REPORT 7

PATTON STATE HOSPITAL

December 7-11, 2009

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Patton 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 Patton 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
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment

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

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

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

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

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

VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from December 7-11, 2009 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 EP, which 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 to the recommendations in any ways it chooses 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 each area, 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

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

Taken as a whole, the key indicators presented by PSH at the time of this review indicate stable or improved performance in a

number of domains over the past six months. However, the data still contain some errors, such as the errors identified in the MRSA counts (see F.8.a.ii), which suggests that a habit of disciplined review, questioning and analysis of key indicator data has not yet taken firm root at PSH more than three years into the court monitoring process. The importance of reviewing key indicator data and utilizing it in quality assessment and performance improvement cannot be emphasized more strongly.

2. Monitoring, mentoring and self-evaluation

   a. The facility has maintained and made further refinements to its training and mentoring programs regarding the process and content of Wellness and Recovery Planning, including the following:
      i. Initiation of Phase II of WRP training, which focused on updating the present status, including discharge criteria, life goals, and writing WRP foci, objectives and interventions;
      ii. Training of 122 staff with plans to have all staff trained all by the next review; and
      iii. Completion of training for 68 RNs specific to completing Focus 6.
   b. In almost all sections of the EP, PSH has maintained significant progress in self-assessment and data presentation since the previous assessment.
   c. 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.
   d. Given the time-intensive nature of the self-monitoring process related to Mall alignment and the non-clinical nature of self-monitoring of fidelity of By Choice implementation, the small sample sizes utilized by the facility with regard to these audits are acceptable.
   e. PSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP. However, the facility has yet to produce or provide information based on the Medical Emergency Response Evaluation Form.

f. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.
g. The DMH has developed sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. At this juncture, there appears to be no need to develop new monitoring tools in this process. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.
h. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
i. DMH has introduced a new electronic system to facilitate hospital operations, including the collection, tracking and trending of self-assessment data related to implementation of the EP. The Court Monitor recognizes that technical difficulties frequently attend the implementation of new information technology systems, and this has proved to be the case with the WaRMSS software system. The DMH must work to resolve these difficulties in an expedient manner and ensure that the system has achieved its objectives.

3. Implementation of the EP

a. At this point in the court monitoring process, all facilities should be either in compliance or on the cusp of compliance with EP requirements. Since the last review, PSH has made significant additional progress towards substantial compliance in most areas of the EP. In some areas, the trajectory of progress over the past six months has not been not as steep as the CM had expected. However, it appears that introduction of the WaRMSS module (MAPP II) during this review period, with attendant technical difficulties, was a significant restraining factor. That factor should not have as significant an impact in the coming six months. The facility should be commended for continuing to make steady progress even with the challenge of a major electronic systems change.
b. In general, the facility's progress met the court monitor's expectations, particularly in the following areas:
   i. The process of WRP reviews;
   ii. The content of WRPs;
   iii. Services that address subpopulations with special needs;
   iv. The quality of all disciplinary assessments;
   v. The process of medication management; and
   vi. Many other clinical services.

This progress is outlined in each corresponding section in the body of the report.

c. The facility has maintained progress in the implementation of the DMH Special Order regarding Risk Management. This progress was evident in the identification and tracking of individuals who met triggers and thresholds regarding high-risk behavior, the WRPTs' responses to these events and the documentation of second-level reviews by the Enhanced Trigger Review Committee.
d. This monitor's interviews with some staff members and reviews of the medical and nursing documentation in the charts found evidence of further significant progress in medical and nursing attention to the needs of individuals since the last review.
e. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.
f. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. PSH has made significant progress towards this goal.

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

(see next page)

DMH PSR MALL HOURS

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

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

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

i. **Progress notes**: PSH has made recent progress in ensuring that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. The facility has yet to ensure consistent completion of these notes, review by the WRPTs of the notes during the WRPCs and integration of the information in the revisions of the WRPs.

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

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. Since the last review, PSH has made significant progress in this area.

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

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

4. Staffing

The table below shows the staffing pattern at PSH as of October 31, 2009:

Patton State Hospital Vacancy Totals as of October 31, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Assistant Coordinator of Nursing Services	5	5	0	0%
Assistant Director of Dietetics	5	5	0	0%
Audiologist I	1	1	0	0%
Chief Dentist	1	1	0	0%
Chief Physician & Surgeon	1	1	0	0%
Chief, Central Program Services	0	0	0	0%
Chief Psychologist	1	1	0	0%
Clinical Dietician/Pre-Reg. Clin Dietician	11	10	1	9%
Clinical Laboratory Technologist	1	0	1	100%
Clinical Social Worker	97	91.75	5.25	5%
Coordinator of Nursing Services	1	1	0	0%
Coordinator of Volunteer Services	1	1	0	0%
Dental Assistant	4	4	0	0%
Dentist	2	2	0	0%
Dietetic Technician	4	3.5	0.5	13%
E.E.G. Technician	0	0	0	0%
Food Services Technician I and II	117	109.5	7.5	6%
Hospital Worker	0	0	0	0%
Health Record Technician I	9	7	2	22%
Health Record Techn II Spec	3	3	0	0%

Patton State Hospital Vacancy Totals as of October 31, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Health Record Techn II Supv	1	1	0	0%
Health Record Techn III	1	1	0	0%
Health Services Specialist	21	18	3	14%
Institution Artist Facilitator	0	0	0	0%
Licensed Vocational Nurse	70	69	1	1%
Medical Technical Assistant	0	0	0	0%
Medical Transcriber	5	5	0	0%
Medical Transcriber Sup	0	0	0	0%
Sr Medical Transcriber	2	2	0	0%
Nurse Instructor	5	5	0	0%
Nurse Practitioner	5	5	0	0%
Nurse Coordinator	10	10	0	0%
Office Technician	34	33	1	3%
Pathologist	0	0	0	0%
Pharmacist I	15	15	0	0%
Pharmacist II	0	0	0	0%
Pharmacist Services Manager	1	1	0	0%
Pharmacy Technician	11	11	0	0%
Physician & Surgeon	22	20.75	1.25	6%
Podiatrist	1	1	0	0%
Pre-Licensed Pharmacist	0	0	0	0%
Pre-Licensed Psychiatric Technician	6	6	0	0%
Program Assistant	8	5	3	38%
Program Consultant (RT,PSW)	2	2	0	0%

Patton State Hospital Vacancy Totals as of October 31, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Program Director	8	6	2	25%
Psychiatric Nursing Education Director	1	1	0	0%
Psychiatric Technician	687.6	676	11.6	2%
Psychiatric Technician Trainee	0	0	0	0%
Psychiatric Technician Assistant	36	36	0	0%
Psychiatric Technician Instructor	1	1	0	0%
Psychologist-HF, (Safety)	72.8	71.15	1.65	2%
Public Health Nurse II	2	2	0	0%
Radiological Technologist	1	1	0	0%
Registered Nurse	378.1	373	5.1	1%
Reg. Nurse Pre Registered	0	0	0	0%
Rehabilitation Therapist	85.8	84.25	1.55	2%
Special Investigator	3	2	1	33%
Special Investigator, Senior	3	3	0	0%
Speech Pathologist I	1	1	0	0%
Sr. Psychiatrist (Spvr)	16.2	11	5.2	32%
Sr. Psychologist (Spvr and Spec)	23.5	22.5	1	4%
Sr. Psych Tech (Safety)	81	81	0	0%
Sr. Radiological Technologist (Specialist)	1	1	0	0%
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor 2	2	2	0	0%
Staff Psychiatrist	87	84	3	4%
Supervising Psychiatric Social Worker	5	5	0	0%
Supervising Registered Nurse	3	3	0	0%
Supervising Rehabilitation Therapist	6	6	0	0%

Patton State Hospital Vacancy Totals as of October 31, 2009				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Teacher-Adult Educ./Vocational Instructor	16.4	11	5.4	33%
Teaching Assistant	0	0	0	0%
Unit Supervisor	33	33	0	0%
Vocational Services Instructor (Landscp Gardn) (S)	0	0	0	0%

Senior psychiatrists are the primary clinical vacancy at this time.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

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

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Patton State Hospital June 7-11, 2010.
2. The Court Monitor's team is scheduled to tour Napa State Hospital January 25-29, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. PSH has continued to refine its training and mentoring systems regarding the process of WRP reviews, with positive outcomes. 2. PSH has maintained progress in the timeliness of WRP reviews. 3. PSH has achieved substantial compliance with the requirements of cells C.1.e and C.1.f. These cells address participation by team members in Wellness and Recovery Planning and communication among team members. 4. PSH has made significant progress in the content of the WRPs, including the following areas: a. Development and implementation of the interdisciplinary case formulation; b. Updates of the individual's present status, including symptoms, interventions and response, risk factors and progress towards individualized discharge criteria (this progress was sufficient to attain substantial compliance with the requirement in C.2.g.iii regarding progress towards discharge); c. Linkages between the case formulations and the foci, objectives and interventions; d. Revision of foci, objectives and interventions; e. Addressing the needs of individuals diagnosed with cognitive impairments, including cognitive screening upon admission, assignment to groups that align with the individual's cognitive status and enhancements of the number of groups (and hours provided) of formal and informal cognitive remediation interventions; f. Addressing the needs of individuals with substance use disorders, including development and implementation of objectives and interventions that align with the individual's stage of change and presenting process and clinical outcome data that verify progress made (this progress was sufficient to attain substantial

		compliance in cells C.2.n and C.2.q); and g. Development and implementation of an adequate process of identifying individuals in need of medication education and providing this intervention for most of these individuals. 5. PSH has maintained progress in self-monitoring and data gathering, analysis and presentation. 6. Most disciplines now are providing the required number of Mall group facilitation hours. 7. PSH now offers an expanded number of enrichment activities. The activities are better organized with a uniform methodology and facilitated by specialists in those activities. 8. Family therapy services had been provided to all individuals identified as needing family therapy services. 9. Mall group assignments take into consideration the individual's cognitive levels.

1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Gari-Lyn Richardson, Director, Standards Compliance 2. George Christison, MD, Acting Medical Director 3. Jinae Su, MD, Acting Senior Psychiatrist, Standards Compliance Issues <u>Reviewed</u>: 1. WRP Phase II Manual, November 11, 2009 2. WRP Revision Checklist, September 28, 2009 3. PSH Clinical Chart Auditing Form summary data (May-October 2009) 4. PSH WRP Observation Monitoring summary data (May-October 2009) 5. PSH WRP Team Facilitator Observation Monitoring Form summary data (May-October 2009) 6. PSH data regarding staffing ratios on admissions and long-term units (May-October 2009) <u>Observed</u>: 1. WRPC (Program I, unit EB-04) for monthly review of GS 2. WRPC (Program I, unit EB-11) for quarterly review of JW 3. WRPC (Program III, unit 30) for annual review of CWL 4. WRPC (Program IV, unit 34) for quarterly review of JE 5. WRPC (Program IV, unit 35) for quarterly review of CAM 6. WRPC (Program IV, unit 35) for annual review of KFS 7. WRPC (Program V, unit N26) for quarterly review of SLB 8. WRPC (Program V, unit N27) for monthly review of JLO 9. WRPC (Program VI, unit EB-02) for 7-day review of ET 10. WRPC (Program VI, unit EB-09) for monthly review of ED 11. WRPC (Program VI, unit 70) for monthly review of MFO 12. WRPC (Program VII, unit 77) for quarterly review of BR

C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor [in this cell in the previous report]. • Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. **Findings:** The following summarizes the facility's actions since the last report: 1. WRP Phase II: a. PSH's WRP Master Trainers (from the Psychology, Social Work, Rehabilitation Therapy and Nursing Departments) developed and implemented Phase II of the WRP training series. This phase (6-8 hours of training) focuses on utilization of the WaRMSS system for writing foci, objectives and interventions, as well as updating the Present Status and Life Goal/Discharge Criteria sections of the WRP. b. The WRP Master Trainers facilitated the trainings in the computer lab with staff, utilizing a WRP of an individual from the staff member's own unit when completing the exercises and competency check. c. In August 2009, 48 staff from unique WRPTs completed the training. Subsequently, the trained staff members mentored their own WRPTs. d. PSH reported that beginning October 19, 2009, the WRP Master Trainers began training the full complement of WRPT members. At the time of the current review, 74 additional staff members had successfully completed the training. e. The facility indicated that it intends to continue the Phase II training for all WRPT members during the next review period.

2. Focus 6 Training:
   a. From August 17 to October 15, 2009, two RN Master Trainers facilitated training specific to completion of Focus 6.
   b. Sixty-eight RNs completed the training.
3. WRP Conference Mentoring
   a. PSH reported that it continued the WRPC mentoring process initiated during the previous reporting period.
   b. The facility increased the number of mentors from eight to 12 (five psychiatrists, six psychologists and one social worker).
   c. Mentors observed WRPCs and provided immediate feedback to the WRPTs weekly.
   d. The mentors completed a three-hour training session on August 12, 2009 to review and discuss the goals of the mentoring process as well as the MAPP II module and Phase II training.

Recommendations 3 and 4, June 2009:

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

Findings:

Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 13% of the quarterly and annual WPRCs held each month (May–October 2009):

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care*	83%

2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services*	62%

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

	Previous period	Current period
Mean compliance rate		
1.	66%	83%
2.	62%	62%
Compliance rate in last month of period		
1.	85%	83%
2	69%	57%

Recommendation 5, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
PSH reported that the training sessions described under Findings for Recommendation 1 above were developed based on a review of the facility's internal monitoring data.

Other findings:
The monitor and his experts attended 12 WRPCs. By and large, the meetings demonstrated that that the facility has achieved substantial compliance with EP requirements regarding the process of WRP reviews and adequately addressed the deficiencies that were outlined in previous

		reports. **Compliance:** Partial; improved compared to last review. **Current recommendations**: 1. Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue to monitor this requirement.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively. • Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009): 1. *Each team is led by a clinical professional who is involved in the care of the individual:* 100% Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period. The facility also used the DMH WRP Team Facilitator Observation

Monitoring Form to assess compliance, based on an average sample of 73% of the required observations (two WRPC observations per team per month) during the review period:

1.	*The team psychiatrist was present during the WRP conference.*	88%
2.	*The team facilitator encouraged meaningful participation of all disciplines.*	98%
3.	*The discussion of the clinical data was substantially incorporated into the Present Status section.*	97%
4.	*The interventions reviewed were linked to the objectives.*	87%

Comparative data indicated improvements or relative consistency in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
1.	91%	88%
2.	86%	98%
3.	64%	97%
4.	42%	87%
Compliance rate in last month of period		
1.	90%	88%
4.	67%	94%

Recommendation 3, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

		Findings: PSH reported that it identified four unit psychiatrists who negatively impacted compliance with item 1. The facility reported that it intends to increase monitoring of identified staff by the senior psychiatrists during the next review period as a corrective action. Additionally, PSH reported an increase in compliance with item 4 subsequent to solving MAPP-2 errors. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009):

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<tr><td>2.</td><td>Each team functions in an interdisciplinary fashion.</td><td>98%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement
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<tr>
<td>C.1.d</td>
<td>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Monitor this requirement using Clinical Chart Audit form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
Using the DMH WRP Clinical Chart Audit, PSH assessed its compliance based on an average sample of 13% of the quarterly and annual WRPs due each month during the review period (May-October 2009):
<table>
<tr><td>1.</td><td>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</td><td>83%</td></tr>
<tr><td>1.a</td><td>The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment</td><td>76%</td></tr>
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</table>

	of compliance)	
1.b	*A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)*	89%

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

	Previous period	Current period
Mean compliance rate		
1.	66%	83%
Compliance rate in last month of period		
1.	85%	83%
1.a	75%	76%
1.b	94%	90%

Recommendation 3, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

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

Compliance:
Partial.

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

<table>
<tr>
<td>C.1.e</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendations 1-3, June 2009:

- Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009):

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<tr>
<td>3.</td>
<td>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</td>
<td>95%</td>
</tr>
</table>

Comparative data indicated improvement in compliance from 65% in the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

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<tr>
<td>C.1.f</td>
<td>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to</td>
<td>**Current findings on previous recommendation:**</td>
</tr>
</table>

	the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** PSH used the DMH Observation Monitoring Form to assess compliance. The mean compliance increased to 96% from 64% during the previous review. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** Using the DMH WRP Observation Monitoring Form, PSH assessed its

<table>
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<td>compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009):

<table>
<tr><td>5.</td><td>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>97%</td></tr>
</table>

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.1.h</td>
<td>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.</td>
<td>Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Ensure that vacancies are filled and improve core members' attendance at WRPCs.
• Monitor this requirement using process observation based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
PSH presented core WRPT member attendance data based on an average sample of 20% of quarterly and annual WRPCs held during the review period (May-October 2009):</td>
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<table>
<tr><td></td><td>Previous review period</td><td>Current review period</td></tr>
<tr><td>Individual</td><td>85%</td><td>85%</td></tr>
<tr><td>Psychiatrist</td><td>87%</td><td>88%</td></tr>
<tr><td>Psychologist</td><td>75%</td><td>77%</td></tr>
<tr><td>Social Worker</td><td>78%</td><td>73%</td></tr>
<tr><td>Rehabilitation Therapist</td><td>70%</td><td>70%</td></tr>
<tr><td>Registered Nurse</td><td>89%</td><td>96%</td></tr>
<tr><td>Psychiatric Technician</td><td>70%</td><td>85%</td></tr>
</table>

PSH reported that further data analysis identified specific staff who contributed negatively to compliance in this area. The facility reported that it intends to implement increased monitoring of identified staff by discipline seniors during the next review period as a corrective action.

Compliance:
Partial.

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

Recommendations 1 and 2, June 2009:
• Ensure compliance with the required ratios on the admission and long-term units.
• Provide comparative data from review period to review period regarding case loads on both the admission and long-term units.

Findings:
The facility provided the following data on average case load ratios:
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<table>
<tr><td></td><td>Previous review period</td><td>Current review period</td></tr>
<tr><td></td><td colspan="2">Admission Units</td></tr>
<tr><td>MDs</td><td>1:16</td><td>1:16</td></tr>
<tr><td>PhDs</td><td>1:15</td><td>1:17</td></tr>
<tr><td>SWs</td><td>1:16</td><td>1:15</td></tr>
<tr><td>RTs</td><td>1:16</td><td>1:16</td></tr>
<tr><td>RNs</td><td>1:6</td><td>1:6</td></tr>
<tr><td>PTs</td><td>1:3</td><td>1:3</td></tr>
<tr><td></td><td colspan="2">Long-Term Units</td></tr>
<tr><td>MDs</td><td>1:27</td><td>1:25</td></tr>
<tr><td>PhDs</td><td>1:31</td><td>1:28</td></tr>
<tr><td>SWs</td><td>1:25</td><td>1:25</td></tr>
<tr><td>RTs</td><td>1:28</td><td>1:28</td></tr>
<tr><td>RNs</td><td>1:8</td><td>1:8</td></tr>
<tr><td>PTs</td><td>1:3</td><td>1:3</td></tr>
</table>

Compliance:
Partial.

Current recommendation:
1. Ensure compliance with the required ratios on the admission and long-term units.
2. Provide comparative data from review period to review period regarding case loads on both the admission and long-term units.
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<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Same as C.1.a through C.1.f.</td>
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		Findings: Same as C.1.a through C.1.f. **Other findings:** PSH reported that 100% of staff across all disciplines completed the WRP Overview Post-test with a score of 95% or higher. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. The following individual: MR 2. Allison Pate, PhD, Senior Supervising Psychologist 3. Andre Bryant, Psychiatric Technician 4. Anthony Ortega, LCSW, Assessment Team Supervisor 5. Brian Starck-Riley, Assistant Director of Nutrition Services 6. Chris Keierleber, Acting Senior Rehabilitation Therapist 7. David Haimson, PhD, Chief of Psychology 8. Edward Williams, LCSW, Family Services Coordinator 9. Gari-Lyn Richardson, Director, Standards Compliance 10. George Christison, MD, Acting Medical Director 11. Georgiana Vinson, RN Focus 5 Coordinator 12. Giancarlo Gonzalez, Program Director Enhancement Services 13. Greg Siples, Chief of Rehabilitation Therapy Services 14. Helga Thordarson, PhD, Senior Supervising Psychologist 15. Hope Marriott, LCSW, Social Worker-WRP Master Trainer 16. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 17. Kevin Garland, Supplemental Activities Coordinator 18. Kitchie Miana, Assistant Director of Nutrition Services 19. Lisa Hilder, LCSW and Auditor, Sections D.6 and E 20. Mark Richards, PT, By Choice Assistant Coordinator 21. Mark Williams, PhD 22. Melanie Byde, PhD, Mall Director 23. Mike Gomes, Senior Rehabilitation Therapist 24. Raafat Girgis, MD, Senior Psychiatrist Supervisor for Substance Abuse 25. Rachel Strydom, LCSW, Supervising Social Worker 26. Renata Geyer, Acting Senior Rehabilitation Therapist 27. Shannon Bader, PhD, Psychologist 28. Susan Velasquez, PhD, PSSC Coordinator

		29. Tai Kim, Director of Nutrition Services <u>Reviewed</u>: 1. The charts of the following 137 individuals: AB, AI, AIR, AJB, AKA, AKS, AMB, AMC, AP, ARB, AS, ASB, AVL, AWM, BAB, BB, BZ, CC, CCR, CDS, CDT, CES, CH, CL, CMM, CPL, CR, DAH, DB, DEB, DEH, DMH, DML, DNW, DS, DWD, ED, EG, ERJ, ET, FCL, FG, FL, FLH, FS, GT, GWS, HAC, HC, HG, HL, HLG, HS, HTS, JA, JAA, JAC, JAM, JB, JBW, JCH, JCM, JD, JDM, JEH, JEM, JLB, JLF, JLO, JM, JR, JS, JSM, JSN, JU, JWB, JWL, KA, KDC, KJE, KLS, LB, LEA, LH, LJP, LJS, LMS, LOL, LP, MD, MDD, MGS, ML, MLP, MLR, MRB, OR, OR, ORL, PC, PHL, PJ, PJB, PJJ, RA, RAF,RB, RCC, RCL, REJ, RH, RH, RM, RP, RRM, RRR, RVM, RW, SEB, SES, SMW, SRS, SS, SWD, TD, TLH, TM, TMS, TS, VEB, VM, WDW, WM, WP, WSB, YG, YR and ZB 2. Recovery Inspired Skills Enhancement (RISE) Program Lesson Plan 3. Cognitive Remediation: Learning 2 "Learn My Treatment Plan" course lesson plans 4. Fundamental Rehabilitation Educational Experience (FREE) Manual - Staff and Individual versions 5. Creative Arts Therapy course outline 6. Data related to number and frequency of cognitive remediation groups 7. Group Psychotherapy AM/PM Process Group course outline 8. Movement and Rhythm lesson plan 9. PSH WRP Observation Monitoring summary data (May-October 2009) 10. PSH Clinical Chart Auditing Form summary data (May-October 2009) 11. PSH Chart Auditing Form summary data (May-October 2009) 12. Examples of Focus 5 objectives and interventions aligned with the Stages of Change 13. Data related to substance abuse process and clinical outcomes 14. PSH Consumer Satisfaction Survey summary data 15. DMH WRP Substance Abuse Auditing Form summary data (May-October 2009)

		16. Medication Education Knowledge Assessment 17. Data regarding medication education groups and individuals enrolled 18. Because You Asked: Answers to individuals' questions to PSR Services regarding changes in Mall structure 19. Completed Request for New Mall Group/Individual Therapy Forms 20. Focus 1: 12 Week Lesson Plans on Cognitive Remediation, R.I.S.E, Movement and Rhythm, Tone Chimes Choir, Medication Education Enrollment Report, Medication Education Knowledge Assessment, Success Stories 21. Focus 1: Instruction per DMHQ on COGNITIVE DISORDER 22. Focus 11: 24 Week Lesson Plan on Discharge Planning PC 2684 23. Focus 2: 12 Week Lesson Plans on Health and Laughter, Psychotherapy PM Process, Choir, Improving Social Skills Through Altered Book Making, 24. Focus 3: 12 Week Lesson Plans on Responsible Sexual Behavior, Nonviolent Communication: Teaching 25. Focus 4: 12 Week Lesson Plans Enhancing Motivation Part 1, 2 and 3, Meaningful Living 26. Focus 6: 24 Week Cancer Support Group Lesson Plan; 12 Week Lesson Plans on How to prevent falls, Risk Prevention Education, Road to Healthy Living, Individuals with elevated BMI not enrolled in exercise group. 27. Focus 6: Post-Test for Physical Activity Training DVD 28. Focus 7: Facilitator Training Goals/Objectives for Conditional Release Training for PC 1370 Competency Education Groups 29. Focus 9: 12 Week Lesson Plans on Study Skills-distance Learning, Veterans In Patton 30. List of individuals with cognitive disorders. 31. List of new enrichment activities/groups offered over the last six months 32. List of new Mall groups 33. List of Scheduled Exercise Groups 34. List of Supplemental Activities Offered

		35. Mall Facilitator Progress Notes 36. Mall Groups Hours Cancelled Report 37. Peer Facilitator: Basics of Peer Facilitation 38. PSH Mall Lesson Plans 39. PSH MAPP data regarding active treatment hours scheduled and attended 40. PSR Mall Operation Schedule 41. Psychology Specialty Services Committee Minutes 42. Psychosocial Enrichment Activity List <u>Observed</u>: 1. WRPC (Program I, unit EB04) for monthly review of GS 2. WRPC (Program I, unit EB11) for quarterly review of JW 3. WRPC (Program III, unit 30) for annual review of CWL 4. WRPC (Program IV, unit 34) for quarterly review of JE 5. WRPC (Program IV, unit 35) for quarterly review of CAM 6. WRPC (Program IV, unit 35) for annual review of KFS 7. WRPC (Program V, unit N26) for quarterly review of SLB 8. WRPC (Program V, unit N27) for monthly review of JLO 9. WRPC (Program VI, unit EB02) for 7-day review of ET 10. WRPC (Program VI, unit EB09) for monthly review of ED 11. WRPC (Program VI, unit 70) for monthly review of MFO 12. WRPC (Program VII, unit 77) for quarterly review of BR 13. Mall Group: Cognitive Remediation 14. Mall Group: Cancer Support 15. Mall Group: Music Appreciation 16. Mall Group: Understanding the 1026 Process 17. Mall Group: Enhancing Self Control-Anger Management 18. Mall Group: Understanding MDO Process 19. Mall Group: Discharge Planning 20. Mall Group: Recovery Inspired Skills Enhancement (RISE) 21. Mall Group: Psychotherapy-Social Skills-ASL (Hearing Impaired)

<table>
<tr>
<td>C.2.a</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendations 1, 2, 3 and 4, June 2009:

- Same as in C.1.a.
- Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the WRPCs held each month during the review period (May-October 2009). The following table summarizes the data:

<table>
<tr>
<td>6.</td>
<td>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.</td>
<td>90%</td>
</tr>
</table>

Comparative data indicated improvement in compliance from 61% in the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

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</table>

C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. **Findings:** PSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (May-October 2009). Based on an average sample of 55% of the A-WRPs, the facility reported a mean compliance rate of 99%, compared to 98% in the previous review period. **Other findings:** This monitor reviewed the charts of 10 individuals admitted during the review period (AMB, BB, CC, CES, FG, HTS, JSM, MRB, RVM and SRS). The review found compliance in all charts except one (RVM). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.

