major injury on 5/12/11</p>	<p>Fall risk listed in WRP dated 6/7/11 but no documentation of trigger or review in risk factor section. Open focus 6.13 for fall injury describes fall incident and has nursing</p>

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			<p>objective and intervention to address injury from fall. No referral for PT or OT noted following fall.</p> <p><i>Progress:</i> No further documented fall incidents in the remainder of the review period.</p>
		MAW	<p>Aspiration pneumonia diagnosis</p> <p>Individual had incident of aspiration pneumonia diagnosed in 12/10. NG tube, then PEG tube placed and individual made NPO status. Speech therapy evaluation performed on 2/15/11, with direct treatment for therapeutic modalities, exercises, and trials for return to safe oral intake initiated 2/16/11, and 24-hour support plan developed and implemented, with most recent revision 5/11. In WRP dated 5/17/11, objectives and interventions for 6.16 choking risk in place.</p> <p><i>Progress:</i> According to WRP on 5/17/11, individual has made progress toward nursing objective. Review of speech therapy progress notes found that he has met speech therapy direct treatment objectives, and is now eating PO modified diet. No report of choking or pneumonia incidents was found in monthly WRP documents from June and July 2011.</p>
		JWS	<p>Aspiration pneumonia diagnosis</p> <p>Individual had incident of aspiration pneumonia that appears to have occurred in 1/11, though the date of onset and diagnosis unclear as no documentation found in WRPs dated 2/7/11 or 2/18/11. PEG tube was placed on 1/18/11 and WRP dated 2/18/11</p>

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			<p>has open objectives and interventions for 6.33 aspiration pneumonia and 6.34 for s/p tube placement. No evidence of a speech therapy assessment was found in the record following reported incident. A 24-hour support plan developed and implemented that lists positioning for enteral nutrition but not bed positioning, dressing and bathing.</p> <p><i>Progress:</i> According to WRP attachment dated 7/18/11, individual has new diagnosis of pneumonia, but there is no documentation as to whether it is aspiration-related.</p>
		BMH	<p>Choking incident on 12/30/10</p> <p>Individual reported to have choked on cookie in dining room, and required Heimlich. Reviewed by PRC on 1/6/11 and summary in risk factor section of WRP dated 4/14/11, with RN objective and intervention and SLP objective and intervention to address choking risk. SLP evaluation completed 1/7/11 and recommended direct speech therapy to learn compensatory strategies to increase safety with regular diet texture and liquids.</p> <p><i>Progress:</i> Individual discharged from speech therapy due to meeting objectives.</p>
		DDC	<p>Choking incident on 3/09/11</p> <p>Individual reported to have choked on a hotdog. Choking risk listed in Present Status of WRP dated 5/23/11, with RN objective and intervention (education-related) and SLP objective and intervention (based on demonstration of safe swallow) to address choking risk (6.15). SLP evaluation</p>

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			<p>completed 3/21/11 and recommended diet modification and direct speech therapy to learn compensatory strategies to increase safety during eating.</p> <p><i>Progress:</i> Individual has made progress toward speech therapy objectives, though no progress has been noted toward nursing objective to address choking risk. Review of record found no documentation of choking incident since 3/9/11.</p>
		MR	<p>Reported choking incidents 2/9/11, 2/14/11</p> <p>Choking risk not listed under risk factors in WRP dated 3/21/11. No discussion or documentation of reported choking incidents found in WRPs from March, June, or July. Open focus 6.22 for oral dysphagia in WRP dated 6/27/11, with objectives and interventions for speech therapy to improve oral motor skills, safe swallowing, and independence with compensatory strategies. Speech therapy evaluation completed 3/22/11 and direct treatment and 24-hour support plan initiated.</p> <p><i>Progress:</i> Individual has met all speech therapy objectives and improved independence in oral motor and compensatory skills; no documentation found of subsequent choking incident in record (though February incidents were not documented in WRPs either).</p>
		AKL	<p>New diagnosis of diabetes on 1/7/11</p> <p>The WRP dated 1/17/11 listed diabetes diagnosis on Axis III. Focus 6.13 objective and intervention in place for blood sugar education. Dietitian assessment dated</p>