		Findings: Based on an average sample of 19% of the 7-day WRPs, the facility reported a mean compliance rate of 98% with this requirement, compared to 92% in the previous review period. **Recommendation 2, June 2009:** Ensure that individuals remain on the admission units for 60 or more days prior to inter-unit transfers. **Findings:** PSH reported that 35% of individuals were transferred to long-term units after less than 60 days, as compared to 42% during the previous reporting period. Individuals committed as incompetent to stand trial were more likely to remain on the admission units for at least 60 days (73%) than other individuals (36%). **Other findings:** A review of the charts of 10 individuals admitted during this review period found compliance in all cases (AMB, BB, CC, CES, FG, HTS, JSM, MRB, RVM and SRS). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low

compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
The following is a summary of the facility's data:

WRP Review	Mean sample size	Mean compliance rate
14-Day	16%	91%
Monthly	18%	80%
Quarterly	23%	80%
Annual	26%	65%

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

	Previous period	Current period
Mean compliance rate		
14-Day Review	88%	91%
Monthly Review	49%	80%
Quarterly Review	49%	80%
Annual Review	46%	65%
Compliance rate in last month of period		
Monthly Review	69%	80%
Quarterly Review	68%	85%
Annual Review	52%	82%

Recommendation 3, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

		Findings: The facility reported that during the current review period, two Programs successfully implemented a system to increase compliance with the timeliness requirements in this cell. PSH indicated that it intends to implement the system (posting of a monthly master schedule in each unit, weekly resolution of scheduling conflicts by the Program Director and notification to the Clinical Administrator of any postponed conferences) facility-wide during the next review period. **Other findings:** A review of the charts of 10 individuals admitted during this review period found compliance in eight cases (BB, CC, CES, HTS, JSM, MRB, RVM and SRS) and partial compliance in two (AMB and FG). **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Implement adequate corrective actions to address the deficiencies outlined by this monitor [in this cell in the previous report]. **Findings:** PSH reported that it increased the number of cognitive remediation groups and hours offered per week as summarized below:

	April - May	October
Number of groups	14	26
Hours offered per week	20	39

Recommendations 2 and 3, June 2009:

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

Findings:

PSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 13% to 100% of the relevant population for each sub-indicator during the review period (May-October 2009).

2.	*Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.*	62%
2.a	*When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.*	21%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	93%
2.c	*When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.*	71%

Comparative data indicated no change in mean compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
2.	62%	62%
Compliance rate in last month of period		
2.	69%	57%
2.a	26%	25%
2.b	87%	96%
2.c	93%	50%

Recommendation 4, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
PSH reported that based on data analysis, it developed the following corrective actions, to be implemented during the next review period:

1. Psychiatry Seniors will assume the responsibility for auditing these items.
2. Psychiatry Seniors will complete a monthly audit of 100% of WRPs of individuals diagnosed with cognitive or seizure disorders.
3. Psychiatry Seniors will provide timely feedback to unit psychiatrists related to audit findings.

Other findings:
This monitor reviewed the charts of 10 individuals diagnosed with a variety of cognitive disorders (AIR, ARB, DAH, FS, JAC, JBW, JSN, LB, LJS and SWD) and five individuals diagnosed with seizure disorders (AKS, CH, GT, ML and YG). The reviews found general evidence of

		further progress in the following areas: 1. Documentation of foci, objectives and interventions that addressed the needs of most individuals diagnosed with cognitive disorders; 2. Documentation in the Present Status section of the case formulation (symptoms and interventions/response) regarding the status of individuals diagnosed with cognitive disorders. including work-up to finalize/refine diagnosis (AIR, ARB, FS, JAC, JSN, LB, LJS and SWD); 3. Provision of group interventions that offer cognitive remediation for individuals suffering from a variety of cognitive disorders (e.g. JBW, LB and LJS); 4. Provision of PBS interventions to address the needs of some individuals with cognitive impairments who display maladaptive behaviors (e.g. FS); 5. Caution in the regular use of high-risk medications, including anticholinergic medications and/or benzodiazepines for individuals suffering from dementing illnesses; 6. Consistency between the WRPs and the corresponding psychiatric progress notes regarding the documentation of diagnoses of cognitive impairments; 7. Documentation in the Present Status section of the case formulation (symptoms and interventions/response) of seizure activity during the interval and the status of interventions/response for individuals suffering from seizure disorders (AKS, CH, GT, ML and YG); 8. Caution in the use of older-generation anticonvulsant medications for individuals diagnosed with both cognitive and seizure disorders (with few exceptions); and 9. Development of learning-based objectives and interventions for some individuals suffering from seizure disorders, including recognizing the experience of an aura, learning about triggers of recurrent seizures and learning ways to decrease the risk of injury during seizure activity.

		The review found a few deficiencies as follows: 1. Individuals diagnosed with cognitive impairments: a. The WRPs did not include a focus statement or objectives/ interventions to address the needs of an individual diagnosed with Drug-Induced Persisting Dementia (ARB). b. The objective listed for an individual diagnosed with Vascular Dementia was vague and subjective (JAC). The WRP of this individual did not document an intervention of speech therapy that was provided for the individual (and was adequate to meet the individual's needs). c. One individual was diagnosed with borderline intellectual functioning and received long-term treatment with a high-risk medication without apparent rationale (SWD). d. One individual was diagnosed with both Moderate Mental Retardation and Cognitive Disorder, NOS without diagnostic justification (JBW). 2. Individuals diagnosed with seizure disorders: a. The WRPs did not specify the morphological diagnosis of the seizure disorder in any of the charts reviewed. This information is needed to assess if the medication regimen is properly matched to the individual's needs. b. The WRP of an individual who suffered recurrent seizure activity during hospitalization included inconsistent information regarding the dates of recurrence (CH). c. The objective for one individual who suffered from seizure disorder was unattainable (ML). d. In general, there was evidence of inadequate development and implementation of learning-based objectives and interventions for individuals with seizure disorders.

		Compliance: Substantial regarding cognitive disorders; partial regarding seizure disorders. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial; improved compared to the last review.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue current training on Case Formulation for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor [in this cell in the previous report]. **Findings:** The facility's training activities are summarized in C.1.a. **Recommendations 2, 3 and 4, June 2009:** • Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

- Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 13% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

3.	*The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.*	90%

Comparative data indicated improvement in compliance from 80% in the previous review period.

The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.

Other findings:
Charts reviewed and WRPCs attended by this monitor and his consultants demonstrated that PSH has made further progress noted during the last review period in the organization and content of the Present Status section of the case formulation.

This monitor reviewed the charts of 24 individuals (AS, AWM, CCR, DMH, EG, HLG, FCL, JAA, JAM, JWL, KDC, LMS, MDS, PC, PJB, RAF, SEB, TD, VEB, WDW, WM, WP, WSB and YR). The review found general evidence of significant further progress in the structure and content of information as evidenced by the following.

		1. The facility maintained progress in the organization and content of information in pertinent history, predisposing, precipitating, perpetuating factors and previous treatment history. 2. The facility achieved further progress in the organization and content of information in the updates of the present status of individuals. 3. The facility implemented adequate corrections of the previously mentioned deficiencies in the following areas: a. Documentation in the Present Status section of the WRPT's discussion of the barriers towards discharge and the individual's progress towards individualized discharge criteria; b. Documentation in the Present Status section of the circumstances of use of restrictive interventions; c. Linkages within the 6-componenets of the case formulation; and d. Linkage between the information in the case formulation and the individual's life goals and strengths as utilized in the objectives and interventions. However, the review found that the facility has yet to make progress in ensuring that the Present Status section documents planned modifications of treatment in response to the use of restrictive interventions. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	4. *The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.* 74%

		4.a	*Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.*	82%
		4.b	*Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.*	65%

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

	Previous period	Current period
Mean compliance rate		
4.	50%	74%
Compliance rate in last month of period		
4.	60%	83%
4.a	77%	89%
4.b	43%	76%

C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	5.	*The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.*	98%

Comparative data indicated improvement in compliance from 86% in the previous review period.

C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues	6.	*Consider such factors as age, gender, culture,*	96%

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<tr>
<td></td>
<td>that October affect the outcomes of treatment and rehabilitation interventions;</td>
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<tr><td></td><td>treatment adherence, and medication issues that October affect the outcomes of treatment and rehabilitation interventions</td><td></td></tr>
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Comparative data indicated improvement in compliance from 82% in the previous review period.
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<tr>
<td>C.2.d.v</td>
<td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and</td>
<td>
<table>
<tr><td>7.</td><td>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</td><td>81%</td></tr>
<tr><td>7.a</td><td>There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter</td><td>89%</td></tr>
<tr><td>7.b</td><td>There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.</td><td>73%</td></tr>
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Comparative data indicated improvement in compliance from the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>43%</td><td>81%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>50%</td><td>84%</td></tr>
<tr><td>7.a</td><td>50%</td><td>93%</td></tr>
<tr><td>7.b</td><td>50%</td><td>75%</td></tr>
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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.	

8.	*The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.*	88%
8.a	*The present status section addresses the following: Treatment, Rehabilitation and Enrichment*	86%
8.b	*The case formulation documents the individual's progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives*	89%
8.c	*The case formulation documents a pathway to the discharge setting*	96%
8.d	*There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section*	81%

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

	Previous period	Current period
Mean compliance rate		
8.	68%	88%
Compliance rate in last month of period		
8.	68%	93%
8.a	75%	94%
8.b	79%	91%

8.c	100%	97%
8.d	18%	89%

C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

4.	*The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).*	80%
4.a	*There is a focus of hospitalization for each axis I, II, and III diagnosis*	85%
4.b	*There is a focus for each discharge criteria*	83%
4.c	*Each focus has an objective and an intervention*	89%
4.d	*Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.*	84%

4.e	*Each objective includes a staff intervention in the therapeutic milieu.*	61%

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

	Previous period	Current period
Mean compliance rate		
4.	62%	80%
Compliance rate in last month of period		
4.	69%	96%
4.a	52%	97%
4.b	74%	90%
4.c	86%	99%
4.d	86%	100%
4.e	45%	92%

Recommendation 3, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

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

Other findings:
This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational, speech, and physical therapy treatment) to assess compliance with the requirements of C.2.e. All records were in substantial compliance.

		This monitor also reviewed the records of 14 individuals who had IA-RTS assessments and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. All records were in substantial compliance. Finally, this monitor reviewed the records of 18 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. Nine records were in substantial compliance (AP, DEB, HG, HL, JLF, KLS, MLR, REJ and SS), eight records were in partial compliance (AVL, DML, DS, ERJ, MD, MGS, ORL and PJ) and one record was not in compliance (DEH). **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the	**Current findings on previous recommendations:**

	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;	**Recommendation 1, June 2009:** Ensure that the training and mentoring provided to the WRPTs addresses the deficiencies outlined by this monitor [in this cell in the previous report]. **Findings:** The facility's training and mentoring activities are summarized in C.1.a. **Recommendations 2, 3 and 4, June 2009:** • Monitor this requirement using the DMH WRP Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** Using the DMH WRP Chart Auditing Form, PSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 19% of the quarterly and annual WRPs due each month during the review period (May-October 2009). One sub-item was removed from this tool to improve alignment with EP requirements. The DMH Substance Abuse Monitoring Form will continue to address the linkage between substance abuse objectives and the individual's stage of change (as in C.2.o). A summary of the facility's data follows: 5. *The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the* — 73%

	need.	
5.a	*All objectives for Focus 1, 3 and 5 are linked to the individual's stage of change.*	91%
5.b	*The individual's strengths are used in the interventions.*	55%
5.c	*There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.*	72%

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

	Previous period	Current period
Mean compliance rate		
5.	33%	73%
Compliance rate in last month of period		
5.	40%	94%
5.a	69%	94%
5.b	39%	94%
5.c	12%	93%

Other findings:
A review of the charts of six individuals found substantial compliance in three (CPL, GT and JSM) charts, partial compliance in two (CDT and RH) and noncompliance in one (TLH).

Compliance:
Partial.

Current recommendation:
Provide data analysis that delineates and evaluates areas of low

<table>
<tr><td></td><td></td><td>compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.f.ii</td><td>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Same as in C.2.f.i.

Findings:
Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 19% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

<table><tr><td>6.</td><td>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</td><td>96%</td></tr></table>
Comparative data indicated improvement in compliance from 70% in the previous review period.

Other findings:
Chart reviews found substantial compliance in all charts (CDT, CPL, GT, JSM, RH and TLH). .

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>C.2.f.iii</td><td>write the objectives in behavioral, observable, and/or measurable terms;</td><td>Current findings on previous recommendation:</td></tr>
</table>

		Recommendation, June 2009: Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 49% compared to 26% in the previous review period. The compliance rate for the last month of this period was 91% compared to 39% in the last month of the previous review period. The facility indicated that its training and mentoring plan summarized in C.1.a is intended to increase compliance in this area. **Other findings:** Chart reviews found substantial compliance in four charts (CDT, GT, JSM and RH) and partial compliance in two (CPL and TLH). **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 91% compared to 68% in the previous review period.

		Other findings: This monitor reviewed the charts of six individuals who were diagnosed with substance use disorders (CDT, DAH, GT, JSM, RH and TLH). The review found compliance in five charts (JSM, GT, RH, CDT and DAH) and noncompliance in one (TLH). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 75%, compared to 44% in the previous review period. The compliance rate for the last month of this period was 99% compared to 58% during the last month of the previous review period. **Other findings:** Reviews by this monitor found substantial compliance in four charts (CDT, GT, JSM and RH), partial compliance in one (TLH) and noncompliance in one (CPL). In addition, there was evidence of persistent flaws in the current electronic format that resulted in significant inconsistencies in the entry of data regarding course information vs. strength description and the persistent error of characterizing milieu therapy interventions as "non-active interventions". These deficiencies must be corrected to achieve substantial compliance with this requirement.

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

Current recommendation:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.f.vi</td><td>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;</td><td>Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Monitor hours of active treatment (scheduled and attended).
• Present data regarding average number of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period).
• Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.

Findings:
PSH presented the following data for the review period (May-October 2009):

<table>
<tr><td></td><td colspan="2">Number of individuals by category</td></tr>
<tr><td></td><td>Mean scheduled hours</td><td>Mean attended hours</td></tr>
<tr><td>N</td><td>1,484</td><td>1,479</td></tr>
<tr><td>Hours:</td><td></td><td></td></tr>
<tr><td>0-5</td><td>65</td><td>235</td></tr>
<tr><td>6-10</td><td>35</td><td>221</td></tr>
<tr><td>11-15</td><td>131</td><td>417</td></tr>
<tr><td>16-20</td><td>1,253</td><td>517</td></tr>
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Mall Attendance		
	Previous period	Current period
Mean number of individuals		
0-5 hours	271	235
6-10 hours	395	221
11-15 hours	486	417
16-20+ hours	375	517

As shown in the tables above, the number of individuals scheduled for between 16 and 20 hours of Mall treatment increased in this review period. The mean attended hours for the various categories of scheduled hours has also shown improvement.

PSH has made efforts to ensure that individuals are enrolled in 20 hours of Mall group services. WRPTs receive e-mails when enrollment gaps are noticed. MAPP II issues hampered progress during the review period, but the facility continues to train staff on use of the system.

Other findings:
This monitor reviewed the charts of nine individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:

Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
VEB	20	20	14
TLH	19	19	17.5

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<table>
<tr><td>RP</td><td>20</td><td>20</td><td>18.8</td></tr>
<tr><td>TS</td><td>20</td><td>20</td><td>13.6</td></tr>
<tr><td>JLB</td><td>20</td><td>20</td><td>17.6</td></tr>
<tr><td>RH</td><td>20</td><td>20</td><td>10.6</td></tr>
<tr><td>LJS</td><td>19</td><td>19</td><td>18</td></tr>
<tr><td>GT</td><td>20</td><td>20</td><td>8.2</td></tr>
<tr><td>SES</td><td>20</td><td>20</td><td>18.2</td></tr>
</table>

The table above shows 100% agreement between the WRP scheduled hours and that listed in the MAPP—a significant improvement from the previous review. In addition, attendance for these randomly selected individuals' was also higher relative to the previous review (attendance for the 10 individuals reviewed during the previous review was between one and 13 hours).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.
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<tr>
<td>C.2.f.vii</td>
<td>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</td>
<td>PSH is legally unable to permit individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer. This is based on the California Welfare and Institutions Code, Section 4107(a), which requires that the security of individuals at Patton State Hospital is the responsibility of the Department of Corrections and Rehabilitation. At the present time, PSH cares for approximately 109 civil individuals who have been determined to exceed the security levels of either Napa State Hospital or Metropolitan State Hospital. According to the staff at PSH, these individuals have been identified by history to pose a high risk to the safety and security of the public if they were to elope during community outings. In addition, outings for these individuals require CDCR approval and supervision which has been</td>
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<td>difficult to obtain. The facility continues to explore the possibility of CDCR supervision support to facilitate community treatment opportunities for the civilly committed individuals.

This monitor reviewed five charts of civilly committed individuals (FLB, JCB, LMA, RA, and RB). All five charts documented a history of or current high-risk behaviors including homicidal, suicidal, aggressive, and/or sexually offending behaviors. The table below lists some of the individuals' diagnoses and presenting behavior problems:

<table>
<tr><th>Individual</th><th>Diagnoses</th><th>Behavioral Issues</th></tr>
<tr><td>FLB</td><td>Schizophrenia, polysub-stance abuse, antisocial, visual impairment</td><td>Assaultive, sexually inappropriate,</td></tr>
<tr><td>JCB</td><td>Schizophrenia, polysubstance dependence, visual impairment</td><td>Assaultive, substance abuse, auditory hallucination</td></tr>
<tr><td>LMA</td><td>Schizoaffective disorder, bipolar, antisocial</td><td>Delusional, paranoid, substance abuse</td></tr>
<tr><td>RA</td><td>Psychotic disorders, obesity, hearing loss, epilepsy</td><td>Psychosis/confusion</td></tr>
<tr><td>RB</td><td>Schizoaffective disorder, substance abuse</td><td>Paranoid delusion</td></tr>
</table>

The staff agrees that with CDCR support and supervision, some of the individuals could be considered for community outings. The facility continues to work on this possibility.</td>
</tr>
<tr>
<td>C.2.f.viii</td>
<td>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Monitor this requirement using the Mall Alignment Monitoring Form</td>
</tr>
</table>

	hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	and present data on the main indicator and the two sub-items. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH implemented the revised MAPP II PSR Mall Progress Note Process in October 2009. Enhancement Services assists the Program Management to collect the Mall progress notes from facilitators and to distribute them. Furthermore, the WaRMSS is used to alert staff when progress notes were due. The WRPTs can review and print PSR Mall notes during WRPCs. Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 17% of the census each month for the review period (May-October 2009): 1. *Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.* — 53% 1.a *According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.* — 54% 1.b *The reviewed course outlines' content (that) is aligned with the corresponding objectives in the individual's WRP.* — 52% Comparative data indicated improvement in compliance since the previous

review period:

	Previous period	Current period
Mean compliance rate		
1.	31%	53%
Compliance rate in last month of period		
1.	48%	96%
1.a	52%	96%
1.b	44%	95%

A review of the charts of nine individuals found substantial compliance in all nine (CES, HAC, HS, JSM, JU, JWB, MRB, OR and RRM). These finding are in agreement with the facility's data for the last month of the current period.

Recommendation 3, June 2009:
Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.

Findings:
Please see findings in C.2.g.iv.

Compliance:
Partial.

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

C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as C.2.t. **Findings:** See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items. **Other findings:** A review of the charts of six individuals found substantial compliance in three (GT, JSM and RH) and noncompliance in three (CDT, CPL and TLH). This monitor reviewed the records of 10 individuals receiving direct occupational, speech and physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance. **Compliance:** Partial. **Current recommendations**: Same as C.2.t.

C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, June 2009:** • Improve documentation in the Present Status section of the four items listed in this monitor's review [in this cell in the previous report]. • Monitor this requirement using the revised monitoring tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 81% of individuals placed in seclusion and/or restraints each month during the review period (May-October 2009): 12. *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)* — 16% 12.a *The Present Status section reviews each use of Seclusion and/or Restraint, including the circumstances leading to its use, and* — 4% 12.b *The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.* — 27% Comparative data indicated a decline in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
12.	37%	16%
Compliance rate in last month of period		
12.	36%	16%
12.a	8%	2%
12.b	63%	29%

Recommendation 4, June 2009:
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
PSH reported that it developed the following corrective actions based on further data analysis and intends to implement them during the next review period:

1. Psychiatry Seniors will assume the responsibility for auditing these items.
2. Psychiatry Seniors will complete a 100% review of seclusion/ restraint episodes and subsequent WRPs.
3. Psychiatry Seniors will provide timely feedback to unit psychiatrists related to audit findings.

Other findings:
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period (DNW, JCH-2, JCM, KA, PHL and RA). The review found general evidence of progress in the documentation of the following in the Present Status section:

1. Events that required the use of restrictive interventions;
2. Treatment provided to avert the use of restrictive interventions; and

		3. Current assessment of risk factors following events that triggered the restrictive intervention. However, deficiencies were found in the following areas: 1. Documentation of modification of ongoing treatment to decrease future risk in all charts; and 2. Entry of accurate information regarding whether or not seclusion/restraint was used during the interval period in some charts (DNW and PHL). This review found partial compliance in four charts (JCH, JCM, KA and RA) and noncompliance in two (DNW and PHL). **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009):

7.	*The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.*	93%

Comparative data indicated improvement in compliance from 63% in the previous review period.

Other findings:
This monitor reviewed the charts of six individuals to assess 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). Two individuals (CPL and JSM) were admitted under PC 1370 and four individuals (CDT, GT, RH and TLH) were admitted under other categories. The review found substantial compliance in four charts (CDT, GT, RH and TLH). These charts demonstrated significant progress in the documentation of barriers to discharge based on individualized discharge criteria and the team's discussion of the individual's progress towards achievement of these criteria. The charts of CPL and JSM demonstrated substantial compliance in the documentation of discharge criteria and partial compliance in the documentation of the team's discussion of the individual's progress.

Compliance:
Substantial.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>C.2.g.iv</td><td>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</td><td>
Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (May-October 2009):

<table>
<tr><td>8.</td><td>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</td><td>90%</td></tr>
</table>

Comparative data indicated improvement in compliance from 46% in the previous review period.

Other findings:
This monitor limited the chart reviews to assessing the documentation of the individual's progress in Mall groups during the months of October and November 2009. This was done in view of the facility's acknowledgment that documentation of the Mall Facilitator progress notes was hampered
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		during most of this review period by the technical difficulties in the implementation of the WaRMSS module (MAPP II). The review found substantial compliance in two charts (CDT and GT), partial compliance in one (CPL) and noncompliance in two (JSM and RH). **Compliance:** Partial. **Current recommendation:** Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. • Continue to offer groups based on the needs of the individuals in the facility. **Findings:** PSH conducted a needs assessment. Data from the assessment was used to schedule individuals according to their needs and cognitive functioning

levels. PSH has increased the number of Cognitive Rehabilitation groups at the assisted and supported functioning levels. New and additional groups have been offered in vocational, education and distance learning (college level, substance abuse, creative art, anger management, risk prevention, peer facilitation training, weight management, CONREP, trial competency, and personal recovery). PSH also has set up a process that allows individuals as well as WRPTs to request new groups/new sections of existing groups directly through MAPP II.

Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 17% of WRPs due each month during the review period (May-October 2009):

2.	*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions*	65%
2.a	*All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP*	64%
2.b	*The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning*	65%

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

	Previous period	Current period
Mean compliance rate		
2.	29%	65%
Compliance rate in last month of period		
2.	55%	95%
2.a	50%	94%

		2.b | 60% | 96% Records of ten individuals were reviewed (GT, JDM, JLB, LJS, RH, RP, SES, TLH, TS and VEB). Eight of the WRPs in the charts showed evidence that the discipline-specific assessments had been reviewed, relevant information was incorporated in the Present Status section of the individual's WRP, and the individual's needs were appropriately addressed through the foci, objectives and interventions (GT, JLB, RH, RP, SES, TLH, TS and VEB). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor correspondence between the foci, objectives, interventions, and recommended PSR Mall services were noted in the remaining two WRPs (JDM and LJS). **Other findings:** This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct occupational, speech, and physical therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance. **Current recommendations**: 1. WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Continue to offer groups based on the needs of the individuals in the facility.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Ensure that the learning outcomes are stated in measurable terms. • Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.

Findings:
Using the DMH WRP Chart Audit Form, PSH assessed its compliance based on an average sample of 19% of WRPs due each month during the review period (May-October 2009):

7.	*The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.*	49%

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

	Previous period	Current period
Mean compliance rate		
7.	26%	49%
Compliance rate in last month of period		
7.	39%	91%

A review of the records of 19 individuals found that 12 of the WRPs in the charts contained objectives written in a measurable/observable manner (AKA, AMB, CES, DAH, FCL, GT, JD, JS, OR, RH, RRM and VEB), and seven (AI, BAB, CDT, HC, JDM, LEA and SRS) did not.

A review of the records of 14 individuals found that the objectives in 13 of the WRPs in the charts were directly linked to a relevant focus of hospitalization (AI, AKA, AMB, CES, DAH, FCL, GT, JD, JDM, OR, RH, RRM and VEB), and were not so linked in one chart (LJS).

Recommendation 3, June 2009:
Ensure that the courses teach to individualized objectives and include evaluation measures for all individuals attending the course.

		Findings: This monitor's interview of Mall facilitators found that the facilitators now have access to the objectives, discharge criteria, and outcome measures in each individual's WRP. The facilitators use the information to teach and assess the individual's performance. As a result of the facility's Phase II training in August 2009, PSH has seen improvement in WRPTs writing objectives in an observable/ measurable manner. PSH will continue to track and monitor and where necessary review and give corrective feedback to the relevant WRPT or a team member. **Current recommendations**: 1. Ensure that the learning outcomes are stated in measurable terms. 2. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. **Findings:** Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 17% of the individuals at PSH each month during the review period (May-October 2009): 1. *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* — 53%

	goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs;	
1.a	*According to the individual's Mall schedule, the individual is assigned to all the Mall courses listed as active treatment in the WRP.*	52%
1.b	*The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP.*	54%

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

	Previous period	Current period
Mean compliance rate		
1.	31%	53%
Compliance rate in last month of period		
1.	48%	96%
1.a	52%	96%
1.b	44%	95%

A review of WRPs of six individuals found that the services documented were aligned with the individual's objectives in five WRPs (AMB, JA, JB, RCC and SRS) and were not in one (HC).

Current recommendation:
Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the objectives identified in the individual's WRP.

C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:**

Recommendations 1 and 2, June 2009:

- Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.
- Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.

Findings:

Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 11% of Mall group facilitators each month during the review period (May-October 2009):

15.	*The group facilitator utilizes the individual's strengths, preferences, and interests.*	90%

Comparative data indicated improvement in compliance from 88% in the previous review period.

A review of WRPs of 10 individuals found that six WRPs specified the strengths of the individual in all active interventions reviewed (DAH, FCL, HC, JA, RCC and VEB). The remaining four WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (AKA, GT, JDM and LJS).

Current recommendations:

1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.
2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.

<table>
<tr>
<td>C.2.i.v</td>
<td>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
- Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
- Update the present status to reflect the current status of these vulnerabilities.

Findings:
Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation of an average random sample of 17% WRPs each month during the review period (May-October 2009):

<table>
<tr>
<td>3.</td>
<td>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</td>
<td>93%</td>
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</table>

Comparative data indicated improvement in compliance from 45% in the previous review period.

A review of WRPs of six individuals found that the individual's vulnerabilities were documented in the case formulation section in all six WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (HC, JA, JLB, RCC, RH and VEB).

Current recommendation:
Continue to monitor this requirement.

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<tr>
<td>C.2.i.vi</td>
<td>is provided in a manner consistent with each individual's cognitive strengths and limitations;</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
- PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.

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- Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to Mall groups that meet their cognitive strengths and limitations.

Findings:
Staff interview, Mall group observations, and documentation review (Integrated Assessments: Psychology Section, curricula, and lesson plans) found that through cognitive assessment, PSH identified 90 individuals with cognitive disorders, dementia and/or mental retardation. Seventy-two of these individuals are scheduled for at least one cognitive remediation group. In addition, Neuropsychological Services has written treatment proposals to address the needs of individuals with cognitive deficits and proposals are being implemented in stages relative to resource availability. Neuropsychological Services is also serving as consultant to the Mall groups and when possible assisting with individuals at the supported levels. Furthermore, the DCAT consults with facilitators in developing appropriate material to meet the needs of the individuals at the assisted and supported levels in the PC 1370 groups. The DCAT also has implemented the Recovery Inspired Skills Enhancement (RISE) program on the campus. The facility expects to expand the programs when space is available to house them.

Using the DMH Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on 11% of the Mall facilitators observed during the review period (May-October 2009):

16.	*Material is presented in a manner consistent with each individual's cognitive strengths and limitations.* *The group facilitator can:*	91%
16.a	*Identify a cognitive strength and limitation of a group participant.*	91%
16.b	*Describe how the cognitive strength and limitation was taken into account by the facilitator during the*	90%

		group. Comparative data indicated improvement in compliance from 88% in the previous review period. A review of the records of six individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in all six of the WRPs (DAH, ED, HC, JA, LH and RCC). The facility has assigned the DCAT to focus on individuals with Mild Mental Retardation to ensure proper assessment and treatment planning; and Neuropsychological Services to focus on individuals with the diagnosis of Cognitive Disorders and Dementia to ensure proper assessment and treatment planning. **Current recommendation**: Continue to monitor this requirement.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. • Automate this system. • Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process. **Findings:** PSH audited 20% of the individuals in each Program for the last month of the review period. The table below showing the number of Progress Notes due for 20% of the individuals in each program (N), the number of Progress Notes available to the WRPTs in each Program (n), and the percentage of compliance (%C) is a summary of the facility's data:

	P1	P3	P4	P5	P6	P7	P8	Mean
N	900	800	800	800	1,200	800	800	871
n	308	192	210	238	204	71	106	190
%C	34	24	26	30	17	9	13	22

The low percentage of notes available in a timely manner is due to a number of factors, including the implementation of automation in October 2009 and the delay caused by having to print the notes and get them signed before filing them in the medical charts.

Comparative data indicated mixed changes in compliance since the previous review period:

Item	Mean Previous Period	Mean Current Period
P1	54%	34%
P3	6%	24%
P4	82%	26%
P5	14%	30%
P6	17%	17%
P7	20%	9%
P8	9%	13%

This monitor observed three WRPCs. The teams reviewed the notes during the conference or had already reviewed and documented the findings in the individual's WRP prior to the conference. The teams reported receiving most of the notes on a timely basis, even if the notes are not in the medical chart due to delays in getting them signed.

A review of the charts of seven individuals found that six contained most or all the progress notes for the month, and had incorporated the information from the progress notes into the Present Status section of the individual's WRP (ED, ET, JLO, RP, TLH and TMS) and one did not

		(LJS). **Other findings:** This monitor reviewed the records of 12 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct speech, occupational and physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. Ten records were in substantial compliance (AP, CDS, CL, FLH, JA, JEH, OR, PJJ, RM and RRR) and two records were in partial compliance (GWS and TD). **Current recommendation**: Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. **Findings:** According to the Mall Director, disciplines' participation in Mall group facilitation has increased during this review period. The increase resulted from notification to Program Management of non-compliance and tracking by discipline chiefs and Program Management. The Executive Director had re-emphasized to all off-unit treatment services staff and program management staff the requirement to provide a minimum of one hour of Mall facilitation each week and as a result, staff from the Development Center provided an average of four hours of Mall group facilitation per week.

		Recommendation 2, June 2009: All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours. **Findings:** According to the Mall Director, the number of late starts of Mall groups is low due to increases in staff participation in Mall facilitation and in coverage. Program Management and Seniors are notified when Mall facilitators are not on time to begin their groups. This monitor observed nine Mall groups and all groups had documented evidence (By Choice point cards and attendance logs) indicating that Mall sessions were conducted for 50 minutes each. **Recommendation 3, June 2009:** Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified. **Findings:** PSH conducted a needs assessment and used the data to enroll individuals in their needed groups. WRPTs make requests for new groups through the MAPP II. Enhancement Services will continue to coordinate Mall service provision through coordination with the Discipline Chiefs and Program Management; coordinate with Administration to lessen Mall group disruption during security searches, which are conducted frequently; meet MAPP II new group requests as soon as possible; and promote WRPT utilization of MAPP II for new group requests. **Current recommendations**: 1. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 2. Continue current practice.

C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. • Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. **Findings:** PSH did not have any bed-bound individuals during this review period. However, the facility has plans in place to address the needs of bed-bound individuals upon admission. **Current recommendations**: 1. If the facility cares for bed-bound individuals, ensure that those individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. 2. If the facility cares for individuals who are unable to ambulate or be transferred, ensure that therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.

Findings:
See C.2.i.i, C.2.i.iii, C.2.i.vi and C.2.i.viii.

Recommendation 2, June 2009:
Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

Findings:
PSH presented the following data regarding cancellation of Mall groups:

	5/09	6/09	7/09	8/09	9/09	10/09	Mean
Groups scheduled	1,694	1,990	1,979	1,979	-	2,109	1,950
Groups cancelled	134	152	196	201	-	168	170
Cancellation rate	8%	8%	10%	10%	-	8%	9%

The cancellation rate was 15% in the previous review period. PSH did not have data for September 2009.

Recommendation 3, June 2009:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
According to the Mall Director, Executive Director directives, tracking and monitoring, and presentation of data on facilitator participation to the Program Directors and Senior Psychologists has made an impact on facilitator participation and increased the discipline hours of Mall group provision. The facility presented the following data regarding Mall group facilitation by discipline:

<table>
<tr>
<td></td>
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<td>
<table>
<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>
<tr><td>Psychiatry ACUTE (4)</td><td>2</td><td>3</td></tr>
<tr><td>Psychiatry L-T (8)</td><td>3</td><td>3</td></tr>
<tr><td>Psychology ACUTE (5)</td><td>4</td><td>5</td></tr>
<tr><td>Psychology L-T (10)</td><td>6</td><td>9</td></tr>
<tr><td>Social Work ACUTE (5)</td><td>5</td><td>5</td></tr>
<tr><td>Social Work L-T (10)</td><td>9</td><td>9</td></tr>
<tr><td>Rehab Therapy ACUTE (7)</td><td>8</td><td>9.2</td></tr>
<tr><td>Rehab Therapy L-T (15)</td><td>11</td><td>12.2</td></tr>
<tr><td>Nursing (10)</td><td>-</td><td>10</td></tr>
<tr><td>Administration (1)</td><td>-</td><td>1.17</td></tr>
</table>

As the table above indicates, all the disciplines have maintained or increased their hours of Mall provision from the previous review period. A number of disciplines (Psychology, Rehabilitation Therapy and Administration) have also provided more than their required Mall group hours.

Current recommendations:
1. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.
2. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.
</td>
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<tr>
<td>C.2.i.xi</td>
<td>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</td>
<td>
Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care.
• Plan and organize these activities such that there is minimal
</td>
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</table>

interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities.

- Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.

Findings:
The Supplemental Activities Coordinator has reorganized the enrichment activities into scatter activities (activities that are conducted daily during the evenings and weekends) that are not uniformly conducted with a common methodology or organization, and New Deal activities (organized activities that are uniformly administered and highly structured with incentives and reinforcements presented to the participants). The Mall Director did not find any systemic issues that could interrupt scheduled supplemental activities on a regular basis.

This monitors observation found that enrichment activity lists were posted on the units, offering a wide range of activities. Observation of an evening enrichment activity (court games) found high attendance and active participation by the individuals.

The facility provided the following data regarding enrichment activities:

	5/09	6/09	7/09	8/09	9/09	10/09	Mean
Hours scheduled	52	52	52	52	52	52	52
Hours offered	52	52	49	49	49	52	51
Compliance rate	100%	100%	94%	94%	94%	100%	98%

The table above shows the number of New Deal Supplemental Program

		Activities (an average of 14 hours/per week). The activities are managed by a small group of specialists who meet weekly to discuss the status of the program and work on further improving the program. Furthermore, a group of staff has been designated to collect and enter the supplemental activity data into the computer. **Current recommendation**: Continue current practice.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** A review of the charts of 10 individuals found that seven contained milieu interventions appropriate to the active intervention (AKA, DAH, FCL, HC, JA, RCC and RH). In the remaining three, the milieu interventions documented were not aligned with the active interventions (JDM, LJS and VEB). **Recommendation 2, June 2009:** Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units. **Findings:** Using the Therapeutic Milieu Observation Monitoring Form, PSH assessed its compliance based on observations of an average sample of 76% of the units in the facility. The following table summarizes the facility's data: 1. *During the 30-min observation, there is more staff in* 99%

	the milieu than in the nursing station.	
2.	*There is some staff interacting (e.g., engaged in conversation or activity) with individuals.*	99%
3.	*There is evidence of a unit recognition program.*	97%
4.	*The posted unit rules reflect recovery language and principles.*	97%
5.	*The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.*	97%
6.	*Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.*	100%
7.	*Staff is observed actively engaged with the individuals.*	99%
8.	*Staff interacts with individuals in a respectful manner.*	100%
9.	*Situations involving privacy occurred and they were properly handled.*	100%
10.	*1If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 6 and 8-10, and improvement in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	83%	99%
2.	65%	99%
3.	72%	97%
4.	57%	97%

		5. 66% 97% 7. 74% 99% **Current recommendation**: Continue to monitor this requirement.
C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-4, June 2009:** • Establish group exercises and recreational activities for all individuals. • Provide training to Mall facilitators to conduct the activities appropriately. • Track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low **Findings:** PSH continues to offer exercise groups to meet the needs of individuals. The facility has produced an instructional DVD for training Mall facilitators on the exercises. Participation by individuals in the exercise groups is being monitored through MAPP II. Individuals not participating regularly are enrolled in different exercise groups to enhance their motivation and participation. The facility presented the following data on exercise groups:

	May	June	July	Aug	Sept	Oct
Number of groups offered	316	480	504	532	600	556
Number of groups needed	168	156	176	200	210	212
Offered/needed	> 100%					

<table>
<tr>
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The facility also presented the following data:

<table>
<tr><th>BMI Level</th><th>Individuals in each category</th><th>Individuals assigned to Exercise Groups</th><th>Percentage assigned</th></tr>
<tr><td>25 – 30</td><td>542</td><td>350</td><td>65%</td></tr>
<tr><td>31 – 35</td><td>295</td><td>200</td><td>68%</td></tr>
<tr><td>36 – 40</td><td>128</td><td>102</td><td>80%</td></tr>
<tr><td>>40</td><td>87</td><td>63</td><td>72%</td></tr>
</table>

As shown in the top table above, PSH offers more groups than needed with the intention of offering a wide variety of exercise groups that will keep the number in each group small for better instruction and attention to the individuals. However, as shown in the second table above, not all individuals who need the exercise are assigned to one of the many exercise groups offered. PSH needs to identify the causes for the non-assignment of individuals to exercise groups and take corrective actions.

Compliance:
Partial.

Current recommendations:
1. Track and review participation of individuals in scheduled group exercise and recreational activities.
2. Implement corrective action if participation is low
</td>
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<tr>
<td>C.2.k</td>
<td>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</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue to provide family services as needed.

Findings:
PSH has continued to offer monthly family workshops. Topics presented
</td>
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</table>

	chart.	each month include: • Mental health commitment codes; • What is the role of the family in recovery; • Schizophrenia and schizoaffective disorder; • Treatment(s) for schizophrenia: a biopsychosocial perspective; • Mood disorders and treatment(s); and • Family Skills Part I: Communication and Problem Solving. The Family Services Social Work staff completed 10-week Family-to-Family Training provided by Orange County NAMI in July. The staff also presented at the Patton's Annual Forensic Conference, and the presentation topics include: "Multifamily Groups and the Treatment of Severe Psychiatric Disorders," and "In Our Own Words: Stories of Families and Consumers." The facility has created a web page to enable family members to access information regarding the facility's policies/procedures and psychoeducation. The Family Therapy Services Social Work staff collaborated with unit social workers, WRPTs and the ETRC to address family issues and facilitate WRPT Family Meetings and visitation requests. The Family Therapy Services staff provided support (via phone, e-mail, contact information to address families' concerns, and education and resources in the community) to 79 families during this review period. The staff also continued and expanded its collaboration with Riverside and San Bernardino Counties to maximize efforts for community mental health treatment for families and individuals upon their discharge. Using the DMH C.2.k Family Therapy Auditing Form, PSH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:

1.	*Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.*	100%
2.	*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.*	100%
3.	*Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	98%	100%
2.	49%	100%
3.	50%	100%

Five charts of individuals with assessed need for family therapy services were reviewed (AB, CH, LP, MDD and ZB). Documentation in the Present Status section found that all five were receiving family therapy services, and/or the SW staff was in contact with the individual's family members.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Increase sample size to 20% for audits regarding items 1-5 [below]. **Findings:** PSH's sample size remains below 20% (15%). **Recommendation 2, June 2009:** Implement strategies as noted [in this cell in the previous report] to increase compliance with this requirement. **Findings:** In August 2009, PSH provided intensive training for 68 nurses regarding writing Focus 6 foci, objectives and interventions. Audit results for September 2009 improved; however, compliance scores decreased in October 2009. PSH continues to implement interventions to increase compliance with this requirement. **Recommendation 3, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Integration of Medical Conditions in WRP Audit, PSH assessed its compliance based on a 15% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (May-October 2009):

1.	*All medical conditions listed on Axis III are included on the Medical Conditions Form.*	76%
2.	*The WRP includes each medical condition or diagnoses listed on Axis III.*	71%
3.	*There is an appropriate focus statement for each medical condition or diagnosis.*	47%
4.	*There is an appropriate objective for each medical condition or diagnosis.*	64%
5.	*There are appropriate interventions for each objective.*	49%

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

	Previous period	Current period
Mean compliance rate		
1.	61%	76%
2.	57%	71%
3.	11%	47%
4.	41%	64%
5.	25%	49%
Compliance rate in last month of period		
1.	66%	95%
2.	59%	89%
3.	15%	81%
4.	46%	89%
5.	30%	80%

Barriers to compliance with this requirement include nurses' difficulties in finding uninterrupted time to work on WaRMSS while taking care of

the individuals on the unit. In addition, difficulties with the software have caused problems and many staff are not accustomed to working on the computer. Also, it takes an extended amount of time to train staff to demonstrable competence. The most critical barrier identified for sustainable competence in this area is the absence of nursing supervisors analogous to the senior supervisors of the clinical disciplines. PSH indicated that creative problem-solving continues to be done to address these barriers. The training for this requirement continues with additional computer classes being offered by the Staff Development Center.

A review of the WRPs of 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that there has been some overall improvement regarding adequate and appropriate nursing objectives and interventions. However, these improvements are inconsistently found in quality of the WRPs.

PSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 21% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:

6.	*Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.*	30%

Comparative data indicated a modest decline in compliance since the previous review period.

	Previous period	Current period
Mean compliance rate		
6.	34%	30%
Compliance rate in last month of period		
6.	22%	25%

During the previous review period; the medical staff developed a refusal of care protocol that was cumbersome and unlikely to be consistently implemented. A new two-step protocol was developed that included:

- Step 1 - Address refusals of care causing high concern;
- Step 2 - Address all other refusals of care including interventions related to basic health maintenance.

Step 1 was implemented in October 2009 and includes specific procedures and timeframes by which the primary care physician (PCP) assesses a refusal as being "high concern" and enlists the WRPT in addressing it. The treating psychologist has one week to assess the reason for the refusal and to develop and implement a plan to address it. The plan is implemented immediately upon completion and the WRPT reviews the plan at the next WRPC and incorporates it into the WRP. The Department of Psychology has formed a subcommittee to develop structured guidelines for formulating plans for treatment refusal and to identify appropriate/necessary training for psychologists in this area. A second subcommittee has been formed to look at related legal issues such as consent and competence to refuse treatment.

Step 2 will be implemented after the medical staff, in collaboration with the Medical Director, analyzes the experience of Step 1 and designs the system accordingly.

		See F.8.a.i and F.9.d for chart review findings. **Compliance:** Partial. **Current recommendations**: 1. Increase sample size to 20% for audits regarding items 1-5. 2. Continue to implement strategies as noted above to increase compliance with this requirement. 3. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Provide summary information regarding specific actions taken as part of the implementation of the improvement plan. **Findings:** The facility's actions are summarized below: 1. During the review period, PSH trained and certified 61 substance

		abuse group providers in the trans-theoretical model of stages of change. Currently, PSH has 130 certified providers. 2. In May 2009, the Substance Abuse Assessment Team assessed and staged each individual with a substance-related disorder. Results were provided to the WRPTs for utilization in selecting appropriate Mall groups. 3. PSH developed a Mall catalogue of substance abuse recovery groups. 4. In September 2009, the Substance Abuse Assessment Team initiated an outreach program to facilitate referral of individuals with positive drug tests to appropriate Mall groups. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Provide an outline of the training provided to WRPTs and SAS providers during this reporting period. **Findings:** During the review period, 61 Mall group providers completed training and certification in substance abuse. The curriculum included the topics of 1. Substance Abuse Overview (Neurobiology-Genetics-Epidemiology); 2. Specific Substances Overview (including medical complications) of: a. Alcohol; b. Sedative hypnotics c. Cocaine; d. Methamphetamine;

		e. Hallucinogens and club drugs; f. Inhalants; g. Nicotine and tobacco; h. Opioids; and i. Anabolic steroids. 3. Stages of Change; 4. The Addiction Severity Index (ASI) including theory, validity and reliability, using the screening instrument and scoring; 5. Practical Sessions; 6. Discussion; 7. Patient Placement Criteria (ASAM PPC 2nd. Edition); 8. Motivational Enhancement Therapy including theory, MET practical principles, ME interviewing, ME treatment (objective and skills in different stages); 9. Matrix Model of Treatment; 10. Cognitive Behavioral Treatment including functional analysis, cognitive restructuring, skills training and relapse prevention; 11. Twelve Step Facilitation; 12. Project MATCH; 13. Contingency Management (theory and application); 14. Modified Therapeutic Community Model; 15. Enhancing Social Development; 16. Community integration; 17. Discharge Planning; 18. Group Therapy (theory and process); 19. Supportive Psychodynamic Continuum; 20. Drug Testing; 21. Co-Occurring Mental Illness and Substance abuse (dual diagnosis); 22. Addiction Treatment in a Forensic Setting; 23. Women and Addiction; 24. HCV/HIV; 25. Prescription Drug Abuse; 26. Cultural Aspects of Addiction Treatment; and

27. Spiritual Aspects of Recovery.

Additionally, PSH developed and distributed examples of potential objectives and interventions aligned with each stage of change.

Recommendation 2, June 2009:
Provide process and clinical outcome data and specify how clinical outcomes were determined if more than one mechanism was used to determine the outcome.

Findings:
The following is a summary of PSH's process outcome data:

Process Outcomes	May–Jun 2009	Jul-Sep 2009	October 2009
Number of SAS groups scheduled	101	93	97
Hours of SAS treatment scheduled per month	3774	3774	5187
%SAS hours provided per month	95%	95%	94%
%SAS hours attended per month	72%	72%	51%
Mean hours of AA/NA scheduled per month	74	75	80

PSH also evaluated the clinical outcomes of SAR services provided during this review period. The table below is the summary of the data:

Clinical Outcomes	May 2009	November 2009
Number of individuals in each stage per SOCRATES assessment:		
Refused assessment	364	282

Pre-contemplation	408	273
Contemplation	122	184
Preparation	54	116
Action	34	91
Maintenance	14	26

PSH reported that it intends to collect data that will allow the facility to determine how many individuals have progressed in the stages of change during the next review period.

The facility's consumer satisfaction surveys summary data is as follows:

Consumer Satisfaction Survey (N= 200)	October 2009
Overall satisfaction with the information and skills provided by the group	
• Excellent	50%
• Good	31%
• Adequate	12%
• Minimal	4%
• Poor	3%
The instructor demonstrated knowledge of the course subject	
• Excellent	47%
• Good	35%
• Adequate	11%
• Minimal	4%
• Poor	3%
The group resulted in change of the way I see substance use	
• Strongly agree	38%
• Agree	38%
• Neutral	10%

• Disagree	8%
• Strongly disagree	6%
The group resulted in change of the way I see myself	N= 200
• Strongly agree	39%
• Agree	32%
• Neutral	17%
• Disagree	7%
• Strongly disagree	5%

Recommendations 3 and 4, June 2009:

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

Findings:

Using the DMH Substance Abuse Auditing Form, PSH assessed its compliance with this requirement based on an average sample of 8% of individuals with a current diagnosis of substance abuse (May – October 2009):

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	94%
2.	*There is an appropriate focus statement listed under Focus 5.*	81%
3.	*There is at least one objective related to the individual's stage of change.*	74%
4.	*There are interventions that are appropriately linked to the active objective(s).*	84%
5.	*The active treatment for substance abuse that is*	78%

	specified in the WRP is aligned with the individual's Mall schedule.	
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	57%

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

	Previous period	Current period
Mean compliance rate		
1.	81%	94%
2.	64%	81%
3.	54%	74%
4.	71%	84%
5.	63%	78%
6.	35%	57%
Compliance rate in last month of period (for indicators < 90%C)		
2.	75%	100%
3.	66%	95%
4.	83%	94%
5.	70%	92%
6.	52%	91%

Other findings:
Chart reviews by this monitor were the same as in C.2.f.iv.

Compliance:
Partial; improved compared to the last review.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Provide summary of both process and clinical outcome data regarding delivery of substance use services.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.p</td><td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td><td>Current findings on previous recommendation:

Recommendations 1 and 2, June 2009:
• Monitor the competency of group facilitators and therapists in providing rehabilitation services.
• Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided.