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			<p>1/07/11 addressed diabetes and made appropriate recommendations (diabetic meal pattern diet, objective and intervention modified to include diabetes education and blood sugar management education). However, NST not changed to reflect change in status and new condition.</p> <p><i>Progress:</i> Individual currently has stable blood sugar, has lost 18 pounds, and is reportedly exercising daily in the gym.</p>
		DHF	<p>New diagnosis of diabetes upon admission on 3/28/11</p> <p>The WRP dated 4/04/11 did not list diabetes as Axis III diagnosis. Focus 6.1 for diabetes with nursing objective and interventions related adhering to treatment plan (maintenance). Dietitian assessment dated 4/1/11 revealed normal blood sugar, and stable diet and no diabetes symptoms.</p> <p><i>Progress:</i> Unable to assess due to short length of stay (two months).</p>
		KMB	<p>New diagnosis of diabetes upon admission on 3/17/11</p> <p>The WRP dated 3/24/11 did not list diabetes as Axis III diagnosis. Focus 6.1 for diabetes with nursing objective in place. Dietitian assessment dated 3/17/11 did not recommend changes as individual already on ADA diet, and attempted to educate regarding diabetes complications but individual refused.</p> <p><i>Progress:</i> Follow-up Nutrition assessment dated 4/28/11 revealed a decrease in blood glucose.</p>
		RP	<p>New diagnosis of diabetes upon admission on</p> <p>The WRP dated 12/09/10 listed diabetes on Axis III. Focus 6.1 for diabetes with nursing objective and interventions related</p>

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			12/1/10	to adhering to treatment plan (maintenance). Dietitian assessment dated 12/2/11 revealed normal blood sugar, and on ADA diet upon admission. Nutrition education regarding diabetes offered, but individual refused. <i>Progress:</i> Unable to assess as individual discharged prior to scheduled follow-up Nutrition assessment update.
		MP	New diagnosis of diabetes 1/5/11	The WRP dated 2/10/11 listed diabetes as Axis III diagnosis; Focus 6.2 for diabetes open with nursing objectives and interventions related to reporting hyper- and hypoglycemia symptoms. Admission nutrition assessment dated 1/06/11 addressed diabetes and underlying factors and made recommendations for diet change. NST level of IV assigned. <i>Progress:</i> As of last Nutrition update, A1C and glucose within normal limits, but he has gained weight although he is still within normal weight range.
		RGK	At high risk for metabolic syndrome	Dietitian assessment 5/9/11 addressed recommendations for hyperlipidemia. Monthly WRP dated 5/31/11 following assessment included RD recommendation for hyperlipidemia in focus 6.2. WRP dated 5/2/11 has high risk identified in Present Status and open 6.1 for hypertension and 6.2 for hyperlipidemia. <i>Progress:</i> Unable to assess as individual discharged prior to scheduled follow-up Nutrition assessment update.
		RS	At high risk for	Dietitian assessment 5/10/11 addressed

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			metabolic syndrome	recommendations for contributing factors of obesity but not hyperlipidemia. High risk identified in the Present Status of the most recent WRP dated 5/14/11; open foci 6.17 for obesity and 6.6 for hyperlipidemia. <i>Progress:</i> Unable to assess as Nutrition update not yet clinically indicated.
		JT	At high risk for metabolic syndrome	High risk identified in the Present Status of the most recent WRP dated 5/31/11, open foci 6.1 for diabetes (nursing objective and intervention in place), and 6.2 for obesity (RN and RD objectives and interventions in place). Dietitian assessment 5/27/11 addressed recommendations for contributing factor of obesity and made no recommendations for changes to current diabetes supports in place. <i>Progress:</i> Unable to assess as Nutrition update not yet clinically indicated.
		CS	At high risk for metabolic syndrome	High risk identified in the Present Status of the most recent WRP dated 4/26/11 listed as high risk for metabolic syndrome. Open foci 6.1 for obesity and 6.3 for elevated cholesterol with nursing objectives in place related to education and weight. Nutrition assessment dated 3/8/11 addressed obesity, hyperlipidemia and waist circumference and included recommendations for nutrition education and no changes to previous treatment plan to address risk condition. <i>Progress:</i> Individual has exhibited increased weight and slight increase in cholesterol since 3/8/11 assessment.