Findings:
Using the DMH Mall Facilitator Observation Monitoring Form. PSH assessed its compliance based on an average sample of 11% of all facilitators for the review month during the review period (May-October 2009):

<table>
<tr><td>1.</td><td>Instructional skills</td><td>93%</td></tr>
<tr><td>2.</td><td>Course structure</td><td>92%</td></tr>
<tr><td>3.</td><td>Instructional techniques</td><td>97%</td></tr>
<tr><td>4.</td><td>Learning process</td><td>92%</td></tr>
</table>

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

Using the DMH Mall Facilitator Observation Monitoring Form PSH assessed its compliance from observation of a 11% sample of all facilitators during the review months (May-October 2009):</td></tr>
</table>

1.	*Session starts and ends within 5 minutes of the designated starting and ending time.*	90%
2.	*Facilitator greets participants to begin the session.*	93%
3.	*There is a brief review of work from prior session.*	89%
4.	*Facilitator introduces the day's topic and goals.*	93%
5.	*Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.*	92%
6.	*Facilitator attempts to engage each participant in the session.*	96%
7.	*Facilitator attempts to keep all participants "on task" during the session.*	95%
8.	*Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.*	91%
9.	*Facilitator attempts to test the participants understanding.*	92%
10.	*Facilitator presents information in a manner appropriate to the functioning level of the participants.*	91%
11.	*The facilitator summarizes the work done in the session.*	87%
12.	*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.*	95%
13.	*The room is arranged in a way that is as conducive to learning as possible.*	98%
14.	*Lesson plan is available and followed.*	94%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2, 6-8, 10 and 12 and

improvement/consistency for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	69%	90%
3.	90%	89%
4.	69%	93%
5.	80%	92%
9.	86%	91%
11.	75%	87%
13.	88%	98%
14.	67%	94%
Compliance rate in last month of period		
3.	65%	85%
11.	76%	85%

Observation of nine Mall found that all group facilitators were prepared with lesson plans and handouts/worksheets. Attendance in all groups was high (over 80% of scheduled individuals were in attendance, though some were late arriving or left early). The physical layout of the groups (seating arrangement, distance to provider, and provider positioning) was appropriate to the size of the room, the number of individuals in the group, and the nature of the activity for the day. Providers can be more mindful of the following areas: ensuring that all individuals attending the group are acknowledged (through verbal and or non-verbal means), ensuring that all individuals are engaged frequently to keep them alert and active, finding appropriate means of disengaging from individuals who monopolize the group, asking individuals what they gained/learned in the group, and informing them where/how they can apply the day's lessons/ objectives before the next group meeting.

This monitor interviewed the President of the Central Council (MR), who

		indicated that individuals generally complain about the size of combined groups and frequently changing group providers, saying that these issues make it difficult for the individuals to participate and to form a therapeutic relationship with the provider(s). Information from the Mall Director and review of the Mall development activities shows that these issues are being resolved with greater participation by disciplines in facilitating Mall groups and better monitoring and problem-solving by the Program Directors, Enhancement Staff, Senior Psychologists, and Mall staff. This monitor also reviewed an individual's complaint regarding the Mall scheduling and practices on unit EB-10 (hearing-impaired individuals). Interview of Mall group providers, an individual from the group, and Dr. George Christison, Acting Medical Director found that the issues brought forward by the individual were caused by poor communication by the provider to the individual regarding why certain actions were taken or rules applied, resulting in the individual misinterpreting the actions by the provider. Other individuals in the group did not have the same concerns. **Other findings:** It came to this monitor's attention that on certain days, the evening shifts in the hearing-impaired unit did not have any or sufficient numbers of staff proficient in sign language, and a few individuals find it to be a problem. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

<table>
<tr>
<td>C.2.q</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
- Ensure that all group facilitators complete the substance abuse training curriculum.
- Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.

Findings:
PSH presented the following data regarding the certification of Substance Abuse facilitators:

<table>
<tr><td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td><td>136</td></tr>
<tr><td>Number of certified SAR providers/co-providers</td><td>130</td></tr>
<tr><td>Percentage of SAR providers/co-providers who are certified</td><td>96%</td></tr>
</table>

Compliance:
Substantial.

Current recommendation:
Continue current practice.

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<tr>
<td>C.2.r</td>
<td>Transportation and staffing issues do not preclude individuals from attending appointments.</td>
<td>

Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
- Establish an automated system to track cancellation of scheduled appointments.
- Ensure that all appointments are completed.

Findings:
PSH tracks appointment scheduling for individuals in the facility through

</td>
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</table>

the WaRMSS system. The facility provided the following data on scheduled and cancelled appointments:

Missed Appointments Monitoring – Medical Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
May 09	224	26	26 staffing 0 transportation 0 other
Jun 09	366	25	25 staffing 0 transportation 0 other
Jul 09	468	9	8 staffing 1 transportation 0 other
Aug 09	431	4	3 staffing 1 transportation 0 other
Sep 09	391	11	10 staffing 1 transportation 0 other
Oct 09	425	17	16 staffing 1 transportation 0 other
Total	2305	92	88 staffing 4 transportation

The table above shows a greater number of scheduled appointments during this review period than in the previous review period (1891 scheduled appointments) and fewer cancellations due to transportation and/or staffing (152 cancellations due to staffing and transportation during the previous review period). PSH needs to identify the causes, especially causes stemming from staffing, contributing to the

		cancellations and remedy them. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments. **Findings:** PSH conducted a PSR Mall Needs Assessment and used the data to restructure Mall groups to meet treatment needs and levels of functioning. Mall groups for the cognitively impaired are provided at the Assisted and Supported levels of functioning. The MAPP II system is available to WRPTs to schedule groups aligned with the individual's level of functioning, treatment needs, and strengths; as well as to request additional/new groups where there are none for the individual in question. Observation of nine Mall groups found that individuals in eight of the groups appeared to be within the same level of functioning. Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 13% of the WRPs due each month during the review period (May-October 2009): 10. *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* — 88%

	consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.	
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.*	91%
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	85%

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

	Previous period	Current period
Mean compliance rate		
10.	58%	88%
Compliance rate in last month of period		
10.	55%	97%
10.a	96%	97%
10.b	14%	96%

A review of the WRPs for six individuals found that five of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (AMB, JA, JB, RCC and SRS), and the remaining one (HC) did not assign the individual to appropriate groups corresponding to diagnosis, needs, and/or cognitive level, or the groups listed in the interventions were not listed in the individual's Mall schedule.

		Recommendation 2, June 2009: Ensure that providers and facilitators are knowledgeable, competent and motivated to translate course content to meet individuals' needs. **Findings:** Observation of nine Mall groups found that the providers were well prepared (lesson plans, hand-outs, and worksheets). Most of the groups observed had the learners engaged with oral, written and/or in role-play activities. The facilitators and co-facilitators were actively engaged (most of the co-facilitators were rarely involved in the Mall groups observed during the previous reviews) in facilitating the groups. Data Facilitator competency (C.2.p) supports these findings. **Other findings:** PSH has continued to have the same staff leaders in most leadership positions (Division Chiefs, Seniors, Mall Director and Supplemental Activities Coordinator) since the last review. There have been some complains from individuals that group facilitators have not been enduring in a number of Mall groups. This issue is expected to be resolved now that most of the disciplines are providing the number of hours allocated to their disciplines and in some cases more hours. In addition, the Mall Director, Program Directors, Seniors, and Enhancement staff are working to ensure that inconsistent facilitation is no longer the case. **Compliance:** Partial. **Current recommendation**: Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational,	**Current findings on previous recommendations:**

	operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Recommendations 1-3, June 2009:** • Implement and monitor PSH Mall Facilitator Monthly Progress Notes. • Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. • Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly. **Findings:** PSH has implemented the Mall Facilitator Monthly Progress Notes. The system now is automated, and WRPTs can access the notes online for review. There still is a delay in getting the notes into the medical charts in a timely manner due to the absence of electronic signature resources. The facility has to print the notes and have them signed by the facilitators before sending them in for filing. Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 13% of the WRPs due each month during the review period (May-October 2009): 11. *Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)* — 65% 11.a *Each objective is observable, measurable and behavioral.* — 72% 11.b *All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.* — 92% 11.c *There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the* — 31%

	individual`s WRP.	
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	49%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	80%

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

	Previous period	Current period
Mean compliance rate		
11.	49%	65%
Compliance rate in last month of period		
11.	62%	80%
11.a	94%	94%
11.b	94%	97%
11.c	2%	55%
11.d	27%	69%
11.e	92%	83%

A review of the WRPs for 12 individuals found that eight of the WRPs met the elements of this requirement (AKA, DAH, GT, HC, LJS, RCC, RH and VEB) and the remaining four (FCL, FL, JA and JDM) were missing one or more elements or did not satisfy the criteria for this recommendation.

PSH plans to continuing with the current procedure of tracking and monitoring low compliance to provide feedback to staff for improvement.

<table>
<tr><td></td><td></td><td>PSH expects performance improvement with the automated Mall Progress Note system. The Senior mentors are to emphasize to the WRPTs the importance of revising and updating WRP objectives.

Compliance:
Partial.

Current recommendations:
1. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.
2. Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.</td></tr>
<tr><td>C.2.u</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, June 2009:
Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include the number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.

Findings:
The table below showing the number of individuals needing WRP education group/number of individuals receiving WRP education group is a summary of the facility's data:

<table>
<tr><td colspan="4">Number of the Recovery Education groups (with hours) needed/offered during the current and previous three Mall terms</td></tr>
<tr><td>Jan-Mar 2009</td><td>Apr-Jun 2009</td><td>Jul-Sep 2009</td><td>Oct-Dec 2009</td></tr>
<tr><td>250/250</td><td>261/261</td><td>246/246</td><td>94/94</td></tr>
</table></td></tr>
</table>

		The table above indicates that PSH has provided Recovery Education Groups to all individuals in need. **Recommendation 2, June 2009:** Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment. **Findings:** This monitor observed three WRPCs. In all three cases, the WRPT members considered giving a copy of the WRP to the individual or made a clinical decision not to do so. All eight WRPs (ASB, DWD, FL, JEM, KJE, LJP, MDD and ZB) reviewed contained documentation indicating whether or not a copy of the report was given to the individual. **Compliance:** Substantial. **Current recommendation**: Continue to provide data regarding this requirement.
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they October experience.	**Current findings on previous recommendations:** **Recommendation, June 2009:** Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, 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. **Findings:** PSH reported that it implemented the Medication Needs Assessment in

<table>
<tr>
<td></td>
<td></td>
<td>October 2009. The facility indicated that 50% of individuals (758) were assessed for need by the end of the review period. Additionally, PSH indicated that WRPTs assumed responsibility for enrolling individuals in Medication Education groups during the October 2009 enrollment period.

<table>
<tr><th colspan="4">Individuals Needing and Provided Medication Education Groups</th></tr>
<tr><th></th><th>Apr-Jun 2009</th><th>Jul-Sep 2009</th><th>October 2009</th></tr>
<tr><td># of individuals needing service</td><td>949</td><td>949</td><td>510</td></tr>
<tr><td># of individuals receiving service</td><td>949</td><td>949</td><td>313</td></tr>
</table>

The facility reported that it is offering 69 medication education groups (114 hours) per week in the current Mall term.

Compliance:
Partial; improved compared to the last review.

Current recommendation:
Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, 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.</td>
</tr>
<tr>
<td>C.2.w</td>
<td>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.
• Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability.</td>
</tr>
</table>

Findings:
PSH continues to apply the non-adherent trigger rule established during the last review to address non-adherence to WRPs. The trigger rule involves monthly identification of 80 individuals with the lowest levels of participation for remediation. Once identified, WRPT psychologists are alerted to the non-adherent individuals. The WRPT will meet with the individual and identify reasons for the individual's non-adherence. The WRPT will then open a focus of treatment for the identified barrier to participation with appropriate objectives and interventions. The focus will remain open until the individual participates in the WRP for a minimum of 80% of groups for at least three months. Interventions can include medical management for psychosis, supportive and problem-solving therapies (including motivational interviewing, CBT and narrative restructuring), Motivation Enhancement groups, and enrolling individuals in more appropriate groups. Psychologists have had training on the "Action Plan/Response" protocol. Further training on Motivational Interviewing and cognitive restructuring has been planned for WRPT staff and unit supervisors.

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

	November 2008 - April 2009	May - October 2009
N	1089	1479
n	878	1311

Five charts of individuals identified as non-adherent to their WRPs were reviewed (DWD, FL, JEM, KJE and RCL). The WRP in RCL's chart did not discuss Mall participation in the Present Status section and no open focus and objectives and interventions were found for non-adherence. Docu-

		mentation in JEM's chart indicates that he is participating in his groups. DWD has medical and physical health issues affecting his participation in groups. FL is reported as attending 42% of his assigned Mall groups. KJE misses many groups because he is out of the facility for dialysis three days per week, yet he is enrolled in 20 hours of groups. These five WRPs indicate problems with documentation, non-adherent identification, and MAPP II errors. These findings also suggest that PSH's non-adherent data may be invalid. PSH should not include in the non-adherent count individuals who are unable to attend Mall groups for medical, physical, or mental illness reasons (for example, DWD and KJE). Mall group enrollment hours should be staged for individuals having medical/physical and other non-motivational issues to progressively add Mall hours as these individuals' physical health and/or mental illness improves. **Recommendation 3, June 2009:** Use systematic methods of behavior change, including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions, to change individuals' attitudes toward participation in assigned groups and individual therapies. **Findings:** PSH does not have any NRT trained staff at the facility at this time. According to the Mall Director, PSH offers DBT, Motivational Interviewing, and Motivation Enhancement groups for non-adherence. However, data are not presented due to MAPP II problems. PSH offers 15 Motivation Enhancement groups. Each group serves two to three individuals who triggered non-adherence to PSR treatment. Thirty individuals were being served during this review period. This monitor interviewed one of the Motivational Enhancement group providers. The provider presented curriculum and lesson plans developed and

		implemented for the group. Her group serves one individual at the time of this review. The provider correctly articulated the mission, goals, and objectives of the Motivation Enhancement group, and her statements were aligned with the purpose of the Motivation Enhancement group and the curriculum. **Other findings:** Documentation in a number of charts indicated that a number of individuals were not receiving credit for participating in Mall groups due to MAPP II errors. **Compliance:** Partial. **Current recommendations**: 1. Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. 2. Use systematic methods of behavior change, including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions, to change individuals' attitudes toward participation in assigned groups and individual therapies. 3. Refine the non-adherent trigger criteria differentiating non-adherence due to motivation from non-adherence due to other issues including medical and mental illness.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. PSH has achieved substantial compliance with the requirements in D.1.a (use of diagnostic criteria) and D.1.c regarding the admission medical, admission psychiatric and integrated psychiatric assessments. 2. PSH has achieved substantial compliance with the requirements regarding the timeliness of psychiatric progress notes (D.1.e). 3. PSH has made significant progress in the quality of psychiatric reassessments during this review period. **Summary of Progress on Psychological Assessments:** PSH has maintained substantial compliance with all requirements of this section. **Summary of Progress on Nursing Assessments:** 1. PSH has made significant outstanding improvements in the quality of both the Nursing Admission Assessments and the Nursing Integrated Assessments. 2. PSH has achieved substantial compliance with the requirements of Section D.3, Nursing Assessments. Based on the systems implemented to achieve substantial compliance in this area, it is expected that PSH will continue to maintain this status. **Summary of Progress on Rehabilitation Therapy Assessments:** PSH has attained substantial compliance with all EP requirements pertaining to Rehabilitation Therapy Assessments. **Summary of Progress on Nutrition Assessments:** PSH has attained substantial compliance with EP requirements pertaining to Nutrition assessments upon admission to the facility (progress remains to be made regarding the timeliness of non-admission assessments).

		Summary of Progress on Social History Assessments: PSH has achieved substantial compliance with all requirements of this section. **Summary of Progress on Court Assessments:** As of the tour conducted in June 2009, PSH 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 will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. George Christison, MD, Acting Medical Director 2. Mohamed Hafez, MD, Physician/Surgeon 3. Rebecca Kornbluh, MD, Acting Assistant Medical Director Reviewed: 1. The charts of the following 69 individuals: AM, AMB, AS, BB, CAL, CB, CC, CDA, CES, CH, CM, CRB, CTH, DAH, DC, DNW, DVL, EG, EJH, FD, FG, FS, GJW, GL, GT, HAG, HC, HTS, JCH, JCM, JL, JLB, JSM, JW, KA, KJF, LLL, LMP, LZ, MC, MH, MLB, MPM, MR, MRB, MV, NC, NJ, NLV, PH, PHL, PM, RA, RCC, RH, RLP, RVM, RW, RWW, SC, SDG, SHH, SQS, SRS, TN, TS, VK, WD and WDC 2. PSH Admission Psychiatric Assessment summary data (May-October 2009) 3. PSH Integrated Assessment: Psychiatric Section summary data (May-October 2009) 4. DMH Monthly Psychiatric Progress Note, May 2009 5. DMH Monthly PPN Audit Form, May 2009 6. DMH Monthly PPN Audit Form Instructions, May 2009 7. PSH Monthly PPN Audit summary data (May-October 2009) 8. PSH Admission Medical Assessment Auditing summary (May-October 2009) 9. PSH Weekly PPN Auditing summary data (May-October 2009) 10. PSH Physician Transfer Note Auditing summary (May-October 2009) 11. Medical Executive Committee minutes (August 26 and October 14, 2009) related to reprivileging
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM")	**Current findings on previous recommendations:**

for reaching the most accurate psychiatric diagnoses.

Recommendations 1-3, June 2009:

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

Findings:

PSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (May-October 2009). The average samples were 57% of admission assessments, 50% of integrated assessments and 17% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:

Admission Assessment		
4.	*Admission diagnosis is documented*	100%

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

Integrated Assessment		
2.b	*Statements from the individual are included, if available.*	100%
2.d	*Includes Diagnosis and medications given at previous facility are included*	95%
7.	*Includes diagnostic formulation*	91%
8.	*Includes differential diagnosis*	92%
9.	*Includes current psychiatric diagnoses*	98%

Comparative data indicated maintenance of compliance at or above 90% from the previous review period for items 2.b, 7 and 9, and improvement in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
2.d	84%	95%
8.	75%	92%

Monthly PPN		
3.a	The PPN includes the 5 Axis Diagnoses.	100%
3.c	The PPN includes a discussion of diagnostic questions that still require resolution including deferred, R/O and NOS diagnoses.	92%

Comparative data indicated improvements in or reasonable maintenance of compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
3.a	99%	100%
3.c	75%	92%

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

<table>
<tr><td>D.1.b</td><td>Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.b.i</td><td>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</td><td>

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
The facility's report on the number and type of positions is summarized below:

<table>
<tr><th>Psychiatric positions</th><th>Previous Period</th><th>Current Period</th></tr>
<tr><td>Direct care</td><td>60</td><td>69</td></tr>
<tr><td>Supervisory</td><td>20</td><td>19</td></tr>
<tr><td>Board-certified</td><td>51</td><td>52</td></tr>
<tr><td>Board-eligible</td><td>37</td><td>40</td></tr>
</table>

PSH indicated that only one psychiatrist who provides direct care to individuals is not board-eligible in psychiatry. The facility reported that this psychiatrist is supervised regularly by a Senior Psychiatrist, who has the responsibility of ensuring that this practitioner's work comports with standards of care. Additionally, this psychiatrist's audit results were reported to be above average.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

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

D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that the process of reprivileging incorporates indicators and operational instructions that provide an objective evaluation of physicians' performance in the areas of: diagnosis/differential diagnosis, admission assessment, integrated assessments, weekly/monthly reassessments, inter-unit transfers, WRPT leadership, and medication management (including high-risk medication uses, ADRs, DUEs and MVRs) as clinically appropriate. **Findings:** PSH reported that it maintained the general structure and process of reprivileging from the previous review. During the current review period, the facility added to the reprivileging process an examination of data from all audits of assessment and diagnosis for the previous two years. If properly implemented, this process is sufficient to meet this requirement. The facility has yet to present data regarding full implementation of this system. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide summary regarding status of implementation of the above-described process.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:**

		Recommendation 1, June 2009: Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. **Findings:** PSH indicated that the DMH Initial Medical Examination Auditing tool was approved in May 2009 and implemented at PSH in June 2009. **Recommendations 2-4, June 2009:** • Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. • Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data. **Findings:** Using the DMH Admission Medical Assessment Monitoring Form, PSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 85% of admissions in each month the form was in use during the review period (June-October 2009). Mean compliance was 99%. Comparative data were not available as the revised form was implemented during the current reporting period. **Other findings:** A review of the charts of ten individuals admitted during this review period (AMB, BB, CC, CES, FG, HTS, JSM, MRB, RVM and SRS) found substantial compliance in eight charts (AMB, BB, CC, CES, HTS, MRB, RVM and SRS) and partial compliance in two (FG and JSM). The review found that the neurological examination (deep tendon reflexes) was

		incomplete in the charts of FG and JSM. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Ensure that the neurological examination of deep tendon reflexes is completed consistently.
D.1.c.i.1	a review of systems;	93% for the review period.
D.1.c.i.2	medical history;	96% for the review period.
D.1.c.i.3	physical examination;	87% for the review period. The facility indicated that further data analysis revealed that failure to record waist circumference and/or BMI negatively impacted compliance for this indicator.
D.1.c.i.4	diagnostic impressions; and	98% for the review period.
D.1.c.i.5	management of acute medical conditions	88% for the review period.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

		Findings: Using the DMH Admission Psychiatric Assessment Audit, PSH assessed its compliance based on an average sample of 57% of admissions each month during the review period (May-October 2009). Mean compliance was 100%, which is consistent with the previous review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of the above-mentioned 10 individuals. The review found substantial compliance in eight charts (AMB, BB, CC, FG, JSM, MRB, RVM and SRS) and partial compliance in two (CES and HTS). The review found few process deficiencies as follows: 1. The history of present illness did not include necessary information in one chart (CES). 2. The mental status examination cited the presence of auditory hallucinations as a recent occurrence but did not provide specific information regarding the nature of this symptom (HTS). **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Ensure consistent documentation of necessary information in the history of present illness as well as specific description of the nature of disturbances of thought content in all cases.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	2. *Psychiatric history, including review of presenting* 100%

		<table><tr><td></td><td>symptoms</td><td></td></tr></table> Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	100%, compared to 98% in the previous review period.
D.1.c.ii.3	admission diagnoses;	100%, compared to 96% in the previous review period.
D.1.c.ii.4	completed AIMS;	92%, compared to 97% in the previous review period.
D.1.c.ii.5	laboratory tests ordered;	99%, compared to 100% in the previous review period.
D.1.c.ii.6	consultations ordered; and	100%, compared to 97% in the previous review period.
D.1.c.ii.7	plan of care.	<table><tr><td>8.</td><td>Plan of care</td><td>99%</td></tr></table> Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, June 2009:** • Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

		Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, PSH assessed its compliance based on an average sample of 50% of Integrated Assessments due each month during the review period (May-October 2009). Mean compliance was 96%, consistent with 97% in the previous review period. The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** Review of the charts of the above-mentioned 10 individuals found substantial compliance in eight cases (AMB, CC, CES, FG, HTS, JSM, RVM and SRS) and partial compliance in two (BB and MRB). The review found few process deficiencies as follows: 1. In general, the strengths formulation was focused on the absence of behavioral abnormalities rather positive attributes that can be used in the process of WRP. In some cases (e.g. AMB), the formulation also included some of the individual's negative traits, which is inappropriate for this section. 2. In some cases (e.g. BB and MRB), the diagnostic formulation was essentially a rehash of the interdisciplinary case formulation rather than a formulation of the individual's diagnosis. **Compliance:** Substantial. **Current recommendations**: 1. Continue to monitor this requirement. 2. Ensure that the strength formulation is consistently focused on the individual's positive attributes and does not include negative traits.

		3. Ensure that the diagnostic formulation is consistently focused on the diagnosis and is not confused with the interdisciplinary case formulation.
D.1.c.iii.1	psychiatric history, including a review of present and past history;	2. *Psychiatric history, including a review of present and past history.* 98% Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.iii.2	psychosocial history;	3. *Psychosocial history is documented.* 98% Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.iii.3	mental status examination;	4. *Complete mental status examination is documented* 100% Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.iii.4	strengths;	98%, compared to 92% in the previous review period.
D.1.c.iii.5	psychiatric risk factors;	6. *Psychiatric risk factors are documented* 97% Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.c.iii.6	diagnostic formulation;	91%, compared to 90% in the previous review period.

D.1.c.iii.7	differential diagnosis;	91%, compared to 75% in the previous review period.
D.1.c.iii.8	current psychiatric diagnoses;	97%, consistent with the previous review period.
D.1.c.iii.9	psychopharmacology treatment plan; and	10. *Psychopharmacology treatment plan is documented* 94% Comparative data indicated improvement from 83% in the previous review period.
D.1.c.iii.10	management of identified risks.	98%, compared to 90% in the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees. **Findings:** PSH provided medical education programs related to a variety of topics for its staff including "Recovery Happens," "To Reach the Criminal Mind: Finding the Alpha-Theta Path for Therapeutic Chang," transgender considerations, effects of banning tobacco, "Practicing the Recovery Philosophy," "The Bullet Train to Competency," false self-reports of HIV infection, non-violent communication, group treatment for competency restoration, "Forced Medication: Treatment for Mental Illness or Punishment for Unacceptable Behavior," obesity, geriatric considerations, schizophrenia and atypical antipsychotic use for depression. The

following is a summary of medication education programs specific to cognitive and other neuropsychiatric disorders.

Date	Title	Speaker/ affiliations	Attendees
9/30/09	Dementia	Behnam Behnam, MD, MSH	MD – 49, RN – 4, RT – 4, PT – 2 and others - 4
10/1/09	Neuropsychology as an Adjunct to a Com-prehensive Mental Health Program	Cecil Whiting, PhD, Mental Health Ser-vices, California State Prison, Corcoran	MD – 40, PhD – 2, RN – 5, RT – 2, PT – 3, and RD – 1

Recommendation 2, June 2009:
Provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.

Findings:
PSH reported 198 individuals with diagnosis as NOS and/or RO for three or more months, compared to 225 during the previous review. However, the facility acknowledged that data for this indicator appeared inaccurate. PSH reported that during the next review period it intends for Senior Psychologists to review the data and make appropriate corrections.

Other findings:
This monitor reviewed the charts of 10 individuals who have received diagnoses listed as NOS for three or more months during this review period:

Initials	Diagnosis
CH	Psychotic Disorder, NOS
CM	Depressive Disorder, NOS
CRB	Mental Disorder, NOS Due to Head Trauma
DAH	Cognitive Disorder, NOS
HTS	R/O Cognitive Disorder, NOS
LLL	Depressive Disorder, NOS
NLV	Mood Disorder, NOS (finalized to Schizoaffective Disorder, Depressive Type)
PH	Impulse Control Disorder, NOS
SQS	Mental Disorder, NOS Due to Guillain-Barre Syndrome
RA	Psychotic Disorder, NOS (finalized to Drug-induced Psychotic Disorder with Hallucinations).

The review found substantial compliance in six charts (CH, CM, DAH, LLL, NLV and RA), partial compliance three (CRB, HTS and SQS) and noncompliance in one (PH). The review found that PSH has made further progress since the last review in the following areas:

1. Finalization and justification of the diagnosis, as indicated;
2. Ensuring appropriate match between diagnosis and prescribed treatment; and
3. Addressing and tracking the status of the individual's cognitive dysfunction.

However, the facility has yet to strengthen and ensure consistency of its practice in the above areas.

Compliance:
Partial; improved compared to the last review.

		Current recommendations: 1. Continue to provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees. 2. Continue to provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in D.1.d.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i.

		Compliance: Partial; improved compared to the last review. **Current recommendation**: Same as in D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to review the charts of all individuals who have received "No Diagnosis" on Axis I to determine clinical justification. **Findings:** PSH reported that no individuals received "No Diagnosis" after the completion of initial assessments. **Other findings:** This monitor found no evidence of "No Diagnosis" listed on Axis I in any of the charts reviewed. **Compliance:** Substantial. **Current recommendations**: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at

	monthly on other units.	least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** Using the DMH Weekly Physician Progress Note (PPN) Audit, PSH assessed its compliance based on an average sample of 27% of individuals with length of stay less than 60 days during the review period (May-October 2009): 1. *The reassessments are completed weekly for the first 60 days on the admission units:* 94% 1.a *There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.* 79% 1.b.1 *The note must contain the subjective complaint,* 96% 1.b.2 *Objective findings,* 98% 1.b.3 *Assessment* 98% 1.b.4 *And plan of care* 99% The facility reported an increase in mean compliance from 85% during the preview review period. PSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 17% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement was 99%, compared to 85% in the previous review period. **Recommendation 3, June 2009:** Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

		Findings: PSH reported that it intends to include all long-term programs in tracking compliance with weekly notes. **Other findings:** This monitor reviewed the charts of 10 individuals (AMB, BB, CC, CES, FG, HTS, JSM, MRB, RVM and SRS) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days, the review found compliance in all charts except one (MRB). Regarding the monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, June 2009:** • Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** PSH used the DMH Monthly PPN Audit to assess compliance, based on an

		average sample of 17% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. **Other findings:** A review of the charts of 36 individuals (AM, AS, CB, CDA, CH, CM, CTH, DC, DVL, DW, EG, EJH, FD, FS, GJW, HAG, HC, HTS, JW, LMP, LZ, MLB, MH, MPM, MV NC, NJ, PM, RCC, RH, SC, SDG, SHH, TN, TS and WDC) found general evidence of improved documentation since the last review, including documentation of interval events and an individualized review of treatment related risks and risk benefit analysis. In some cases, the rationale for continuation of high risk treatment was inadequate, but in almost all these cases, the notes documented a plan to taper off these treatments in favor of safer alternatives, as clinically appropriate. In a few charts, the progress notes did not adequately address significant laboratory abnormalities (FS) or results of psychopharmacology consultations to decrease the risks of current treatment (KJF). This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (DNW, JCH, JCM, KA, PHL and RA). The review focused on the use of PRN/Stat medications prior to seclusion and/or restraints (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found general evidence of progress in the following areas: 1. Timely administration of PRN medications that were appropriately tailored to the symptoms in order to avert the use of seclusion/ restraints; 2. Timely adjustment of regular medication regimen based on a review of the efficacy of PRN/Stat medication use; and 3. The development and implementation of behavioral guidelines for some individuals who were refractory to current medication trials

		(JCH). However, deficiencies were noted in the following areas: 1. Prescription of PRN medications for specified behavioral indications; 2. Nursing documentation of the circumstances that led to the use of PRN/Stat medications and of the individual's response to these intervention; and 3. Documentation of the rationale for limited use of Stat medications (in order to avert the use of more restrictive interventions) in an individual who had inadequate response to attempted Stat medications (KA) and subsequently required the use of restraints. **Compliance:** Partial; improved compared to the last review. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	2. *Progress notes address changes /developments in the individual's clinical status with appropriate psychiatric follow-up including identified target symptoms* 98% The facility reported an increase in mean compliance from 88% in the previous review period.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	3. *Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.* 97%

		Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table><tr><td>5.</td><td>*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.*</td><td>97%</td></tr></table> The facility reported an improvement in mean compliance from 86% in the previous review period.
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;	<table><tr><td>4.</td><td>*Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks*</td><td>94%</td></tr></table> The facility reported an improvement in mean compliance from 83% in the previous review period.
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<table><tr><td>5.d</td><td>*Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.*</td><td>92%</td></tr></table> The facility reported an improvement in mean compliance from 66% in the

<table>
<tr><td></td><td></td><td>previous review period.</td></tr>
<tr><td>D.1.f.vi</td><td>Timely review of the use of “pro re nata” or “as-needed” (“PRN”) and “Stat” (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and</td><td><table><tr><td>6.</td><td>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</td><td>97%</td></tr></table>
The facility reported an improvement in mean compliance from 74% in the previous review period.</td></tr>
<tr><td>D.1.f.vii</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</td><td><table><tr><td>7.</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</td><td>94%</td></tr></table>
The facility reported an improvement in mean compliance from 83% in the previous review period.</td></tr>
<tr><td>D.1.g</td><td>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</td><td>Current findings on previous recommendations:

Recommendations 1-4, June 2009:
• Provide ongoing feedback and mentoring to correct the deficiencies outlined by this monitor with respect to transfer psychiatric assessments.
• Monitor this requirement using the DMH Physician Inter-Unit</td></tr>
</table>

Transfer Note Auditing Form based on at least a 20% sample.

- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Findings:
PSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 19% of the individuals who experienced inter-unit transfer per month during the review period (May-October 2009):

1.	*Psychiatric course of hospitalization,*	96%
2.	*Medical course of hospitalization,*	98%
3.	*Current target symptoms,*	94%
4.	*Psychiatric risk assessment,*	96%
5.	*Current barriers to discharge,*	96%
6.	*Anticipated benefits of transfer.*	97%

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

	Previous period	Current period
Mean compliance rate		
1.	51%	96%
2.	61%	98%
3.	70%	94%
4.	58%	96%
5.	40%	96%
6.	67%	97%

Recommendation 5, June 2009:
Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

Findings:
PSH reported that during the review period, it implemented a new procedure for inter-unit transfers related to severe management problems. Transfers related to behavioral problems are reviewed by ETRC for appropriateness of transfer, with consideration given to other clinical interventions that may decrease the need for transfer. PSH reported that since implementation of this procedure, two individuals were transferred related to severe management problems. Each individual had behavioral guidelines in place.

Other findings:
This monitor reviewed the charts of the following six individuals who experienced inter-unit transfers during the review period:

Initials	Date of transfer
CAL	8/19/09
MC	8/27/09
MR	9/3/09
RLP	9/14/09
RWW	8/18/09
VK	8/31/09

The reviews found substantial compliance in one chart (RLP), partial compliance in three (CAL, MC and MR) and noncompliance in two (RWW and VK). The main barrier towards compliance continued to be inadequate content of the assessments as follows:

		1. The anticipated benefits of the transfer were either not mentioned or stated in generic terms (e.g. continuation of treatment); and 2. In general, the target symptoms, course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers were incomplete, generic and inadequate to ensure continuity of care at the receiving unit. **Compliance:** Partial. **Current recommendation**: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Allison Pate, PhD, Senior Supervising Psychologist 2. David Haimson, PhD, Chief of Psychology 3. Helga Thordarson, PhD, Senior Supervising Psychologist 4. Jette Warka, PhD 5. Mark Williams, PhD 6. Melanie Byde, PhD, Mall Director 7. Shawn Evans, Ph.D 8. Sheri Curtis, PhD 9. Susan Velasquez, PhD, PSSC Coordinator <u>Reviewed</u>: 1. Charts of the following 39 individuals: AB, AT, BDT, CB, CMT, DB, DE, DJ, DLJ, FM, GGS, GS, GW, HS, IG, JA, JD, JG, JM, JRT, JS, KF, LB, LL, MAC, OR, PT, RK, RPP, RR, SAV, SH, ST, SV, TS, UDN, WH, YG, and YM 2. Integrated Psychological Assessments: Psychology Section 3. Psychological Focused Assessments 4. Structural/Functional Assessments 5. List of individuals needing cognitive and academic assessments within 30 days of admission 6. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 7. List of individuals who were 22 years or younger during the current evaluation period 8. List of individuals whose primary/preferred language is not English 9. List of individuals tested in their primary/preferred language 10. List of school-age/other individuals needing cognitive and academic assessments within 30-days of admission 11. Cognitive/academic assessments

		12. List showing senior psychologists' observation of psychological assessments <u>Observed</u>: 1. WRPC (Program V, unit N-27) for monthly review of JLO 2. WRPC (Program VI, unit EB-02) for 7-day review of ET 3. WRPC (Program VI, unit EB-09) for monthly review of ED 4. Mall Group: Cognitive Remediation 5. Mall Group: Cancer Support 6. Mall Group: Music Appreciation 7. Mall Group: Understanding the 1026 Process 8. Mall Group: Enhancing Self Control-Anger Management 9. Mall Group: Understanding MDO Process 10. Mall Group: Discharge Planning 11. Mall Group: Recovery Inspired Skills Enhancement (RISE) 12. Mall Group: Psychotherapy-Social Skills-ASL (Hearing Impaired)
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.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** The DMH Psychology, PBS and By Choice manuals have been completed and aligned across DMH hospitals. Manuals are revised regularly to reflect updated processes and protocols, as needed. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

<table>
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<td>D.2.b</td>
<td>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.</td>
<td>

Current findings on previous recommendations:

Recommendation, June 2009:
Continue current practice.

Findings:
This monitor's documentation review found that PSH cared for a total of two individuals below 23 years of age who required the completion of cognitive and academic assessments within 30 days of admission. Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (May-October 2009):

<table>
<tr>
<td>1.</td>
<td>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</td>
<td>100%</td>
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Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.

A review of the charts of the two individuals meeting the criteria for assessments during this review period (OR and WH) found that the assessment had been completed in a timely fashion.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

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D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP. • Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. **Findings:** The following table describes PSH's psychology staffing pattern as of October 2009:

	Filled positions	Vacant positions
Unit psychologist	67	1
Senior psychologist	8	0
Neuropsychologist	6	0

Other findings:
The following table shows the proportions of psychology staff involved in performing evaluations, meeting the facility's credentialing and privileging requirements, and observed and found to be competent:

1.a	*Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations*	99
1.b	*Number of psychologists who meet the hospital's credentialing and privileging requirements*	99
2.a	*Number of psychologists observed while undertaking psychological assessments*	12
2.b	*Number observed to be verifiably competent in assessment procedures*	12

Documentation review found that all admission psychologists are observed

		using the Admission Psychologist Monitoring Form to establish competency. According to the Chief of Psychology, PSH has eight Senior Supervising Psychologists. These Seniors have sufficient time to mentor and supervise the psychology staff. The Seniors provide supervision and oversight through PRC and the combined Trigger and FRC meetings. Furthermore, six senior psychologists provide between two and twelve hours per week of WRP mentoring and supervise WRPCs. During this review period, PSH's Psychology staff conducted a total of 490 Integrated Assessments: Psychology Section, 117 Focused Assessments and 36 Functional Behavior Assessments and developed and implemented 28 Positive Behavior Support Plans and Behavior Guidelines. The facility anticipates increasing the number of Focused Assessments performed as trainees become oriented and are able to complete the assessments. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Substantial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice.

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Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

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

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

A review of the Focused Psychology Assessments for 10 individuals found that all 10 contained clear and concise statements with a rationale for the referral (CMT, JD, JG, JM, KF, LB, MAC, RPP, SH and TS)

Current recommendation:
Continue to monitor this requirement.

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<tr>
<td>D.2.d.ii</td>
<td>include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

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

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

A review of the Focused Psychology Assessments for 16 individuals found that all 16 addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (BDT, CMT, DLJ, GW, JD, JG, JM, JRT, JS, KF, LB, MAC, RPP, SAV, SH, and TS)

Current recommendation:
Continue to monitor this requirement.

D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009): 5. *Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.* 100% Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.

<table>
<tr><td></td><td></td><td>A review of the Focused Psychology Assessments for nine individuals found that all nine indicated if the individual would benefit from individual and/or group therapy (JD, JS, KF, LB, MAC, RPP, SAV, SH and TS).

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>D.2.d.iv</td><td>be based on current, accurate, and complete data;</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

<table>
<tr><td>6.</td><td>Be based on current, accurate, and complete data.</td><td>98%</td></tr>
</table>

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

A review of the Focused Psychology Assessments for nine individuals found that all nine included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (BDT, CMT, DLJ, GW, JD, JG, JM, JRT and LB).

Current recommendation:
Continue to monitor this requirement.</td></tr>
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<td>D.2.d.v</td>
<td>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

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

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

A review of the Focused Psychology Assessments for nine individuals found that all nine indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (JD, JG, JM, JRT, JS, KF, LB, MAC and RPP).

Current recommendation:
Continue to monitor this requirement.

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</tr>
<tr>
<td>D.2.d.vi</td>
<td>include the implications of the findings for interventions;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

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Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

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

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

A review of the Focused Psychology Assessments for 10 individuals found that all 10 contained documentation of the implications of the findings for PSR and other interventions (JD, JS, KF, LB, LB, MAC, RPP, SAV, SH and TS.

Current recommendation:
Continue to monitor this requirement.
</td>
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<tr>
<td>D.2.d.vii</td>
<td>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

<table>
<tr><td>9.</td><td>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further</td><td>100%</td></tr>
</table>
</td>
</tr>
</table>

		observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.

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

A review of the Focused Psychology Assessments for nine individuals found that all nine contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (BDT, CMT, DLJ, GW, JD, JG, JM, JRT and LB).

Current recommendation:
Continue to monitor this requirement.

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.	**Current findings on previous recommendation:**

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 74% of the Focused Psychological Assessments due each month for the review period (May-October 2009):

10.	*Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*	97%

Comparative data indicated maintenance of compliance at or greater than

		90% from the previous review period. A review of the Focused Psychology Assessments for 10 individuals found that all 10 assessments had been conducted using tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (JD, JRT, JS, KF, LB, MAC, RPP, SAV, SH and TS). **Current recommendation**: Continue to monitor this requirement.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	PSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and, where indicated, conducted re-assessments. **Compliance:** Substantial.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Substantial.

<table>
<tr>
<td>D.2.f.i</td>
<td>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that integrated psychological assessments are conducted in a timely manner as required.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 95% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (May-October 2009):

<table>
<tr>
<td>12.</td>
<td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td>
<td>98%</td>
</tr>
</table>

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

A review of the IAPs for seven individuals found that all seven were conducted in a timely manner (AB, AT, DJ, GS, IG, LL and RK).

Current recommendation:
Continue to monitor this requirement.

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<tr>
<td>D.2.f.i.1</td>
<td>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed

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<tr>
<td></td>
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<td>its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (May-October 2009):

<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>99%</td></tr>
</table>

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

A review of the IAPs for eight individuals found that all eight documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AB, AT, DJ, GGS, HS, JG, LL and RK).

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

Recommendation, June 2009:
Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (May-October 2009):

<table>
<tr><td>14.</td><td>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic</td><td>98%</td></tr>
</table></td>
</tr>
</table>

		and rehabilitation service planning process. Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period. A review of the IAPs for eight individuals found that all eight provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs to determine the interventions needed for the individual's rehabilitation (AB, AT, DJ, GS, HS, IG, LL and RK). **Current recommendation**: Continue to monitor this requirement.
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	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** PSH conducts structural and functional assessments prior to developing and implementing any positive behavior support plans or behavior guidelines. See F.2.c.i for data. **Current recommendation**: Continue current practice.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and	**Current findings on previous recommendation:** **Recommendation 1, June 2009:** Ensure that additional psychological assessments are performed as required.

"NOS" diagnoses.

Findings:
Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month during the review period (May-October 2009). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:

16.	*Differential diagnosis*	100%
17.	*Rule-out*	97%
18.	*Deferred*	98%
19.	*No diagnosis*	100%
20.	*NOS diagnosis*	97%

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

	Previous period	Current period
Mean compliance rate		
16. *Differential diagnosis*	75%	100%
17. *Rule-out*	73%	97%
18. *Deferred*	72%	98%
19. *No diagnosis*	98%	100%
20. *NOS diagnosis*	81%	97%

This monitor reviewed the charts of 13 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all 13 of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AT, CB, DB, DE, HS, IG, JA, LB, PT, ST, SV, UDN and YG).

		Recommendations 2 and 3, June 2009: • Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues. • Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters. **Findings:** This monitor reviewed the charts of seven individuals with "no diagnosis." The review found that all seven of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (DB, DE, JA, LB, PT, ST and UDN). **Current recommendation**: Continue to monitor this requirement.
D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month during the review period (May-October 2009): 21.a — *Number of individuals who needed assessment during the evaluation period whose primary language was not English* — 16 21.b — *Of those in 21.a, number of individuals who were* — 11

	assessed in their primary language	
22.a	*Of those in 21.a, number of individuals who could not be assessed*	5
22.b	*Of those in 22.a, number of individuals who had plans developed to meet their assessment needs*	5
23.	*Of those in 22.b, number of individuals whose plans for assessment were implemented*	5

A review of the charts of five individuals (FM, GGS, JM, RR and YM) found that all five individuals were assessed in their primary or preferred language. All five individuals were Spanish-speaking and were evaluated by a Spanish-speaking psychologist or with assistance from a Spanish-speaking clerk working with the psychologist (for example, YM).

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

3. Nursing Assessments		
		Methodology: Interviewed: Sandra Doerner, RN, Acting Nurse Administrator Reviewed: 1. PSH's progress report and data 2. PSH training rosters 3. Medical records for the following 40 individuals: AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Substantial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (May-October 2009): 1. *A description of presenting conditions* 97% Comparative data indicated improvement in compliance from 83% in the previous review period.

A review of Nursing Admission Assessments for 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that PSH has made significant improvement in the quality of the Nursing initial and integrated admission assessments. The section addressing the narrative description of the presenting conditions has continued to show remarkable improvement regarding the individual-specific information contained in this section. The strategies addressing the nursing admission/integrated assessments that PSH has implemented since the last tour have resulted in an increase in the clinically relevant content contained in the assessments. Also, a majority of the goals that were included in the admission assessments were more aligned with the information contained in the assessment. In addition, there was significant improvement in the assessments for individuals who were not fully cooperative with the admission process. These assessments were noted to include more individual-specific observations on elements such as eye contact, posture and nonverbal reactions to questions asked than in previous assessments reviewed. PSH needs to continue producing the quality of admission/integrated assessments that was seen during this review.

Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (May-October 2009):

1.	*The present status of the Integrated Assessment: Nursing section is complete, or there is documentation that the individual is non-adherent with the interview.*	95%

Comparative data indicated improvement in compliance from 88% in the previous review period.

		A review of Integrated Nursing Assessments for 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that there has been significant improvement in the quality and content of the Integrated Nursing Assessments. The most notable improvement was in the Present Status section, which included updated information since the individual was admitted rather than a repeat of the documentation found in the Nursing Assessment. In addition, other sections of the Integrated Assessments were updated with additional information gathered days after the initial admission assessment was completed. The only noted exception to this was two Integrated Assessments that were completed too soon after the individual was admitted to the facility. **Current recommendation**: Continue current practice.
D.3.a.ii	current prescribed medications;	<u>Admission Assessments</u> 2. *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.* — 98% Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

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<u>Integrated Assessments</u>
<table>
<tr><td>2.</td><td>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.</td><td>99%</td></tr>
</table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.
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<tr>
<td>D.3.a.iv</td>
<td>allergies;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>100%</td></tr>
</table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

<u>Integrated Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>99%</td></tr>
</table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.
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<tr>
<td>D.3.a.v</td>
<td>pain;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>5.</td><td>Pain</td><td>100%</td></tr>
</table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.
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<table>
<tr><td></td><td></td><td>Integrated Assessments
<table><tr><td>5.</td><td>Pain</td><td>98%</td></tr></table>
Comparative data indicated improvement in compliance from 87% in the previous review period.</td></tr>
<tr><td>D.3.a.vi</td><td>use of assistive devices;</td><td>Admission Assessments
<table><tr><td>6.</td><td>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</td><td>100%</td></tr></table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

Integrated Assessments
<table><tr><td>6.</td><td>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</td><td>99%</td></tr></table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.</td></tr>
<tr><td>D.3.a.vii</td><td>activities of daily living;</td><td>Admission Assessments
<table><tr><td>7.</td><td>Activities of daily living</td><td>100%</td></tr></table>
Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.</td></tr>
</table>

		Integrated Assessments 7. *Activities of daily living* 99% Comparative data indicated improvement in compliance from 80% in the previous review period.
D.3.a.ix	conditions needing immediate nursing interventions.	Admission Assessments 9. *Conditions needing immediate nursing interventions* 100% Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period. Integrated Assessments 9. *Conditions needing immediate nursing interventions* 99% Comparative data indicated improvement in compliance from 87% in the previous review period.
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** PSH's Nursing Department's Policy and Procedures and practices demonstrate that they are consistently using the Wellness and Recovery Model for Nursing. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Patton State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** PSH's training and licensing rosters verified that 100% of the RNs conducting assessments received competency-based training regarding nursing assessments and that all nurses were currently licensed. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Substantial.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (May-October 2009):

		<table><tr><td>10.</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission.</td><td>99%</td></tr></table> Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period. A review of Nursing Admission Assessments for 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that all 40 were timely completed. **Current recommendation**: Continue current practice.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Provide barriers and plan of correction for required items. **Findings:** PSH's current compliance data for this requirement were above 90% and thus an analysis of barriers to compliance and plan of correction was not required. **Recommendation 2, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 98% mean sample of admissions each month during the review period (May-October 2009):

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<table>
<tr><td>10.</td><td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</td><td>93%</td></tr>
</table>

Comparative data indicated improvement in compliance from 75% in the previous review period.

A review of Integrated Nursing Assessments for 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that 38 were timely and two (REJ and SV) were completed too soon (at three days) relative to the required timeframe listed on the admission form.

Current recommendation:
Continue current practice.
</td>
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<tr>
<td>D.3.d.iii</td>
<td>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Observation Monitoring Audit, PSH assessed its compliance based on a mean sample of 20% of WRPCs observed each month during the review period (May-October 2009):

<table>
<tr><td>3.</td><td>Each team functions in an interdisciplinary fashion</td><td>95%</td></tr>
</table>

Comparative data indicated improvement in compliance from 59% in the previous review period.
</td>
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</table>

		A review of the charts of 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that an RN and a PT were in attendance at the WRPCs. **Current recommendation**: Continue current practice.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Chris Keierleber, Acting Senior Rehabilitation Therapist 2. Debra Taylor-Tatum, Acting Senior Rehabilitation Therapist 3. Erin Cross, Rehabilitation Therapist 4. Greg Siples, Chief of Rehabilitation Therapy Services 5. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 6. Mike Gomes, Senior Rehabilitation Therapist 7. Renata Geyer, Acting Senior Rehabilitation Therapist 8. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 9. Stan Hydinger, Acting Senior Rehabilitation Therapist Reviewed: 1. List of individuals who had IA-RTS assessments from May-October 2009 2. Records of the following 11 individuals who had IA-RTS assessments from May-October 2009: AP, CC, CES, CR, HAC, HL, JHR, LOL, MLP, RW and VM 3. List of individuals who had Occupational Therapy assessments from May-October 2009 4. Records of the following three individuals who had Occupational Therapy assessments from May-October 2009: AJB, GWS and TM 5. List of individuals who had Physical Therapy assessments from May-October 2009 6. Records of the following four individuals who had Physical Therapy assessments from May-October 2009: AMC, FL, FLH and JM 7. List of individuals who had Speech Therapy assessments from May-October 2009 8. Records of the following three individuals who had Speech Therapy assessments from May-October 2009: JR, MB and MR 9. List of individuals who had Vocational Rehabilitation assessments

		from May-October 2009 10. Records of the following six individuals who had Vocational Rehabilitation assessments from May-October 2009: DH, HDC, LAR, LC, SEB and SMW 11. List of individuals who had CIPRTA assessments from May-October 2009 12. Records of the following two individuals who had CIPRTA assessments from May-October 2009: DB and RAC
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Current protocols for admission and focused assessments appear to continue meet generally accepted professional standards of care. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy

Assessments due each month for the review period May-October 2009 (total of 526):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of 11 individuals to assess compliance of IA-RTS assessments with timeliness found all records in compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period May-October 2009 (total of 33):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of three individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample

of 100% of Physical Therapy Focused Assessments due each month for the review period May-October 2009 (total of 12):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data indicated improvement in compliance from 13% in the previous review period.

A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.

The facility reported that physical therapy evaluation services were unavailable during the months of May, June, and July due to limited staff and therefore the number of physical therapy assessments completed was lower for this review period than for previous review periods. A full-time permanent physical therapist was hired in October and a second contract physical therapist assistant has been hired with an anticipated start date of December 1, 2009.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period May-October 2009 (total of 44):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of three individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period May-October 2009 (total of 108):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	99%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found five records in compliance (DH, HDC, LAR, LC and SMW) and one record not in compliance (SEB).

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period May-October 2009 (total of five):

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that,*	100%

				consistent with generally accepted professional standards of care:	| Comparative data indicated improvement in compliance from 79% in the previous review period. A review of the records of two individuals to assess compliance of CIPRTA assessments with timeliness found both records in compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Continue current practice. • Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2009 (total of 526): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 98% Comparative data indicated that PSH maintained compliance at or greater

		than 90% from the previous review period. A review of the records of 11 individuals to assess compliance of IA-RTS Assessments with D.4.b.i criteria found all records in substantial compliance. Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH 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 May-October 2009 (total of 33): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 100% Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period. A review of the records of three individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance. Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period May-October 2009 (total of 12): 2. *Is accurate and comprehensive as to the individuals functional abilities;* 100% Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period. A review of the records of four individuals to assess compliance of

Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period May-October 2009 (total of 44):

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of three individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH 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 May-October 2009 (total of 108):

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	99%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

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.