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			Dietitian subsequently recommended omega-3 supplement in reassessment dated 6/28/11.
	VC	At high risk for impaired skin integrity	High risk not identified in the Present Status of the most recent WRP dated 07/20/11; focus 6.12 open with objective and intervention to address cellulitis. <i>Progress:</i> Unable to assess as this is new objective included in WRP attachment.
	CEF	At high risk for choking	High risk identified in the Present Status of the most recent WRP dated 5/03/11, with 6.3 objectives and interventions in place to address risk, and focused on demonstration of improved swallow techniques and no evidence of signs and symptoms of choking or aspiration during PO trials with speech therapist. Speech therapy assessment completed 5/18/11 for evaluation of eating and swallowing, and direct speech therapy initiated for therapeutic PO trials and swallowing function. In addition, individual has 24-hour support plan that addresses safe positioning for enteral nutrition, <i>Progress:</i> Individual has partially met both objectives related to choking risk.
	JHH	At high risk for choking	High risk identified in the Present Status of the most recent WRP dated 5/10/11, with 6.5 nursing objective and interventions in place to address risk. Speech therapy assessment completed 3/22/11 for evaluation of eating and swallowing, and direct speech therapy initiated. Recommended speech therapy objectives not

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			<p>included in the WRP. <i>Progress:</i> No documentation of progress toward nursing objective 6.5 noted. Speech therapy progress notes indicated that he made progress with speech therapy objectives and was able to tolerate a diet upgrade with no signs and symptoms of choking or aspiration, and was discharged from therapy. No documented incidents of choking were found in record.</p>
		RDF	<p>At high risk for falls High risk identified in the Present Status of WRP dated 4/25/11. Open focus 6.11 for learning fall risk strategies. <i>Progress:</i> Has not made progress toward objective but has had no falls since 1/29/11.</p>
		RG	<p>At high risk for falls High risk identified in the Present Status of the most recent WRP dated 5/02/11; focus 6.5 nursing objective and intervention in place to address fall risk. Individual also attending occupational therapy direct treatment to improve safety with functional mobility and activities of daily living. <i>Progress:</i> Objective 6.5 partially met in WRP dated 5/2/11 and review of OT progress notes showed progress toward OT objectives. However, individual experienced a fall on 5/24/11.</p>
		<p>Current recommendation: Continue current practice and monitoring.</p>	
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and	<p>Current findings on previous recommendations:</p>	