<table>
<tr>
<td></td>
<td></td>
<td>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH 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 May-October 2009 (total of five):

<table>
<tr><td>2.</td><td>Is accurate and comprehensive as to the individuals functional abilities;</td><td>100%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found both records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>D.4.b.ii</td>
<td>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</td>
<td>Current findings on previous recommendations:

Recommendation, June 2009:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2009 (total of 526):</td>
</tr>
</table>

3.	*Identifies the individual's current functional status, and*	99%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of 11 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH 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 May-October 2009 (total of 33):

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

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of three individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each

month for the review period May-October 2009 (total of 12):

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

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period May-October 2009 (total of 44):

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

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of three individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an

average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period May-October 2009 (total of 108):

3.	*Identifies the individual's current functional status, and*	95%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	97%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found four records in substantial compliance (DH, HDC, SEB and SMW) and two records in partial compliance (LAR and LC).

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period May-October 2009 (total of five):

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

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for both items.

A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found both records in substantial compliance.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2009 (total of 526): 5. *Identifies the individual's life goals,* 97% 6. *Strengths, and* 97% 7. *Motivation for engaging in wellness activities* 99% Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items. A review of the records of 11 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found all records in substantial compliance. Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments

due each month for the review period May-October 2009 (total of 33):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items.

A review of the records of three individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period May-October 2009 (total of 12):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items

A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period May-October 2009 (total of 44):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items.

A review of the records of three individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period May-October 2009 (total of 108):

5.	*Identifies the individual's life goals,*	100%
6.	*Strengths, and*	100%
7.	*Motivation for engaging in wellness activities*	98%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items.

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.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH 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 May-October 2009 (total of five):

<table>
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<td>
<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>100%</td></tr>
<tr><td>6.</td><td>Strengths, and</td><td>100%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities</td><td>100%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items.

A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
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<tr>
<td>D.4.c</td>
<td>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</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.

Findings:
Five out of five newly hired Rehabilitation Therapists were trained to competency in IA-RTS assessment completion.

Compliance:
Substantial.
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		Current recommendation: Continue current practice.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.	All conversion assessments were completed as of the June 2009 tour of PSH.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Jeanie Kim, Assistant Director of Nutrition Services 4. Kitchie Miana, Assistant Director of Nutrition Services 5. Tai Kim, Director of Nutrition Services Reviewed: 1. Nutrition Care Monitoring audit data for May-October 2009 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from May-October 2009 for each assessment type 3. Records of the following seven individuals with type D.5.d assessments from May-October 2009: CAO, DS, HG, JAA, MGS, REJ and REK 4. Records of the following seven individuals with type D.5.e assessments from May-October 2009: DIB, DLH, ERJ, GWP, HL, LRM and RL 5. Records of the following five individuals with type D.5.f assessments from May-October 2009: CEW, DEH, LH, PT and RMO 6. Records of the following seven individuals with type D.5.g assessments from May-October 2009: ABR, CMM, JLF, KW, PJ, RAF and SS 7. Records of the following ten individuals with type D.5.i assessments from May-October 2009: AMH, AVL, CH, DEB, GP, KLS, LEM, MD, MEH and SH 8. Records of the following three individuals with type D.5.j.i assessments from May-October 2009: AP, DBP and MLR 9. Records of the following four individuals with type D.5.j.ii assessments from May-October 2009: FS, DML, KLD and ORL

D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendations:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** No individuals were admitted during the review period who met criteria for a type D.5.a New Admit with 24-Hour High Risk Referral. **Compliance:** Unable to determine compliance at this time. **Current recommendation**: Continue current practice.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable. PSH does not have a medical-surgical unit.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d

	be completed within 7 days of admission.	assessments due each month for the review period May-October 2009 (total of 50):

1.	*Assessment is completed on time per policy*	90%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	92%
4.	*Estimated daily needs for nutrients specified are appropriate*	90%
5.	*Assessment utilizes findings from subjective and objective data*	96%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	96%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	96%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	94%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	96%
18.	*Each page of the assessment is signed*	92%

		Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period for all items (items 9 and 14 were N/A in both periods). A review of the records of seven individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period May-October 2009 (total of 32): 1. *Assessment is completed on time per policy* 88% 2. *All required subjective concerns are addressed* 97% 3. *All pertinent objective nutrition information is accurately addressed* 94% 4. *Estimated daily needs for nutrients specified are appropriate* 94% 5. *Assessment utilizes findings from subjective and objective data* 100% 6. *Nutrition diagnosis is correctly formulated,* 100%

	prioritized and validated	
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	97%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	94%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	97%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2-8, 10-12, and 15-18, and improvement in compliance since the previous review period for the remaining items (items 9 and 14 were N/A in both periods):

	Previous period	Current period
Mean compliance rate		
1.	65%	88%
13.	0%	100%
Compliance rate in last month of period		
1.	56%	100%

		A review of the records of seven individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance. The facility reported that compliance with timeliness was affected by late notification of diet orders by nursing staff during the month of August. However, data for this item was reported at 100% for four out of six months during the review period. The facility reported that the new procedure for nurses to provide written therapeutic diet orders to dietitians has resulted in increased compliance with timeliness overall for assessment type D.5.e. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period May-October 2009 (total of 43): 1. *Assessment is completed on time per policy* 93% 2. *All required subjective concerns are addressed* 98% 3. *All pertinent objective nutrition information is accurately addressed* 95%

4.	*Estimated daily needs for nutrients specified are appropriate*	93%
5.	*Assessment utilizes findings from subjective and objective data*	98%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	98%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	98%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	98%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 4-8, 10, 12, 13, and 15-18, and improvement in compliance since the previous review period for the remaining items (items 9 and 14 were N/A in both periods):

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<tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>64%</td><td>93%</td></tr>
<tr><td>2.</td><td>88%</td><td>98%</td></tr>
<tr><td>3.</td><td>81%</td><td>95%</td></tr>
<tr><td>11.</td><td>68%</td><td>98%</td></tr>
</table>

A review of the records of five individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>D.5.g</td>
<td>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.g assessments due each month for the review period May-October 2009 (total of 74 out of 352):

<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>99%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>99%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>99%</td></tr>
</table>
</td>
</tr>
</table>

4.	*Estimated daily needs for nutrients specified are appropriate*	93%
5.	*Assessment utilizes findings from subjective and objective data*	97%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	99%
7.	*Nutrition education is documented*	96%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	N/A
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	99%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	95%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	N/A
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	97%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	96%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1, 2, 4, 5, 7, 8, 10-12, and 15-18, and improvement in compliance from the previous review period for the remaining items (items 9, 13 and 14 were N/A in both periods):

<table>
<tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>89%</td><td>99%</td></tr>
<tr><td>6.</td><td>89%</td><td>99%</td></tr>
</table>

A review of the records of seven individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
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<tr>
<td>D.5.h</td>
<td>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.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 25% of Nutrition assessments (all types) due each month of the review period May-October 2009 (587 out of 2368). The facility reports that a weighted mean of 97% of Nutrition admission assessments had evidence of a correctly assigned NST level.

A review of the records of 43 individuals found that all records had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.
</td>
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</table>

		Compliance: Substantial. **Current recommendation**: Continue current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of Nutrition Type D.5.i assessments due each month for the review period May-October 2009 (total of 202 out of 991):

1.	*Assessment is completed on time per policy*	34%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	86%
4.	*Estimated daily needs for nutrients specified are appropriate*	91%
5.	*Assessment utilizes findings from subjective and objective data*	97%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
7.	*Nutrition education is documented*	95%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	99%
10.	*Nutrition goals are individualized, relate to the*	91%

	nutrition diagnosis, and are realistic and measurable	
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	94%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	99%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	97%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2, 4, 5, 8-13 and 15-18, and improvement in compliance from the previous review period for the remaining items (item 14 was N/A in both periods):

	Previous period	Current period
Mean compliance rate		
1.	31%	34%
3.	71%	86%
6.	84%	97%
7.	84%	95%
Compliance rate in last month of period		
1.	23%	46%
3.	100%	91%

The facility reviewed the data and reported that poor compliance with timeliness was attributed to RD vacancies and high caseloads (each dietitian has an average caseload of 150 individuals).

<table>
<tr>
<td></td>
<td></td>
<td>A review of the records of 10 individuals to assess compliance with Nutrition type D.5.i criteria found eight records in substantial compliance (AMH, AVL, DEB, GP, KLS, MD, MEH and SH) and two records in partial compliance (CH and LEM).

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.5.j.i</td>
<td>Individuals will be reassessed when there is a significant change in condition.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue current efforts to achieve compliance.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.j.i assessments due each month for the review period May-October 2009 (total of 76 out of 363):
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>83%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>99%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>84%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>90%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>97%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>93%</td></tr>
</table></td>
</tr>
</table>

7.	*Nutrition education is documented*	90%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	99%
9.	*Progress is monitored, measured, and evaluated*	99%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	97%
11.	*Recommendations are appropriate and complete*	97%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	99%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	99%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	99%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2, 4-13, and 15-18, and mixed changes in compliance for the remaining items (item 14 was N/A in both periods):

	Previous period	Current period
Mean compliance rate		
1.	93%	83%
3.	82%	84%
Compliance rate in last month of period		
1.	92%	100%
3.	100%	94%

		A review of the records of three individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance. The facility reported that poor compliance with timeliness was attributed to RD vacancies and high caseloads (each dietitian has an average caseload of 150 individuals). The Nutrition department has developed a process to prioritize consults according to acuity level by requesting that physicians specify the number of days for a consultation. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current efforts to achieve compliance. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.j.ii assessments due each month for the review period May-October 2009 (total of 111 out of 537): 1. *Assessment is completed on time per policy* 43% 2. *All required subjective concerns are addressed* 94% 3. *All pertinent objective nutrition information is accurately addressed* 86% 4. *Estimated daily needs for nutrients specified are appropriate* 96%

5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	96%
7.	*Nutrition education is documented*	95%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	98%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	N/A
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	N/A
15.	*Assessment utilizes approved abbreviations*	98%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	96%
18.	*Each page of the assessment is signed*	98%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2, 4-12, and 15-18 and modest improvement in compliance for the remaining items (items 13 and 14 were N/A in both periods):

	Previous period	Current period
Mean compliance rate		
1.	34%	43%

3.	79%	86%
Compliance rate in last month of period		
1.	39%	58%
3.	80%	80%

A review of the records of four individuals to assess compliance with Nutrition type D.5.j.ii criteria found three records in substantial compliance (FS, KLD and ORL) and one record in partial compliance (DML).

The facility reported that poor compliance with timeliness was attributed to RD vacancies and high caseloads (each dietitian has an average caseload of 150 individuals).

Compliance:
Partial.

Current recommendation:
Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Anthony Ortega, LCSW, Assessment Team Supervisor 2. Edward Williams, LCSW, Family Services Coordinator 3. Hope Marriott, LCSW, Social Worker-WRP Master Trainer and Section E Leader 4. Lisa Hilder, LCSW and Auditor, Sections D.6 and E 5. Rachel Strydom, LCSW, Supervising Social Worker 6. Tiffany Rector, LCSW, (A) Supervising Social Worker and Section D.6 Leader: Reviewed: 1. Charts of the following 20 individuals: AH, CESP, CL, EK, HC, HS, HT, JA, JB, JSM, JWB, MZ, OR, RCC, RM, RRM, SK, SPC, SR and TB 2. DMH Integrated Assessments: Social Work Section 3. DMH 30-Day Psychosocial Assessments 4. PSH Progress Report Data 5. Family Education Assessments
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that the five-day and 30-day Social History Assessments are timely, accurate, and comprehensive. **Findings:** Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 95% of the Integrated Assessments: Social Work Sections due each month during the review period (May-October 2009):

1.	*Is, to the extent reasonably possible, accurate*	99%
2.	*Current, and*	100%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	100%

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

This monitor reviewed the charts of 12 individuals to evaluate the Integrated Assessments: Social Work Sections. All 12 assessments were current and comprehensive (CESP, CL, HC, HS, JA, JB, JSM, OR, RCC, RM, RRM and SPC).

Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the 30-Day Psychosocial Assessments due each month during the review period (May-October 2009):

1.	*Is, to the extent reasonably possible, accurate*	100%
2.	*Current, and*	100%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	100%

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

This monitor reviewed the charts of 10 individuals to evaluate the 30-Day Psychosocial Assessments. Nine of the assessments were timely and

<table>
<tr><td></td><td></td><td>comprehensive (CESP, CL, HC, JA, JB, JSM, OR, RCC and SPC), and one was untimely (RRM).

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>D.6.b</td><td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td><td>Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Ensure that Social History assessments contain all relevant information.
• Ensure that social workers identify and address the inconsistencies in current assessments.
• Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.

Findings:
Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the 30-Day Psychosocial Assessments due each month during the review period (May-October 2009):

<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>99%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>100%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>100%</td></tr>
</table>

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

		This monitor reviewed the charts of nine individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies. All nine assessments identified and resolved factual inconsistencies (AH, EK, HC, HT, JWB, MZ, SK, SR and TB). **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC. **Findings:** Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 95% of Integrated Assessments: Social Work Sections due each month during the review period (May-October 2009): 7. *Is included in the 7-day integrated assessment* 96% Comparative data indicated improvement in compliance from 89% in the previous review period. This monitor reviewed six charts to evaluate timeliness of the Social Work Integrated Assessments. All six assessments were timely (CL, HS, JSM, RCC, RRM and SPC).

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Recommendation 2, June 2009:
Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.

Findings:
Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of 30-Day Psychosocial Assessments due each month during the review period:

<table>
<tr><td>8.</td><td>Fully documented by the 30th day of the individual's admission.</td><td>95%</td></tr>
</table>

Comparative data indicated improvement in compliance from 77% in the previous review period.

This monitor reviewed six charts to evaluate timeliness of the 30-Day Psychosocial Assessments. All six assessments were timely (CESP, HC, JA, JB, OR and RM).

Compliance:
Substantial.

Current recommendation:
Continue current practice.
</td>
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<tr>
<td>D.6.d</td>
<td>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.
</td>
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</table>

Findings:
Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 95% of 30-day Psychosocial Assessments due each month during the review period:

9.	*Social factors*	100%
10.	*Educational status*	100%

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

This monitor reviewed 12 charts to evaluate documentation of the individual's social factors in the 30-day Psychosocial Assessments. All 12 assessments included information on the individual's social factors and educational status (CESP, CL, HC, HS, JA, JB, JSM, OR, RCC, RM, RRM and SPC).

Compliance:
Substantial.

Current recommendation:
Continue current practice.

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 June 2009, PSH 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 will be 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	

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

E. Discharge Planning and Community Integration		
		Summary of Progress: 1. PSH has achieved substantial compliance with most of the requirements of this section. 2. PSH has improved in the identification and documentation of the skills and supports the individual needs in order to be discharged. 3. Individuals when discharged are receiving greater support and assistance to adjust to their community placements, including getting an SSI, driver's license, referral to community services and family therapy. Documentation of support given has improved.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Anthony Ortega, LCSW, Assessment Team Supervisor 2. Edward Williams, LCSW, Family Services Coordinator 3. Hope Marriott, LCSW, Social Worker-WRP Master Trainer 4. Lisa Hilder, LCSW and Auditor, Sections D.6 and E 5. Rachel Strydom, LCSW, Supervising Social Worker <u>Reviewed</u>: 1. The charts of the following 34 individuals: AE, AI, AKA, AW, BAB, BB, BDT, CCH, CDT, DH, FCL, FG, HC, HT, HTS, JB, JDM, JLB, JLO, JM, JU, LS, MAH, MRB, MRT, MS, MVV, RB, RH, SES, SRS, SRS, VEB and WAH 2. List of individuals referred for discharge but still hospitalized 3. List of individuals assessed to need family therapy <u>Observed</u>: 1. WRPC (Program V, unit N-27) for monthly review of JLO 2. WRPC (Program VI, unit EB-02) for 7-day review of ET 3. WRPC (Program VI, unit EB-09) for monthly review of ED

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 subcells for compliance findings.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendation:** **Recommendations 1-3, June 2009:** • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. • Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of quarterly and annual WRPs due each month during the review period (May-October 2009): 1. *Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.* 90% Comparative data indicated improvement in compliance from 23% in the previous review period. A review of the records of nine individuals found that eight 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 (AI, BB, FG, HC, HTS, JU, MRB and SRS). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining WRP (JM). **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. **Findings:** Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (May-October 2009): 2. *The individual's level of psychosocial functioning* 96% Comparative data indicated improvement in compliance from 78% in the previous review period. A review of the records of five individuals found that all five WRPs included the individual's psychosocial functioning in the Present Status section (CCH, JLB, RH, SES and VEB).

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

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>E.1.c</td><td>any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17 % of the quarterly and annual WRPs due each month during the review period (May-October 2009):

<table>
<tr><td>3.</td><td>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</td><td>90%</td></tr>
</table>

Comparative data indicated improvement in compliance from 58% in the previous review period.

A review of the records of 11 individuals found that all 11 WRPs contained documentation of the individual’s discharge barriers and progress towards overcoming those barriers (AE, AKA, AW, BAB, CDT, FCL, JDM, MS, RH, SES and VEB).

Compliance:
Substantial.</td></tr>
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<table>
<tr><td></td><td></td><td>Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>E.1.d</td><td>the skills and supports necessary to live in the setting in which the individual will be placed.</td><td>
Current findings on previous recommendations:

Recommendations 1-3, June 2009:
• Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.
• Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual.
• Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

<table>
<tr><td>4.</td><td>The skills and supports necessary to live in the setting in which the individual will be placed.</td><td>97%</td></tr>
</table>

Comparative data indicated improvement in compliance from 81% in the previous review period.

A review of the records of 11 individuals found that all 11 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (DH, FG, GT, HTS, JB, JU, LS, MRT, RH, SRS and VEB).
</td></tr>
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<table>
<tr><td></td><td></td><td>Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>E.2</td><td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td><td>Current findings on previous recommendations:

Recommendations 1-2, June 2009:
• Ensure that the individual is an active participant in the discharge planning process.
• Ensure that the individual understands all of the discharge requirements before leaving the WRPC.

Findings:
Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

<table>
<tr><td>9.</td><td>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</td><td>95%</td></tr>
</table>

Comparative data indicated improvement in compliance from 57% in the previous review period.

A review of the records of five individuals found that four WRPs contained documentation indicating that the individual was an active participant in the discharge process (BDT, JLO, MVV and RH). The</td></tr>
</table>

		remaining WRP contained no documentation that the individual participated in the discussion (WAH). This monitor observed three WRPCs (ED, ET and JLO). The WRPTs sought the individual's input into discharge criteria and explained the individual's progress towards discharge. However, documentation in the individuals' WRPs does not reflect the WRPC process regarding discussion with individuals regarding discharge barriers. WRPTs should consider making more focused and direct statements about this discussion in the Present Status section of the individual's WRP. **Recommendation 3, June 2009:** Prioritize objectives and interventions related to the discharge process. **Findings:** A review of the records of nine individuals found that all nine of the WRPs in the charts prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (FG, HC, HTS, JB, JM, JU, MAH, MRB and RB). **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
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.

E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** According to the Compliance Director and Social Work staff, PSH focused on improving WRP documentation during the "WRP Clean-Up Phase II" in May 2009. SW staff continued to provide mentoring and supervision regarding completion of objectives and foci associated with the writing of objectives in observable/measurable manner. Documentation review found that SW work staff prepared samples of Section E documentation. This was followed up with training and consultation on the linkage between the individual's discharge criteria and focus of hospitalization. Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (May-October 2009): |		
	Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	
6.	*Measurable interventions regarding these discharge considerations*	74% | Comparative data indicated improvement in compliance since the previous

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<td>review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>29%</td><td>74%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>24%</td><td>92%</td></tr>
</table>
A review of the WRPs of 10 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in eight WRPs (AI, BB, FG, HT, JB, JM, JU and MRB). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining two WRPs (HC and SRS).

Other findings:
WRPTs have a tendency to lump together compound goals under one discharge criteria (for example, group participation and following unit/ hospital rules and routines), to use unobservable/unmeasurable terms (for example, “intention”), and to not state how the criteria is measured, when, where and by whom (for example, “describe a WRAP to prevent the use of SA in the future”).

Compliance:
Partial.

Current recommendation:
Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</td>
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<tr>
<td>E.3.b</td>
<td>the staff responsible for implement the interventions; and</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

Recommendation 1, June 2009:
Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of quarterly and annual WRPs due each month during the review period (May-October 2009):

7.	*The interventions specify the name(s) of specific staff responsible for implementing each one*	100%

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

All interventions listed under Foci 1, 3, and/or 5 were reviewed to evaluate if the person(s)/discipline(s) responsible for implementing the intervention(s) were listed. A review of the records of eight individuals found that all eight WRPs identified the staff member responsible for the interventions (AI, BB, FG, HC, JB, JM, JU and MRB).

Recommendation 2, June 2009:
Ensure that all elements required for fulfilling the intervention section of the WRP are completed.

Findings:
A review of the records of 15 individuals found that 14 of the WRPs in the charts included all elements required for fulfilling the intervention section of the WRP (AI, AKA, AW, BB, FCL, FG, HC, HTS, JB, JDM, JU, MRB, SRS and VEB) and one did not (HC).

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

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>E.3.c</td><td>The time frames for completion of the interventions.</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.

Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 17% of quarterly and annual WRPs due each month during the review period (May-October 2009):

<table>
<tr><td></td><td>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:</td><td></td></tr>
<tr><td>8.</td><td>The time frames for completion of interventions</td><td>93%</td></tr>
</table>

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

A review of the records of 11 individuals found that eight WRPs clearly stated the time frame for the next scheduled review of each intervene-tion in the Mall or individual therapy (BB, FG, HC, HTS, JM, JU, MRB and</td></tr>
</table>

		SRS). The remaining three did not specify a time frame or the stated time frame was not aligned with the next scheduled WRPC (AI, HC and JB). **Compliance:** Partial. **Current recommendation**: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Substantial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Use objective data for all discharge criteria and planning. **Findings:** PSH established a Discharge Planning Committee in October 2009. The committee is chaired by the Discharge Planning and Community Integration Director and exists to address specific discharge needs of individuals of various commitment types. PSH also has created an electronic database to efficiently track discharge trends. In addition, the CONREP Referral Process Flowchart evaluation and update is ongoing. Documentation review found that 31 individuals referred for discharge are still hospitalized. Twenty-two of these individuals (70%) were referred for discharge within the last six months of this review period. Nine have been in the facility for more than six months after referral for discharge.

<table>
<tr>
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<td>
The table below, showing the date of referral for discharge and the reasons for continued stay at PSH, is a summary of the facility's data:
<table>
<tr><td>AE</td><td>11/5/08</td><td>INS issue, COREP to arrange for placement</td></tr>
<tr><td>AM</td><td>7/7/08</td><td>Court ordered 4/09, awaiting CONREP placement notification</td></tr>
<tr><td>CB</td><td>2/2/09</td><td>CONREP denied COT, awaiting court ruling</td></tr>
<tr><td>CS</td><td>3/19/09</td><td>Need locked facility, is on waiting list for Sylmar</td></tr>
<tr><td>LS</td><td>8/07</td><td>Court ordered COT, but CONREP would not place due to PC 290 barriers</td></tr>
<tr><td>MDeV</td><td>2008</td><td>Initial approval, but CONREP has recently asked for more assessments</td></tr>
<tr><td>RP</td><td>3/10/09</td><td>Waiting for CONREP placement</td></tr>
<tr><td>TB</td><td>2007</td><td>INS issue, pro-bono attorney working on INS hold</td></tr>
<tr><td>TE</td><td>3/25/09</td><td>Awaiting CONREP interview to determine placement</td></tr>
</table>
Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>E.4.b</td>
<td>Individuals receive adequate assistance in transitioning to the new setting.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:

Document specific assistance provided to the individual when transitioned to a new setting.
Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP.

</td>
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</table>

<table>
<tr><td></td><td></td><td>Findings:
Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due each month during the review period (May-October 2009):

<table>
<tr><td></td><td>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:</td><td></td></tr>
<tr><td>10.</td><td>Individuals receive adequate assistance in transitioning to the new setting.</td><td>99%</td></tr>
</table>

Comparative data indicated improvement in compliance from 21% in the previous review period.

Skills and supports the individual needs upon placement in the community initially are addressed through the Social Work 30-Day Psychosocial Assessments and other discipline-specific assessments. The information from the discipline assessments are incorporated into the individual's WRP. A review of the records of eight individuals found that all eight WRPs contained documentation of the assistance needed by the individual in the new setting (BB, FG, HC, HTS, JB, JU, MRB and SRS).

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>E.5</td><td>For all children and adolescents it serves, each State hospital shall:</td><td rowspan="3">The requirements of cell E.5 and sub-cells are not applicable to PSH as it does not serve children and adolescents.</td></tr>
<tr><td>E.5.a</td><td>develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and</td></tr>
<tr><td>E.5.b</td><td>establish a regular review forum, which includes</td></tr>
</table>

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

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. The DMH's Psychopharmacology Advisory Committee, led by PSH's psychopharmacology consultant has made further appropriate revisions, updates and additions to the DMH Psychotropic Medication Policy. 2. PSH has made significant progress in the justification of high-risk medication uses, including benzodiazepines, anticholinergics, polypharmacy and new generation antipsychotic medications for individuals at risk. 3. PSH has attained substantial compliance with the requirement in F.1.d. This section addresses the monitoring of individuals at risk for metabolic and endocrine dysfunction. 4. PSH has increased reporting of Adverse Drug Reactions (ADRs) and conducted appropriate intensive case analysis of ADRs as indicated. 5. PSH has made progress in data collection and processing of medication variances and conducted appropriate intensive case analyses of variances that reached severity thresholds for these analyses. 6. PSH has attained substantial compliance with the requirement in F.1.g regarding Drug Utilization Reviews (DUEs). 7. PSH has improved the laboratory monitoring of individuals receiving New Generation Antipsychotic Agents (NGAs) regarding the risks of metabolic, endocrine and pancreatic dysfunction. 8. PSH has made progress in the monitoring and tracking of tardive dyskinesia. **Summary of Progress on Psychological Services:** 1. PSH has made significant improvement in the quality of the PBS plans and Behavior Guidelines developed and implemented during this review period. 2. Documentation of the By Choice point earning and allocation in the

	Present Status section of the individual's WRP has improved. 3. The PSSC tracks and monitors all individuals meeting trigger threshold and where appropriate conducts assessments and interventions. **Summary of Progress on Nursing Services:** 1. PSH has implemented a number of creative strategies to provide real-time mentoring in spite of limited resources and staffing issues. 2. PSH has implemented systems to monitor, review and analyze its overall medication administration practices. 3. PSH has achieved substantial compliance with a number of requirements in the area of Nursing Services. **Summary of Progress on Rehabilitation Therapy Services:** PSH has attained substantial compliance with all EP requirements pertaining to Rehabilitation Therapy Services. **Summary of Progress on Nutrition Services:** PSH has continued to provide an interdisciplinary weight management group and has maintained substantial compliance with tray accuracy and provision of individualized nutrition education. **Summary of Progress on Pharmacy Services:** PSH has maintained substantial compliance with EP requirements in this section. **Summary of Progress on General Medical Services:** 1. PSH has made significant progress in ensuring timely and appropriate medical care to individuals. 2. PSH has made significant progress in ensuring the timely availability of medical records from outside hospitals following the return transfer of individuals from these hospitals.

	Summary of Progress on Infection Control: 1. PSH has achieved substantial compliance in all but one area of the Enhancement Plan regarding Infection Control. With procedures implemented to ensure accurate Key Indicator data regarding Infection Control, they should be able to obtain substantial compliance in all areas of the Infection Control section. 2. PSH has implemented a number of strategies and interventions addressing their barriers to compliance in areas regarding refusals. **Summary of Progress on Dental Services** 1. PSH Dental Department has been approved to hire an additional part-time dentist. This addition should allow the department to come into substantial compliance with all areas of the EP by the next review. 2. In spite of staffing issues, the department has maintained substantial compliance with a number of EP requirements pertaining to dental services.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Andrew Blaine, MD, Chief of Medical Staff 2. George Christison, MD, Acting Medical Director 3. George Proctor, MD, Acting Psychopharmacology Consultant 4. Rebecca Kornbluh, MD, Acting Assistant Medical Director Reviewed: 1. The charts of the following 30 individuals: AD, ARB, AS, AW, CDA, CTD, DB, EG, FS, GL, GMM, GT, HEH, HTS, JBW, JL, JLB, JSN, KF, KJF, MR, MRB, PC, PH, RAF, RPJ, RW, SAV, SES and SSM 2. PSH Admission Psychiatric Assessment Auditing summary data (May-October 2009) 3. PSH Integrated Assessment: Psychiatry Section Auditing summary data (May-October 2009) 4. PSH Monthly PPN Audit summary data (May-October 2009) 5. PSH PRN and Stat monitoring summary data (May-October 2009) 6. PSH Benzodiazepine Auditing Form summary data (May-October 2009) 7. PSH Anticholinergics Auditing Form summary data (May-October 2009) 8. PSH Polypharmacy Auditing Form summary data (May-October 2009) 9. PSH Tardive Dyskinesia Database 10. PSH TD Monitoring summary data (May-October 2009) 11. PSH aggregated data regarding adverse drug reactions (May-October 2009) 12. Last ten ADRs for this reporting period 13. PSH aggregated data regarding medication variances (May-October 2009) 14. Last ten MVRs for this reporting period 15. Intensive Case Analyses completed during this review period

		16. Drug Utilization Evaluations completed by PSH during this review period 17. Pharmacy and Therapeutics Committee Minutes (May 6, July 1, August 5, September 2 and October 7, 2009)
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the revisions made during the review period. **Findings:** The following summarizes the modifications to PSH's medication guidelines during the review period: 1. Initiated analysis of all identified variances for each medication variance, rather than focusing on a primary variance; 2. Defined "baseline" or "pretreatment" laboratory measurements to be labs obtained within 30 days of initiating the relevant medication; 3. Added a protocol for zonisamide with reference to zonisamide use as a mood stabilizer in preliminary studies by Keck and McElroy, et al; and 4. Revised the SGA Monitoring Tables to include new tables for iloperidone (Fanapt) and asenapine (Saphris). **Recommendations 2-4, June 2009:** • Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly PPN Auditing Forms based on at least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

<table>
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<td></td>
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<td>compared to the last period).
• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

Findings:
PSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 57%, 50% and 17% respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.

Compliance:
Partial; improved compared to the last review (substantial compliance is contingent on compliance with F.1.c).

Current recommendation:
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>F.1.a.i</td>
<td>specifically matched to current, clinically justified diagnoses or clinical symptoms;</td>
<td>
<table>
<tr><th colspan="3">Admission Psychiatric Assessment</th></tr>
<tr><td>8.</td><td>Plan of care includes [regular psychotropic medications with rationale; PRN and/or Stat medication as applicable, with specific behavioral indications; and special precautions to address risk factors as indicated]</td><td>99%</td></tr>
</table>
Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.

<table>
<tr><th colspan="3">Integrated Psychiatric Assessment</th></tr>
<tr><td>7.</td><td>Diagnostic formulation is documented</td><td>91%</td></tr>
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</tr>
</table>

10.	*Psychopharmacology treatment plan includes:*	94%
10.a	*Current target symptoms*	97%
10.b	*Specific medication to be used*	99%
10.c	*Dosage titration schedules, if indicated.*	92%
10.d	*Adverse reactions to monitor for*	89%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation*	92%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications.*	90%
10.g	*Medication consent issues were addressed*	98%

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

	Previous period	Current period
Mean compliance rate		
7.	90%	91%
10.	87%	94%

Monthly PPN		
2.b	*Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.*	100%
3.	*Timely and justifiable updates of diagnosis and treatment, as clinically indicated.*	97%
3.a	*The 5 Axis Diagnosis*	100%
3.b	*The individual's target symptoms are consistent with the diagnosis.*	99%
3.c	*A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.*	92%

<table>
<tr><td></td><td></td><td>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period for all items except 3.c, which increased from 75% in the previous review period.</td></tr>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>5.b</td><td>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</td><td>99%</td></tr>
</table>
Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>5.c</td><td>Monitored for effectiveness against clearly identified target variables</td><td>99%</td></tr>
</table>
Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.
</td></tr>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
<table>
<tr><th colspan="3">Monthly PPN</th></tr>
<tr><td>2.g</td><td>Current AIMS</td><td>98%</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>92%</td></tr>
</table>
</td></tr>
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<table>
<tr><td></td><td></td><td>Comparative data indicated improvement in compliance from the previous review period:

<table><tr><td></td><td>Previous period</td><td>Current period</td></tr><tr><td colspan="3">Mean compliance rate</td></tr><tr><td>2.g</td><td>87%</td><td>98%</td></tr><tr><td>5.d</td><td>66%</td><td>92%</td></tr></table></td></tr>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td><table><tr><td colspan="3">Monthly PPN</td></tr><tr><td>5.a</td><td>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</td><td>99%</td></tr><tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>92%</td></tr></table>
Comparative data indicated maintenance of compliance at or above 90% for item 5.a and improvement for item 5.d from 66% in the previous review period.</td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td><table><tr><td colspan="3">Monthly PPN</td></tr><tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and</td><td>92%</td></tr></table></td></tr>
</table>

		atypical antipsychotics and other psychiatric medications.
		Comparative data indicated improvement in compliance from 66% in the previous review period.
F.1.a.viii	Properly documented.	Admission Psychiatric Assessment: 8.a, 8.b and 8.c: 99% Integrated Assessment (Psychiatry): 7 and 10: 94% Monthly PPN: 2.b, 3 and 5.a-5.d: 98% PSH did not provide comparative data.
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.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least 20% samples. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 17% of individuals who have been hospitalized for 90 or more days during the review period (May-October 2009). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 22% and 23% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

Monthly PPN		
6.	*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.*	97%

Comparative data indicated improvement in compliance from 74% in the previous review period.

Nursing Services PRN		
1.	*Safe administration of PRN medication.*	98%
2.	*Documentation of the circumstances requiring PRN medication.*	91%
3.	*Documentation of the individual's response to PRN medication.*	83%

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

	Previous period	Current period
Mean compliance rate		
1.	94%	98%
2.	62%	91%
3.	44%	83%
Compliance rate in last month of period		
3.	54%	86%

Nursing Services Stat		
1.	*Safe administration of Stat medication.*	97%
2.	*Documentation of the circumstances requiring Stat medication.*	96%

3.	*Documentation of the individual's response to Stat medication.*	83%

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

	Previous period	Current period
Mean compliance rate		
1.	95%	97%
2.	80%	96%
3.	52%	83%
Compliance rate in last month of period		
3.	68%	91%

Recommendation 3, June 2009:
Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Findings:
PSH reported that unless PRN/Stat usage causes a trigger (in which case it is reviewed by the ETRC), Senior Psychiatrists had not been reviewing nursing documentation. The facility indicated that it intends to include these indicators for the psychiatrists' review during the next review period.

Other findings:
Same as in D.1.f.

Compliance:
Partial.

		Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1 and 3, June 2009:** • Monitor this requirement using the current DMH tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** During this review period, this monitor reviewed the revised DMH Monthly PPN Audit Form and found it to be sufficient to provide self-assessment data relative to EP requirements while simplifying and consolidating the monitoring processes for the use of benzodiazepines, anticholinergics and polypharmacy. PSH used the standardized DMH Monthly PPN Audit Form to assess compliance (May-October 2009). The sample sizes were 15% (5.d.i), 9% (5.d.ii) and 13% (5.d.iii). The samples were based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates: **PPN** 5.d. *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:*

5.d.i.	*Benzodiazepines.*	91%
5.d.ii.	*Anticholinergics.*	91%
5.d.iii.	*Polypharmacy.*	90%

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

	Previous period	Current period
Mean compliance rate		
5.d.i.	36%	91%
5.d.ii	52%	91%
5.d.iii	55%	90%

Additionally, PSH reported the following comparative data:

	Indicators	Previous Period	Current Period
1.	*Total number of individuals receiving benzodiazepines for 60 days or more*	92	94
2.	*Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more*	61	59
3.	*Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more*	54	50
4.	*Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual*	11	13

	functioning)		
5.	*Total number receiving anticholinergics for 60 days or more*	141	129
6.	*Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above*	24	21
7.	*Total number with intra-class polypharmacy*	401	387
8.	*Total number with inter-class polypharmacy*	220	184

Recommendations 2, June 2009:
Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Findings:
The following summarizes the facility's analysis and corrective actions:

1. PSH indicated that it added a second psychopharmacology consultant during the review period.
2. Consultation requests sent to the psychopharmacology consultants increased by 25%. Consultations often included reviews of polypharmacy and high-risk medications.
3. PSH reported that frequency of high-risk medication use is in alignment with other California state hospitals.
4. Dr. Stephen Stahl provided a consultation to the facility in which he initiated the development of a collaborative psychopharmacology fellowship between PSH and the Neuroscience Education Institute.
5. Unit-matched analysis of physicians' prescribing patterns showed the most variability in benzodiazepine use. PSH completed a DUE to follow up on this finding.

		Recommendation 4, June 2009: Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. **Findings:** The following summarizes the facility's analysis and corrective actions: 1. PSH developed and implemented the Physician Performance Analysis. 2. Analysis of the Physician Performance Analysis identified 15 psychiatrists with prescribing practices determined to be of higher risk than unit-matched peers. 3. Senior Psychiatrists followed up with increased mentoring of these staff. 4. The Clinical Review Team reviewed physicians involved in ADRs due to deviation from established guidelines. 5. The second psychopharmacology consultant provided education programs at the Department of Psychiatry, Department of Medicine and Pharmacy and Therapeutics Committee Meetings. **Other findings:** This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following medication uses: 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders and/or elderly individuals; and 3. Various forms of polypharmacy. This monitor also reviewed the charts of20 individuals receiving the above types of medication regimens. There was evidence of significant progress since the last review in the justification of treatment and assessment of the individuals for the risks associated with this practice.

For individuals currently receiving these modalities, there was general evidence that practitioners documented plans to taper off high-risk treatment in favor of lower-risk treatment, as clinically appropriate. The following outlines the reviews:

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AD	Lorazepam	Polysubstance Dependence
JBW	Lorazepam	Polysubstance Dependence, Cognitive Disorder NOS and Moderate Mental Retardation
KF	Lorazepam	Alcohol Abuse (by history) Substance Abuse
PC	Lorazepam	Polysubstance Dependence
RAF	Lorazepam	Polysubstance Dependence
RPJ	Clonazepam	Cognitive Disorder NOS and Alcohol Dependence and Cannabis Dependence
SAV	Clonazepam	Polysubstance Dependence

This review found substantial compliance in three charts (KF, RAF and RPJ), partial compliance in three (JBW, PC and SAV) and noncompliance in one (AD).

Anticholinergic use

Individual	Medication(s)	Diagnosis
DB	Benztropine (discontinued in October 2009)	Borderline Intellectual Functioning

HTS	Benztropine	Borderline Intellectual Functioning, R/O Cognitive Disorder, NOS
JSN	Benztropine	Cognitive Disorder
MR	Diphenhydramine	Dementia, NOS, R/O Vascular Dementia.

Anticholinergic use for elderly individuals (age 65 or above)

Individual	Medication(s)	Diagnosis
HEH	Diphenhydramine	
SSM	Benztropine	

This review found substantial compliance in three charts (DB, HEH and HTS), partial compliance in two (JSN and SSM) and noncompliance in one (MR).

Polypharmacy use

Individual	Medication(s)	Diagnosis
JM	Risperidone, clozapine, clonazepam, benztropine, lamotrigine, zolpidem and trazodone	Polysubstance Dependence
JRB	Haloperidol, quetiapine, clozapine and lamotrigine	
KLA	Clozapine, duloxetine, lamotrigine, olanzapine, divalproex, risperidone and divalproex	
PC	Risperidone, olanzapine, lorazepam and zolpidem	
RD	Quetiapine, lithium, venlafaxine and trazodone	

SFA	Haloperidol, lithium, clonazepam and diphenhydramine	
TS	Clozapine, clonazepam, zolpidem, levetiracetam and lamotrigine	

This review found substantial compliance in four charts (KLA, RD, SFA and TS), partial compliance in two (JM and JRB) and noncompliance in one (PC).

Compliance:
Partial; improved compared to the last review.

Current recommendations:
1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
2. Continue to provide comparative data regarding the following:
   a) Total number of individuals receiving benzodiazepines for 60 days or more;
   b) Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more;
   c) Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more;
   d) Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning);
   e) Total number receiving anticholinergics for 60 days or more;
   f) Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above;
   g) Total number receiving intra-class polypharmacy; and

<table>
<tr><td></td><td></td><td>h) Total number receiving inter-class polypharmacy</td></tr>
<tr><td>F.1.d</td><td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td><td>

Current findings on previous recommendations:

Recommendations 1, 2 and 3, June 2009:

- Monitor this requirement using the DMH New Generation Antipsychotic Medications Auditing Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.

Findings:
During this review period, the DMH has simplified the current self-auditing tool to focus the monitoring process on areas in need of improvement.

Using the DMH Monthly PPN Auditing Form, PSH assessed its compliance based on an average sample of 17% of individuals receiving these medications during the review period (May-October 2009):

<table>
<tr><td></td><td>If prescribed any medication except aripiprazole, justification is documented in the PPN for individuals with diagnosis of:</td><td></td></tr>
<tr><td>5.</td><td>Dyslipidemia</td><td>92%</td></tr>
<tr><td>6.</td><td>Diabetes Mellitus</td><td>92%</td></tr>
<tr><td>7.</td><td>Obesity</td><td>92%</td></tr>
</table>

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

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

	Previous period	Current period
Mean compliance rate		
5.	53%	92%
6.	65%	92%
7.	52%	92%

Recommendation 4, June 2009:
Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:
Same as F.1.c, Recommendation 4 above.

Other findings:
This monitor reviewed the charts of 12 individuals receiving new-generation antipsychotic agents, most of whom were diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
AS	Quetiapine	Diabetes Mellitus and Obesity
CDA	Risperidone	Dyslipidemia, Hyperprolactinemia and Metabolic Syndrome
EG	Olanzapine	Diabetes Mellitus and Obesity
FS	Clozapine	Diabetes Mellitus
GL	Clozapine	Diabetes Mellitus and Hyperlipidemia
GT	Paliperidone	None documented
JL	Olanzapine	Diabetes Mellitus, Obesity, Hyper-triglyceridemia, Metabolic Syndrome and Hypertension
JLB	Olanzapine	Diabetes Mellitus and Obesity

KJF	Olanzapine, risperidone, quetiapine (and haloperidol)	Diabetes Mellitus and Obesity
MRB	Risperidone	Diabetes Mellitus
PH	Clozapine	Pure Hypercholesterolemia
RW	Olanzapine	Diabetes Mellitus and Hyperlipidemia

In general, the review found evidence of adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. This monitor found only a few process deficiencies as outlined below:

1. The psychiatric progress notes did not address results of a psychopharmacology consultation nor include accurate listing of current high-risk antipsychotic medications that were prescribed for an individual suffering from Diabetes Mellitus, Hyperlipidemia and Obesity and receiving high-risk treatment with polypharmacy (KJF).
2. A psychiatric progress note indicated that an individual who was receiving high-risk treatment with clozapine had a lipid profile within normal limits. However, the corresponding laboratory records showed a new finding of significant elevation of serum triglycerides during the same time period of the psychiatric review (FS). The psychiatric management of this individual did not account for this adverse event.
3. The psychiatric progress notes did not adequately address the clinical status of a female individual who was receiving high-risk treatment with risperidone (CDA) and diagnosed with hyperprolactinemia.

Compliance:
Substantial.

Current recommendations:
1. Continue to monitor this requirement.

		2. Ensure documentation of adequate clinical monitoring of individuals at risk for endocrine dysfunction.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on a 100% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** During this review period, the DMH modified its TD Auditing Form in order to streamline the auditing indicators. Using the new DMH Movement Disorders Auditing Form, PSH assessed its compliance based on average samples ranging from 11% to 57% of individuals relevant to each indicator during the review period (May-October 2009):

1.	*A baseline assessment shall be performed for each individual at admission.*	92%
2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.*	98%
3.	*Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.*	98%
4.	*All individuals with movement disorders are appropriately treated.*	100%
5.	*A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with*	100%

	complicated movement disorders.	
6.	*Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).*	98%
7.	*The Movement Disorder is included in Focus 6 of the WRP.*	98%
8.	*The WRP reflects objectives and interventions for the Movement Disorder.*	98%

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

	Previous period	Current period
Mean compliance rate		
1.	97%	92%
2.	57%	98%
3.	41%	98%
4.	not = to previous tool	100%
5.	77%	100%
6.	48%	98%
7.	56%	98%
8.	55%	98%

Other findings:
The facility's database identified 40 individuals as meeting one or more of the following three criteria: current diagnosis of TD, history of TD or current abnormal AIMS score. At the time of the last review, the database identified 89 individuals in these categories. The facility attributed this decrease to further refinements in the criterion of identification regarding the timeframes of history of TD. During the review period, a psychiatrist assumed oversight of this task.

		This monitor reviewed the charts of six individuals (ARB, AW, CTD, FS, GMM and SES) currently diagnosed with Tardive Dyskinesia and found progress since the last review. The following are examples: 1. Admission AIMS tests were completed on all individuals who were admitted during the past year. 2. Quarterly AIMs monitoring was completed in most charts reviewed (ARB, AW, FS, GMM and SES). 3. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed (ARB, CTD, FS, GMM and SES). 4. The psychiatric progress notes contained evidence of tracking of the status of TD in all charts reviewed. 5. The objectives related to TD utilized appropriate learning outcomes for some individuals (FS and SES). 6. Some charts documented attempts to use safer treatment alternatives for the individuals, including clozapine (ARB and FS). 7. None of the individuals diagnosed with TD received unnecessary long-term treatment with anticholinergic agents during this review period. The review found the following deficiencies: 1. Some WRPs included objectives and interventions that were inappropriate (ARB), unattainable (FS and GMM) or not properly matched to the individual's needs (CTD). 2. The WRP did not include focus, objectives or interventions to address the individual's condition in a few charts 3. The AIMS tests were not completed quarterly as required by the facility's policy in some charts (CTD). **Compliance:** Partial; improved compared to the last review.

		Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Increase reporting of ADRs. • Continue review and analysis of ADRs and present summary of aggregated data to address the following: a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). **Findings:** The following table summarizes the facility's data:

	Previous period	Current period
Total ADRs	107	147
Classification of Probability of ADRs		
Doubtful	28	33

Possible	42	58
Probable	31	47
Definite	6	9
Classification of Severity of ADRS		
Mild	63	79
Moderate	41	61
Severe	3	7

Of the seven severe ADRs, none resulted in permanent sequelae to the individual involved. PSH conducted intensive case analyses (ICAs) on the seven severe ADRs. The ICAs employed appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate.

Recommendation 3, June 2009:
Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.

Findings:
The following summarizes PSH's corrective actions during the review period:

1. Completed a DUE on oxcarbazepine indications and monitoring;
2. Reviewed monitoring requirements for individuals prescribed valproic acid with baseline hepatic dysfunction;
3. NMS case review by the P&T Committee and Department of Psychiatry;
4. Provided training on lithium monitoring; and
5. Initiation of revision of guidelines for the monitoring of constipation.

Compliance:
Partial; improved compared to the last review. Substantial compliance is contingent on increased reporting of ADRs. [A compliance rating of

		Substantial was mistakenly noted in the previous report; it should have been Partial.] **Current recommendations**: 1. Increase reporting of ADRs. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: a. The number of ADRs reported each month during the current review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). 3. Continue to provide analysis of patterns and trends, with corrective/educational actions related to ADRs.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Conduct further DUEs based on a specified calendar and ensure that all DUEs include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/ educational activities based on the review. **Findings:** PSH reported that it completed DUEs on oxcarbazepine indications and monitoring, treatment of individuals on risperidone with hyperprolactin-

		emia, oxcarbazepine follow-up and physician prescribing of anticholinergics, benzodiazepines, and polypharmacy. **Other findings:** Review by this monitor found that the facility's DUEs employed appropriate methodologies and comported with generally accepted standards in this process. **Compliance:** Substantial. **Current recommendation**: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Present and ensure validity of data to address the following: 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 by category (e.g. prescription, administration, documentation, etc.); d. Number of variances 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.

Findings:
PSH reported the following data regarding MVRs. The facility did not provide comparative data:

Number of Medication Variances	Current Period
Prescribing	18
Transcribing	93
Ordering/Procurement	125
Dispensing	153
Administration	238
Drug Security	171
Documentation	113
Total variances	911

PSH reported that discrepancies between the MVR data represented here and MVR data in the Key Indicator report is related to the timing of data collection cut-offs for each report.

Breakdown Points	Current Period
Total Critical Breakdown Points	648
Potential MVRs	360
Actual MVRs	288
# Prescribing	18
# Transcribing	89
# Ordering/Procurement	106
# Dispensing	131
# Administration	119
# Drug Security	124
# Documentation	61
Outcome A	353
Outcome B	30

Outcome C	261
Outcome D	4
Outcome E	0
Outcome F	0
Outcome G	0
Outcome H	0
Outcome I	0

Recommendation 2, June 2009:
Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.

Findings:
PSH reported that it completed four ICAs with corrective actions related to medication variances. The following is a summary of the corrective actions that addressed the four incidents:

1. In-serviced night nurses on checking for new orders;
2. Increased review of transcription; and
3. Efforts to decrease wait time for medication.

Other findings:
Reviews by this monitor found that the facility's data were internally consistent and adequately covered the range of categories and critical breakdown points. The facility also conducted adequate analyses and corrective actions related to four variances events during this review period. However, all analyses were triggered by actual variances. In order to achieve substantial compliance, the facility should assess trends and patterns and institute corrective actions related to both actual and potential variances based on regular, systemic and timely reviews of the data.

		Compliance: Partial; improved compared to the last review. **Current recommendations**: 1. Continue to present data to address the following: 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. 2. Continue to provide analysis of patterns and trends, with corrective/educational actions related to MVRs.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial; improved compared to the last review.

		Current recommendations: Same as in F.1.a through F.1.h.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Other findings:** PSH reported the following modifications to practice during the review period: 1. The second psychopharmacology consultant began chairing the P&T committee. 2. The Chair of the P&T committee began completing ICAs.

		3. The Acting Assistant Medical Director began chairing the Clinical Review Team and selecting the DUE topics. 4. The Pharmacy Department began reporting to the Acting Assistant Medical Director, which is intended to increase integration of pharmacy activities with clinical practice. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial; improved compared to the last review.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendation:**

		Recommendation, June 2009: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Current recommendation**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive	**Current findings on previous recommendation:**

	impairments, regardless of duration of treatment; and	**Recommendation, September 2008:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with	**Current findings on previous recommendation:**

	substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Recommendation, June 2009:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: Same as in C.2.o and F.1.c.
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 October be provided either onsite or through attendance at conferences elsewhere.	This requirement applies exclusively to Metropolitan State Hospital.