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	<p>corrective actions and appropriate follow up.</p>	<p>Recommendation 1, January 2011: 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</p> <p>Findings: Please see the cells above for the positive results regarding the WRPTs responses to the risk behaviors and medical conditions and discussion of the changes made in the operation of the RM committees.</p> <p>Recommendation 2, January 2011: Improve oversight of high-risk situations at the daily morning executive meetings.</p> <p>Findings: The Morning Management Meeting reviews all incidents from the preceding day.</p> <p>Other findings: The Court Monitor and his Psychology/Behavioral expert assessed the facility's implementation of its Risk Management process. The monitor selected eight individuals (CR, DP, JT, MO, RK, RT, SL and SV) from the facility's risk management databases. The charts of these individuals were reviewed and the WRPT members who provided care to these individuals were interviewed. The individuals had met a variety of high-risk triggers/thresholds during this review period, including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions (seclusion/restraints.).</p> <p>This review found general evidence that the facility has made adequate progress in correcting the deficiencies that were identified by the monitor</p>
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		<p>during the previous tour. This progress included acceptable practice in the following areas:</p> <ol style="list-style-type: none">1. Timely and appropriate documentation of the incident;2. Review of the incident by the treating, covering or on-call psychiatrists within 24 hours of the event and institution of pharmacological or special observation measures as needed to ensure safety of the individuals and/or others;3. Review by the WRPT of the incident during the first team meeting following the incident and documentation of necessary interdisciplinary measures to reduce the risk, as needed;4. Timely and adequate behavioral assessments and interventions;5. Tracking by risk management staff of the incidents that constituted triggers or thresholds requiring progressive levels of reviews; and6. Review and recommendations by the Program Review Committees and the Facility Review Committee of situations that require this level of oversight. <p>The review and interviews found general evidence of positive clinical outcomes in response to adequate practice in the above areas.</p> <p>The following summarizes findings in the area of behavioral assessments and interventions of the individuals:</p> <ol style="list-style-type: none">1. In all eight cases, the PBS team and/or the Unit Psychologist in collaboration with the WRPT had initiated behavioral assessments and where appropriate had implemented behavioral interventions even before the trigger threshold was met. When the individual had met trigger threshold the PBS teams and Unit Psychologists had followed up with the review committees' advice. However, in a number of cases, the review teams had few or no recommendations for the WRPTs as the problem was being appropriately handled or the problem had been ameliorated by the WRPTs and PBS teams.
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		<ol style="list-style-type: none"> 2. The behavioral assessments revealed that the psychologists had conducted structural and functional assessments prior to developing and implementing intervention plans. In general, the assessments were of acceptable quality. 3. A review of the behavioral intervention plans found that many were well developed. However, a number of them were deficient in the way functions were hypothesized, the way predictive variables were used, the way de-escalation strategies were used, and the way "active strategies if behavior escalates" were applied. In one (MLB), the active strategy relating to aggression was not relevant to the individual's targeted self-injurious behavior. However, the WRP/PBS team members provided the correct information when asked during the Risk Management review meeting, an indication of a lack of focus at the writing stage. Furthermore, unit staff responsible for implementing the plans correctly stated the intervention strategies of the behavioral plans. 4. The outcome data presented showed that there had been a reduction in the frequency of the challenging behaviors since the implementation of the behavioral intervention plans and other therapeutic interventions. <p>Current recommendation: Continue current practice.</p>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Implement corrective actions that were initiated or planned by the facility's Quality Council and provide periodic updates to this monitor regarding the status of implementation.</p> <p>Findings: Listed below are selected initiatives approved by the Quality Council directed at a central goal of the hospital to develop and maintain a safe</p>

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		<p>environment for staff and individuals in care.</p> <ul style="list-style-type: none">• Senior psychiatrists completed four Drug Utilization Evaluations dealing with medications used to treat aggression or that are associated with problematic behaviors. This resulted in bupropion, which is reportedly often abused in prisons and can induce a stimulant effect leading to impulsive or psychotic aggression when snorted, being moved from formulary status to non-formulary status.• In response to analysis of aggression patterns, the facility developed interim guidelines and a consulting contract to improve pain management using opiate analgesics. These are the forerunners of revised Administrative Directives on this topic.• NSH has submitted to DMH proposals for a campus-wide personal alarm system, a specialty unit for individuals displaying predatory and aggressive behavior, and for increased hospital police presence within the Secure Treatment Area, including a permanent substation within the STA. A unit presently in use at the hospital has been identified as the site of the proposed specialty unit. Entrance and exit criteria have been established.• The hospital is in Phase II of the reorganization of the Secure Treatment Area, which when fully implemented will result in smaller and centralized admission units and the opening of the specialty unit. Nearly all individuals in the STA have been assessed for placement.• A Morning Management Meeting is held each morning Monday-Friday in which those attending receive a report of all incidents since the last meeting and the daily nursing and hospital police report.• The Quality Council has set a schedule for the review of reports from standing hospital committees studying behavioral and medical Key Indicators, expected and unexpected deaths, alleged A/N/E, and Environment of Care as well as the Safety and Security Monthly Action Report.• Hospital police have received training on gang affiliation and activities.• Some individuals who required a level of custodial security that cannot
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		<p>be provided at the facility were identified and recently transferred to more appropriate settings within DMH (one individual was transferred to CDCR under legislation 7301). These individuals were selected based on a review and analysis of aggression data and risk assessment methods consistent with currently generally accepted standards.</p> <p>Other findings: See also I.2.a.ii for changes the hospital has made in the processes and structure of the Risk Management Committees.</p> <p>The monitor reviewed the facility's documents regarding unexpected mortalities that occurred during this review period. The mortalities included the suicide of one individual by jumping (LL) and the death of one individual (WR) during prone containment. The mortality reviews of WR, RA, CS and BN were adequate from a process standpoint. In the review of the mortality of LL, the facility appropriately identified a variety of contributing factors and implemented corresponding corrective actions. However, in the monitor's judgment, this review did not adequately explore some potential breakdown points (e.g. the scope and responsibilities of on-call psychiatrists in response to notifications by nursing staff of significant change in the individual's condition). Additionally, in the interview with the facility's leadership, this monitor believed that the leadership had a tendency for premature closure regarding the question of whether or not the suicide was predictable.</p> <p>The monitor reviewed the facility's documents regarding the review and analysis of a sentinel event involving the serious injury of an individual (TM) during prone containment (January 10, 2011). The document titled "In-Depth Analysis (IDA)" regarding this event contained an appropriate recommendation to review and update Nursing Procedure 1501, Assaultive Individuals: Guidelines for Interventions to be completed in September 2011. Other documents presented by the facility indicated that Nursing Procedure 1506, Behavioral Seclusion and Restraints was revised on June 24,</p>
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		<p>2011 to include a new section on prone restraints and prone transportation precautions. However, two significant deficiencies were noted in the IDA:</p> <ol style="list-style-type: none">1. The IDA was not finalized although the incident had occurred in January 2011. Nursing Procedure 1506 was revised in June 2011 and the IDA identified an implementation date in September 2011 for the update of Nursing Procedure 1506. This is evidence of untimely review/analysis and corrective actions.2. No review of psychiatric care was conducted. The facility's document indicated that a designee of the Medical Director had participated in the process. However, this did not happen. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure full and proper implementation of the DMH Strategic Plan to Reduce Aggression.2. Ensure adequate implementation of other planned actions that were initiated and/or recommended per the facility's most recent Court Monitor Safety and Security Monthly Action Report.3. The death of an individual while in prone containment and the prone containment of another individual that resulted in his sustaining an arm and a leg fracture should be clear signals of the dangers inherent in this position. The EP prohibits the use of this method and these dangers have been addressed by The Joint Commission, SAMHSA and accrediting and review bodies as well as in professional literature. The hospital should take all means necessary to discourage staff from restraining individuals face down on the floor.4. NSH must improve the medical leadership's participation in the sentinel event reviews and analyses in order to assess the performance of medical and/or psychiatric systems, as indicated
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3. Environmental Conditions		
I.3	<p>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>	<p>Methodology:</p> <p><u>Interviewed/Conversed with :</u></p> <ol style="list-style-type: none"> 1. Several individuals on the units toured 2. Several staff on the units toured 3. M. McQueeney, Acting Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRPs of 11 individuals with the problem of incontinence 2. Clinical records of eight individuals involved in sexual incidents <p><u>Toured:</u></p> <p>Five units: T-11, T-13 (location of the planned Specialty Unit), Q3/4, A2 and A7.</p>
I.3.a	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue to address suicide and other safety hazards as resources permit.</p> <p>Findings: On all units toured, staff were able to identify the location of the cut-down instrument and locate working flashlights for conducting nighttime bed checks. Bathroom stalls in the T units had short supports that do not provide a place for looping a ligature and the end stalls were flush to the wall, again eliminating a looping hazard. Showers had push-button on/off mechanisms, sloped shower heads and closed-gap grab bars.</p> <p>Observations on T-13 (the planned location of the Specialty Unit) found that bedrooms on the unit have solid doors with no observation windows. This unit has 15 bedrooms. The Specialty Unit is expected to house 27 individuals. Some individuals will be sharing a bedroom, and staff will need</p>

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		<p>to enter the bedrooms during nighttime rounds and whenever someone is not accounted for. Given the nature of the population expected to be housed in this unit, this configuration represents a foreseeable hazard to both individuals and staff members. The Acting Hospital Administrator explained that a licensing requirement prohibits the facility from refurbishing the doors and installing windows.</p> <p>During the tour of Q3/4, there was confusion when staff could not find Mr. C during the 2:30 PM count. There was no single place/list where all individuals could be accounted for. Instead, staff had to sift through escort sheets to determine who was off the unit for groups and different sheets to determine who was off the unit for other purposes, such as clinics or at the package room. It was finally determined that Mr. C was in a library group, but the escort sheet had not been completed. The unit leadership agreed that a single sheet that listed all the individuals and their location was necessary.</p> <p>Other findings: The facility identified the following measures to improve the safety of the environment. Some were begun earlier and implementation continues as resources become available:</p> <ul style="list-style-type: none">• New style dining room tables were delivered to four dining rooms.• A total of 486 no-throw chairs have been purchased and distributed.• Thermostat covers were modified with stainless steel mesh that prevents looping of material.• Shower valve modifications were completed on six A units.• Stainless steel toilet seat covers were installed on all 12 designated units.• Installation of no-gap hand rails continues.• The x-ray and dental suites are now covered by the Personal Alarm System.• Construction of a Satellite Police Station within the STA and near the
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		<p>Specialty Unit is expected to be completed by the end of September.</p> <ul style="list-style-type: none"> • Hiring procedures for additional hospital police officers were simplified. • Funding for a \$4 million hospital-wide WiFi alarm system was proposed to DMH for inclusion in the May revisions to the Governor's budget. <p>See also the environmental changes made in the A7 courtyard following a suicide discussed in I.1.b.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address the solid door issue with DMH to determine if there is a variance or some other method that would permit observation windows in the doors of this Specialty Unit and those in the other facilities where this same issue might surface. 2. Take steps to simplify the process for accounting for individuals on Q3/4.
I.3.b	<p>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation , January 2011: Continue current practice.</p> <p>Findings: During the tour of the hospital units, all living areas were a comfortable temperature.</p> <p>Other findings: The facility reported that the number of calls regarding "too cold" temperature increased—65% "too cold" v 35% "too hot." This is due, according to the facility, to the deteriorating heating coils in the R&T building that were unable to maintain temperatures during the winter</p>

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		<p>months. Plant Operations is in the process of replacing these coils.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																											
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, January 2011: Continue current practice.</p> <p>Findings: The facility provided the following results of its internal audit:</p> <table border="1" data-bbox="955 784 1892 1016"> <thead> <tr> <th>Criterion</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>Incontinence status is addressed in Present Status</td> <td>96%</td> </tr> <tr> <td>Incontinence identified in Focus 6</td> <td>100%</td> </tr> <tr> <td>Objectives promote dignity and self-reliance</td> <td>93%</td> </tr> <tr> <td>Individual is clean, dry and odor-free.</td> <td>100%</td> </tr> <tr> <td>Nursing staff explain how they assist the individual</td> <td>100%</td> </tr> </tbody> </table> <p>Other findings: The individuals sampled were chosen from different units from a listing of all individuals with the problem of incontinence.</p> <table border="1" data-bbox="961 1200 1612 1429"> <thead> <tr> <th>Individual</th> <th>WRP Date</th> <th>Focus 6 related to incontinence</th> </tr> </thead> <tbody> <tr> <td>AS</td> <td>8/22/11</td> <td>6.16</td> </tr> <tr> <td>AT</td> <td>6/27/11</td> <td>6.11</td> </tr> <tr> <td>CH</td> <td>8/10/11</td> <td>6.12</td> </tr> <tr> <td>CR</td> <td>8/22/11</td> <td>6.33</td> </tr> </tbody> </table>	Criterion	Compliance rate	Incontinence status is addressed in Present Status	96%	Incontinence identified in Focus 6	100%	Objectives promote dignity and self-reliance	93%	Individual is clean, dry and odor-free.	100%	Nursing staff explain how they assist the individual	100%	Individual	WRP Date	Focus 6 related to incontinence	AS	8/22/11	6.16	AT	6/27/11	6.11	CH	8/10/11	6.12	CR	8/22/11	6.33
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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 to instances of sexual contact; and</p>	<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> <p>Current findings on previous recommendations:</p> <p>Recommendation, January 2011: Ensure that expectations for addressing sexual incidents are clear and monitor implementation.</p> <p>Finding: All of the incidents reported below were categorized as Sexual Contact between Adults, defined in SO 263 as "unwanted sexual contact which does not involve force or violence. Examples include groping, grabbing, or touching intimate areas."</p> <table border="1"> <thead> <tr> <th data-bbox="953 1166 1119 1276">Individual Incident date</th> <th data-bbox="1119 1166 1896 1276">Documented Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1276 1119 1424">JM 12/2/10</td> <td data-bbox="1119 1276 1896 1424">12/2/10: Long psychology IDN states the psychologist, SW and PM Shift Lead met with JM regarding the report of sexual fondling and notes that JM claimed the activity was consensual. JM was informed of the expectations for</td> </tr> </tbody> </table>	Individual Incident date	Documented Response	JM 12/2/10	12/2/10: Long psychology IDN states the psychologist, SW and PM Shift Lead met with JM regarding the report of sexual fondling and notes that JM claimed the activity was consensual. JM was informed of the expectations for																		
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			behavior at the S complex (mall location). JM was advised his WRPT will address the incident. JM cooperated with the meeting.
		JR 12/2/10	12/2/10: Incident reporting note poorly describes the incident, making it difficult to determine whether JR observed the activity between two other individuals or was involved in the incident himself. WRP 1/12/11 notes the incident.
		GW Sept/ October	12/29/10: IDN reports the receipt of a phone call from GW's father stating that his son alleged he was sexually assaulted and/or threatened with rape by a peer in September and early October, but did not tell anyone. 12/30/10: Monthly psychiatric review states the allegations and that the team met with GW to discuss the alleged incidents. GW expressed relief that the alleged perpetrator individual is no longer on the unit.
		VC 1/17/11	1/17/11: IDN reports the allegation that a male peer asked VC for a hug and then fondled her. VC said this bothered her, but she did not want the police involved. Staff reminded her of the unit rule prohibiting hugging and advised VC in the future to say "No." Second 1/17/11 IDN states VC met with hospital police and this made her fear the male peer might retaliate. She was provided medication and 1:1 staff to sit with her.
		VS 2/6/11	2/7/11: Incident reporting note states VS was reported by a peer engaging in sexual contact with a male peer identified as her boyfriend in the dayhall after the Superbowl. The note states that the WRPTs of both individuals were notified. No IDN found describing the unit staff's or WRPT's interactions with VS over the incident.
		JT 2/6/11	JT saw and reported the incident above. It is unclear why he was identified on the incident log as an actor in this incident.

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		<p>DD 2/19/11</p>	<p>2/23/11: Incident reporting note states DD convinced a peer to engage in sexual contact with him. No IDN found describing the unit staff's or WRPT's interactions with DD about the incident.</p>
		<p>DS 2/19/11</p>	<p>2/23/11: Incident reporting note states that DD convinced DS to engage in sexual contact. IDN (2/22/11) states the incident was reported by DS to the SW. Stated he did not want to talk about it to nursing staff. Nursing stated he did not appear to be in any distress and emotional support was provided. The psychologist was notified. DS was encouraged to report any pain or discomfort. He was moved to a bedroom on another wing for his safety.</p>
		<p>Compliance: Partial—related to inadequate responses to sexual incidents.</p> <p>Current recommendation: Continue to monitor the response of staff members and WRPTs to individuals involved in sexual incidents and address inadequate responses.</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, January 2011: Continue to provide the required training to non-clinical Mall providers.</p> <p>Findings: The facility reported that non-clinical Mall providers have an overall compliance rating of 79% in meeting the training requirements. This is an improvement over the 77% reported in the previous review period.</p> <p>Compliance: Substantial.</p>	

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		Current recommendation: Continue to provide training to non-clinical Mall providers.
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Section J: First Amendment and Due Process

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.