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** <u>Interviewed</u>: 1. Gari-Lyn Richardson, Director, Standards Compliance 2. George Christison, MD, Acting Medical Director 3. Hope Marriott, LCSW, Social Worker-WRP Master Trainer 4. Melanie Byde, PhD, Psychologist, Mall Director 5. Allison Pate, PhD, Senior Supervising Psychologist 6. David Haimson, PhD, Chief of Psychology 7. Susan Valesquez, PhD, PSSC Coordinator 8. Helga Thordarson, PhD, Senior Supervising Psychologist <u>Reviewed</u>: 1. The charts of the following 36 individuals: AFF, ALT, AR, AS, AWM, DB, DK, DLR, FM, FS, GJ, GLG, GPJ, GS, HB, IG, JA, JEB, JLB, JP, JPL, JRB, KA, LAR, MB, MDD, MG, MH, MLB, OC, RAF, RAS, RR, SM, TG and YM 2. Behavioral guidelines developed and implemented in the last six months 3. By Choice Implementation Monitoring Form 4. By Choice Training Documents 5. Completed By Choice audits 6. List of individuals identified as needing neuropsychological services 7. List of individuals reviewed by the Psychology Specialized Services Committee 8. List of individuals receiving DCAT services 9. List of individuals with PBS Plans 10. List of individuals who have utilized higher than threshold levels of seclusion, restraints, and psychiatric PRN or Stat medication for maladaptive behaviors in the last six months 11. Structural and functional assessments completed in the last six months

		12. PSSC meeting schedules and attendance logs 13. PSSC reports 14. Neuropsychological assessments completed in the last six months <u>Observed</u>: 1. WRPC (Program V, unit N-27) for monthly review of JLO 2. WRPC (Program VI, unit EB-02) for 7-day review of ET 3. WRPC (Program VI, unit EB-09) for monthly review of ED 4. Mall Group: Cognitive Remediation 5. Mall Group: Cancer Support 6. Mall Group: Music Appreciation 7. Mall Group: Understanding the 1026 Process 8. Mall Group: Enhancing Self Control-Anger Management 9. Mall Group: Understanding MDO Process 10. Mall Group: Discharge Planning 11. Mall Group: Recovery Inspired Skills Enhancement (RISE) 12. Mall Group: Psychotherapy-Social Skills-ASL (Hearing Impaired)
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure the required number of PBS teams to meet the 1:300 ratio. **Findings:** PSH still is short of the number of PBS teams to meet the 1:300 ratio. The facility's census dictates that five teams are needed, and PSH has four teams, all of which currently lack a behavior/data analyst. According to the Chief of Psychology these positions have not been allocated, but the hiring of one data analyst is being attempted. The fifth team is at the beginning stage with the hiring of a psychologist, and the hiring of the other team members is in process.

		Compliance: Partial. **Current recommendation**: Ensure the required number of PBS teams to meet the 1:300 ratio.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to train all relevant staff on all aspects of PBS training. **Findings:** PSH did not present information regarding general staff training on PBS during the review period. A review of 13 PBS plans and Behavior Guidelines (AFF, AR, AS, DK, FS, GJ, HB, JA, JLB, JP, MG, MLB and TG) found that staff responsible for implementing the PBS plans and behavior guidelines had been trained for all 13 intervention plans. Fidelity data had been collected on all 13 plans and staff training had been conducted based on the fidelity data. The quality of the PBS plans developed and implemented during this review period has improved significantly since the last review period. Seven of the eight PBS plans reviewed showed a positive outcome in addressing the challenging behaviors targeted for reduction. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system,	**Current findings on previous recommendations:**

referred to as "By Choice" that encompasses self-determination and choice by the individuals served.

Recommendation 1, June 2009:
Report By Choice point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.

Findings:
See F.2.c.xii.

Recommendation 2, June 2009:
Ensure that the program receives adequate resources.

Findings:
The By Choice system still needs two computers for two incentive stores to implement the By Choice WaRMSS Module.

Recommendation 3, June 2009:
Train all staff in correctly implementing the By Choice program.

Findings:
The following table summarizes general staff training on By Choice during the review period (May-October 2009):

	Mean
Number of staff eligible for training	2077
Number of staff trained	1952
Percentage of eligible staff trained	95%

The following table summarizes clinical staff training on By Choice during the review period (May-October 2009):

	Mean
Number of staff eligible for training	1862
Number of staff trained	1378
Percentage of eligible staff trained	74%

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, PSH assessed its compliance based on a mean sample of sample of 2% of the unit Nursing staff:

1.	*Staff correctly states the current point cycle.*	100%
2.	*Staff correctly states the procedures for assigning participation levels on point cards.*	100%
3.	*Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.*	100%
4.	*Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.*	100%
5.	*Staff locates the By Choice Manual.*	100%
6.	*Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.*	100%
7.	*Staff correctly states where the point reallocation documentation is located.*	100%
8.	*Staff can locate a current By Choice Manual in their work site.*	100%
9.	*There is a system to orient new individuals to the By Choice Incentive System.*	100%
10.	*Staff is able to state their unit's incentive store hours of operation.*	100%
11.	*Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1-5, 9 and 10 and improvement in the remaining items:

	Previous period	Current period
Mean compliance rate		
6.	83%	100%
7.	85%	100%
8.	84%	100%
11.	82%	100%

Other findings:
Using the Fidelity of Implementation by Individuals Form, PSH also assessed fidelity of By Choice implementation based on a mean sample of 4% of individuals in the facility:

1.	*The individual understands the goal of the By Choice system.*	78%
2.	*Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.*	93%
3.	*The individual can state, to the best of his/her ability how they earn points throughout the day.*	90%
4.	*The individual can state how they spend their By Choice points and what types of items they can purchase with their points.*	95%
5.	*The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.*	78%
6.	*Individual can indicate how many points he or she may earn each day.*	79%
7.	*Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.*	51%
8.	*Individual can correctly state the procedure for reallocating their By Choice points.*	55%
9.	*The individual is able to state their unit or program's*	88%

	incentive store hours of operation.	
10.	*Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.*	22%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2-4 and mixed changes in the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	75%	78%
5.	75%	78%
6.	78%	79%
7.	52%	51%
8.	58%	55%
9.	88%	88%
10.	31%	22%
Compliance rate in last month of period		
1.	67%	64%
5.	75%	78%
6.	80%	79%
7.	61%	51%
8.	57%	55%
9.	88%	88%
10.	31%	22%

Using the By Choice Monitoring Form: Satisfaction Check, PSH surveyed a mean sample of 12% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

		Previous period	Current period
1.	*By Choice motivates me to participate in treatment*	70%	76%
2.	*The point system motivates me to improve my behavior*	63%	75%
3.	*The point system motivates me to learn new skills*	63%	66%
4.	*When staff completes my Point Card, they explain what I did to earn an FP, MP or NP*	54%	55%
5.	*My WRPT discusses By Choice with me during my WRPC*	57%	64%
6.	*During my WRPC I have input into how my points are allocated on my Point Card*	59%	67%
7.	*My WRPT uses By Choice to help me improve my behavior*	63%	67%
8.	*My WRPT uses By Choice to help me learn new skills*	65%	67%
9.	*My unit staff uses By Choice to help me improve my behavior*	64%	66%
10.	*My unit staff uses By Choice to help me learn new skills*	59%	63%
11.	*I like the selection of ITEMS at the Incentive Store*	73%	75%
12.	*I like the selection of ACTIVITIES at the Incentive Store*	61%	62%
13.	*I like the prices of the ITEMS at the Incentive Store*	55%	58%
14.	*I like the price of the ACTIVITIES at the Incentive Store*	57%	62%

15.	*Overall, I am satisfied with the By Choice Incentive system*	74%	76%

Using the Fidelity of Implementation by the By Choice Staff Form, PSH further assessed fidelity of implementation based on an average sample of 60% of By Choice staff:

1.	*The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.*	100%
2.	*The incentive store includes a delivery system that ensures that all individuals have access to incentive items.*	100%
3.	*The incentive store is well stocked with appropriate items from the incentive list.*	98%
4.	*The incentive store has an inventory control system.*	100%
5.	*The incentive store has a system to track and remove outdated food items.*	100%
6.	*There is a By Choice Manual located in the incentive store.*	100%
7.	*The incentive store staff has completed incentive store training.*	100%
8.	*The individuals bring their point cards to the store to make a purchase.*	100%
9.	*There is a By Choice Calorie Activity Guide located in the incentive store.*	98%
10.	*There is an Alert list in the incentive store for staff reference.*	97%
11.	*There is an Alert List in the incentive store, for use by store staff.*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2 and 4-8 and mixed

<table>
<tr>
<td></td>
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<td>changes in the remaining items:
<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>76%</td><td>100%</td></tr>
<tr><td>3.</td><td>80%</td><td>98%</td></tr>
<tr><td>9.</td><td>36%</td><td>98%</td></tr>
<tr><td>10.</td><td>25%</td><td>97%</td></tr>
<tr><td>11.</td><td>42%</td><td>100%</td></tr>
</table>
Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), PSH assessed fidelity of implementation based on average samples of 2% of the level of care staff, 4% of the individuals, and 60% of the By Choice program staff. The table below is a summary of the data:
<table>
<tr><td>Level of Care Staff</td><td>100%</td></tr>
<tr><td>Individuals</td><td>73%</td></tr>
<tr><td>By Choice Program Staff</td><td>99%</td></tr>
</table>
Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.</td>
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<tr>
<td>F.2.b</td>
<td>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.</td>
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</table>

		Findings: The Chief of Psychology continues to have all clinical and administrative authority for the PBS teams and the By Choice incentive program. The Chief of Psychology has allowed the Coordinator of Psychology Specialty Services to share some of the responsibility. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Substantial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that behavioral assessments include structural and functional assessments and, as necessary, functional analysis. **Findings:** Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009): 1. *The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.* 100% 2. *The WRPT and the PSST determined the goals of the intervention.* 100% 3. *At least one specific behavior of concern was defined in clear, observable and measurable terms* 100%

4.	*Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).*	100%
5.	*Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.*	100%
6.	*A functional assessment interview was completed for the structural assessment.*	100%
7.	*Direct observations of the challenging behavior were undertaken, as applicable*	100%
8.	*Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]*	100%
9.	*A functional assessment rating scale was completed.*	100%
10.	*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.]*	100%
11.	*Patterns of challenging behavior were recognized based on the structural and functional assessments.*	94%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 1-9 and improvement in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
10.	44%	100%
11.	77%	94%

A review of ten PBS plans (AFF, AR, DLR, GLG, JA, JEB, KA, LAR, RAS

<table>
<tr><td></td><td></td><td>and TG) found that all ten plans had been developed and implemented based on data derived from structural and functional assessments.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.ii</td><td>hypotheses of the maladaptive behavior are based on structural and functional assessments;</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Ensure that proper assessments are conducted prior to developing and implementing intervention plans.
• Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009):

<table>
<tr><td>12.</td><td>Hypotheses of the maladaptive behavior are based on structural and functional assessments</td><td>100%</td></tr>
</table>

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

A review of 10 PBS plans (AFF, AR, DLR, GLG, JA, JEB, KA, LAR, RAS and TG) found that the hypotheses for these 10 plans had been developed from the structural and functional assessments conducted, and the hypotheses were aligned with the functional assessment data.

Current recommendation:
Continue to monitor this requirement.</td></tr>
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<tr>
<td>F.2.c.iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure documentation of previous behavioral interventions and their effects.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009):

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<tr>
<td>7.</td>
<td>There is documentation of previous behavioral interventions and their effects</td>
<td>100%</td>
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Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period.

A review of ten structural/functional assessments (AFF, AR, DLR, GLG, JA, JEB, KA, LAR, RAS and TG) found that all 10 had documented the previous behavioral interventions and their effects.

Current recommendation:
Continue to monitor this requirement.

</td>
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<tr>
<td>F.2.c.iv</td>
<td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the

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<td>review period (May-October 2009):

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<tr><td>17.</td><td>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</td><td>98%</td></tr>
</table>

Comparative data indicated improvement in compliance from 73% in the previous review period.

A review of ten PBS plans (AFF, AR, DLR, GLG, JA, JEB, KA, LAR, RAS and TG) found that all ten behavioral interventions were based on a positive behavioral support model without any use of aversive or punishment contingencies.

Current recommendations:
Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.2.c.v</td>
<td>behavioral interventions are consistently implemented across all settings, including school settings;</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans.
• Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (May-October 2009):

<table>
<tr><td>9.</td><td>Behavioral interventions are consistently implemented</td><td>100%</td></tr>
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		across all settings, including school settings

Comparative data indicated improvement in compliance from 73% in the previous review period.

This monitor's review of fidelity/integrity check for ten PBS plans and behavior guidelines (AR, DK, FS, GJ, HB, JA, JLB, JPL, MLB and TG) found that PSH had conducted fidelity checks on all ten PBS plans and PBS-driven behavior guidelines. PBS fidelity of implementation data had been reviewed and feedback/retraining had been conducted where necessary (for example, JPL). Many of the PBS outcome data graphs included the graphing of plan implementation fidelity data.

Current recommendation:
Continue to monitor this requirement.

F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of individuals who have triggered one or more of the thresholds during this review period (May-October 2009):

10.	*Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control*	100%

Comparative data indicated maintenance of compliance at or greater than

90% from the previous review period.

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

DMH Psychology Services Monitoring Form							
2008/2009	May	Jun	Jul	Aug	Sep	Oct	Mean
Restraint	20	8	10	3	8	9	10
%C	100	100	100	100	100	100	100
Seclusion	1	0	0	0	0	0	1
%C	100	-	-	-	-	-	100
1:1	107	107	33	58	60	65	72
%C	100	100	100	100	100	100	100
Aggression to others	23	5	5	12	11	11	
%C	100	100	100	100	100	100	100
Aggression to self	2	0	3	0	6	4	3
%C	100	100	100	100	100	100	100

As the table above indicates, the Psychology Specialty Services Committee has been tracking and monitoring all triggers during this review period. The committee discussed each referral and made a determination if the referral was suitable for behavioral services. Cases determined to be appropriate for behavioral services are referred to the PBS/DCAT teams for assessments and intervention plans. According to the PSSC Coordinator, 305 reviews resulted in 126 assessments and/or behavioral interventions.

Current recommendation:
Continue to monitor this requirement.

<table>
<tr>
<td>F.2.c.vii</td>
<td>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that treatment modalities are integrated to better serve individuals, as indicated.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009):

<table>
<tr>
<td>11.</td>
<td>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</td>
<td>100%</td>
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</table>

Comparative data indicated improvement in compliance from 29% in the previous review period.

Eleven PBS plans were reviewed. Psychiatry and/or Psychology progress notes showing interdisciplinary collaboration were evidenced for all 11 PBS assessments and intervention plans (DK, FS, GPJ, JEB, JLB, JPL, JRB, LAR, MB, MH and RAF). Interdisciplinary collaboration had occurred during WRPT meetings and the PSSC/ETRC meetings. The strong collaboration between Psychiatry and Psychology and the meaningful assessments and interventions arising out of these collaborations were well documented in JPL's FRC Case Review and Recommendations.

Current recommendation:
Continue to monitor this requirement.

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<tr>
<td>F.2.c.viii</td>
<td>all positive behavior support plans are specified in the objectives and interventions</td>
<td>

Current findings on previous recommendation:

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<td>sections of the individual's Wellness and Recovery Plan;</td>
<td>
Recommendation, June 2009:
Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009):

<table>
<tr><td>19.</td><td>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</td><td>100%</td></tr>
</table>

Comparative data indicated improvement in compliance from 44% in the previous review period.

A review of the records of 18 individuals with PBS plans or PBS assessments (AFF, AR, DK, DLR, FS, GLG, GPJ, JA, JEB, JLB, JRB, KA, LAR, MB, MH, RAF, RAS and TG) found that all 18 of the WRPs in the charts properly discussed the PBS plans in the Present Status section, with objectives and interventions in the relevant sections in the WRP.

Current recommendation:
Continue to monitor this requirement.
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<tr>
<td>F.2.c.ix</td>
<td>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Collect objective information to evaluate the effectiveness of the PBS plans and behavior guidelines, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change.
• Continue to track and monitor that PBS plans and behavior guidelines
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are updated using outcome data in the individual's present status section of the WRP.

Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (May-October 2009):

<table>
<tr><td>24.</td><td>The WRPT psychologist discusses the individual's monthly outcome data during the WRPC.</td><td>100%</td></tr>
</table>

Comparative data indicated improvement in compliance from 57% in the previous review period.

A review of the records of 19 individuals with PBS plans and behavior guidelines (AFF, AR, DK, DLR, FS, GLG, GPJ, JA, JEB, JLB, JRB, KA, LAR, MB, MH, OC, RAF, RAS, TG) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in all cases. The outcome data for PBS plans were graphed and analyzed to determine intervention effectiveness.

Current recommendation:
Continue to monitor this requirement.
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<tr>
<td>F.2.c.x</td>
<td>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Provide competency-based training on behavioral interventions to all staff.
• Ensure that behavioral interventions are fully implemented once the plans are "tested" in the unit and the unit staff is trained.
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Findings:
Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of behavior guidelines developed during the review period (May-October 2009):

<table>
<tr><td>20.</td><td>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the BG plan.</td><td>100%</td></tr>
</table>

Comparative data indicated improvement in compliance from 64% in the previous review period.

Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (May-October 2009):

<table>
<tr><td>21.</td><td>The PSST ensures that the individual's enduring staff (e.g. unit and Mall) is trained on the PBS plan.</td><td>100%</td></tr>
</table>

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

A review of eight PBS plans and related assessment and staff training data (DK, FS, GJ, HB, JA, JP, MLB and TG) found that the staff responsible for implementing the PBS plans had been trained in all eight cases.

Current recommendation:
Continue to monitor this requirement.
</td>
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<tr>
<td>F.2.c.xi</td>
<td>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</td>
<td>Current findings on previous recommendation:</td>
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Recommendation, June 2009:
Continue current practice.

Findings:
According to the Chief of Psychology and the PBS team members, the PBS team members have as their primary responsibility the provision of behavioral interventions.

<table>
<tr><td>15.a.i</td><td>All PBS team members are primarily responsible for the provision of behavioral interventions</td><td>16/16</td></tr>
<tr><td>15.a.ii</td><td>All PBS team members facilitate one PSR Mall group weekly during their assigned work hours</td><td>16/16</td></tr>
<tr><td>15.b</td><td>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</td><td>16/16</td></tr>
</table>

Current recommendation:
Continue to monitor this requirement.
</td>
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<tr>
<td>F.2.c.xii</td>
<td>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, June 2009:
Ensure that By Choice point allocation is updated monthly in the individual's WRP.

Findings:
Using the By Choice Chart Audit Form, PSH assessed its compliance based on an average sample of 11% of the individuals at PSH each month during the review period (May-October 2009):

<table>
<tr><td>16.</td><td>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</td><td>97%</td></tr>
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		Comparative data indicated improvement in compliance from 69% in the previous review period. A review of the records of 14 individuals found that 13 of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (AFF, ALT, AWM, FM, GLG, GS, IG, JA, KA, MDD, RR, SM and YM). In the remaining one WRP (DB) the By Choice point allocation was not properly documented or was not updated. The quality of the documentation has improved. Most of the documentation was comprehensive, with data and analysis showing areas of participation and points earned. This monitor observed three WRPCs. The teams used graphing data to show and explain the individual's By Choice point status and in each case asked the individual if he/she would like to make changes to the point allocation. **Current recommendation**: Continue to monitor this requirement.
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	**Current findings on previous recommendations:** **Recommendations 1-5, June 2009:** • Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. • Ensure that all individuals with cognitive challenges are assessed by the DCAT. • Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level. • Ensure that DCAT members' primary responsibility is consistent with

	interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	the EP. • Ensure that DCAT members receive appropriate training. **Findings:** PSH has one Developmental and Cognitive Assessment Team (DCAT). The DCAT lacks a Nursing member and a Behavior/Data analyst. Documentation review found that the DCAT conducts cognitive assessments and provides support to the Mall groups, the discharge planning process, and the cognitive rehabilitation Mall group program, and acts as a liaison with the Regional Center. The DCAT has worked with 49 individuals during this review period. The DCAT continues to work closely with the PSB teams and attends all training sessions conducted for and by the PBS teams. According to the Chief of Psychology, all DCAT members have DCAT duties as their primary responsibility, consistent with EP requirements. **Compliance:** Partial. **Current recommendations**: 1. Ensure full staffing of the DCAT. 2. Provide data confirming that the DCAT is providing services to all individuals in need of its services.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive	**Current findings on previous recommendation:** **Recommendation, June 2009:** Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly. **Findings:** The PSSC/ETRC has held over 90% of its scheduled meetings during this review period (May-October, 2009). A review of a sample of the

	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.	attendance sheets found that attendance at these meetings was high (>90%). The PSSC now reviews all triggers, including seclusion, restraint, 1:1 and aggression with and without injury to self and others. The PSSC has reviewed 129 case referrals during this review period and triaged them for PBS, DCAT and/or Neuropsychology assessments/services. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. • Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. • Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion. **Findings:** Neuropsychology referrals are being made by psychologists, psychiatrists, the Risk Management System, and WRPT members. There were 80 neuropsychology referrals during this review period. The Neuropsychology Service has established trigger criteria to prioritize referrals and continues to train relevant staff, especially the newly hired psychiatrists, on making appropriate referrals. To further refine the process of making neuropsychology referrals, senior psychologists will work at the WRPT levels to increase awareness

of neuropsychology referrals and to continue to train psychologists and psychiatrists.

Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of referrals received each month during the review period (May-October 2009):

		May	Jun	July	Aug	Sep	Oct	Mean
18.a.i	*Number of neuro-psychological assessments due for completion in the review month*	13	26	17	22	13	13	173
18.a.ii	*Of those in 18.a.i, number completed*	5	9	7	6	2	2	5.2
18.a.iii	*Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period*							52 days

The Neuropsychology Service completed a greater number of assessments per month (5.2 in this period compared to 3.3 in the previous period) and reduced the time taken to complete assessments from 91 to 52 days. According to the facility's data 82.5% of the assessments were completed within 30 days.

The Neuropsychology Service had to work under staffing constraints during this review period due to one staff being on maternity leave since July 2009 and another staff being on paternity leave.

The Neuropsychology Wait List reviewed by this monitor showed a total of 51 referrals as of November 16, 2009.

The Neuropsychology Service has 4.5 full-time staff (one staff was hired

		onto the service during this review period. The facility also has a postdoctoral fellow in Neuropsychology. The facility is planning on hiring additional Neuropsychologists to ensure sufficient numbers of Neuropsychologists to serve the needs of the individuals in the facility. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Psychologists at PSH 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. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: Sandra Doerner, RN, Acting Nurse Administrator Reviewed: 1. PSH progress report and data 2. PSH training rosters 3. Medical records for the following 34 individuals: ADA, AG, AKR, BJN, BRA, BRF, BV, CG, DCV, DG, DGA, DLB, DWD, FNM, GB, HC, HE, JD, JPL, KLA, LAB, MEB, MGG, NW, OVM, RC, RDS, RF, RK, RMH, RTH, SAR, SBP and YW Observed: 1. WRPC (Program I, unit EB-04) for monthly review of GS 2. WRPC (Program IV, unit 34) for quarterly review of JE 3. WRPC (Program VI, unit 70) for monthly review of MFO 4. Shift report on unit EB-02 5. Medication Administration on Program I, unit EB-04
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Increase sample size for PRN data to 20%.

Findings:
PSH increased the sample size to 23% for the PRN data.

Recommendation 2, June 2009:
Address problematic issues noted above in the PRN/Stat/Emergency Medication notes.

Findings:
PSH's PRN/Stat data was discussed with the Nurse Executive Council members, one-on-one training was provided under the direction of the Psychiatric Nurse Education Director (PNED) and units with noted poor compliance have been required to fax their PRN/Stat documentation to the CNS Office prior to the conclusion of the shift. The ACNSs are providing real-time instruction to the nursing staff.

Recommendation 3, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 23% mean sample of PRNs administered each month during the review period (May-October 2009):

1.	*Safe administration of PRN medications*	97%

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (May-October 2009):

<table>
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<table>
<tr><td>2.</td><td>Safe administration of Stat medications</td><td>96%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of 225 PRN and Stat orders (170 PRN and 55 Stat) for 23 individuals (AKR, BJN, BRA, BRF, BV, DG, DGA, FNM, GB, HC, JD, JPL, KLA, LAB, MEB, MGG, NW, OVM, RF, RK, RMH, RTH and SAR) found that 221 included specific individual behaviors. In addition, 224 notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were consistently documented.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>F.3.a.ii</td>
<td>documentation of the circumstances requiring PRN and Stat administration of medications;</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
See F.3.a.i.

Findings:
Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 23% mean sample of PRNs administered each month during the review period (May-October 2009):

<table>
<tr><td>3.</td><td>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</td><td>91%</td></tr>
</table>

Comparative data indicated improvement in compliance from 62% in the previous review period.
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<td>A review of 170 incidents of PRN medications for 16 individuals (AKR, BJN, BRA, BRF, DGA, FNM, HC, JD, JPL, LAB, MEB, MGG, RF, RMH, RTH and SAR) found adequate documentation in the IDNs of the circumstances requiring the PRN in 153 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (May-October 2009):

<table>
<tr><td>4.</td><td>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</td><td>96%</td></tr>
</table>

Comparative data indicated improvement in compliance from 80% in the previous review period.

A review of 55 incidents of Stat medications for 14 individuals (AKR, BJN, BRF, BV, DG, GB, JD, JPL, KLA, LAB, NW, OVM, RK and RTH) found adequate documentation in the IDNs of the circumstances requiring the PRN in 50 incidents.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.3.a.iii</td>
<td>documentation of the individual's response to PRN and Stat medication.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
See F.3.a.i.</td>
</tr>
</table>

Findings:
Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 23% mean sample of PRNs administered each month during the review period (May-October 2009):

5.	*There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.*	83%

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

	Previous period	Current period
Mean compliance rate		
5.	44%	83%
Compliance rate in last month of period		
5.	54%	86%

A review of 170 incidents of PRN medications for 16 individuals (AKR, BJN, BRA, BRF, DGA, FNM, HC, JD, JPL, LAB, MEB, MGG, RF, RMH, RTH and SAR) found a timely comprehensive assessment of the individual's response in the IDNs in 149 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (May-October 2009):

6.	*There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.*	83%

Comparative data indicated improvement in compliance since the previous

<table>
<tr>
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<td>review period:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>52%</td><td>83%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>68%</td><td>91%</td></tr>
</table>

A review of 55 incidents of Stat medications for 14 individuals (AKR, BJN, BRF, BV, DG, GB, JD, JPL, KLA, LAB, NW, OVM, RK and RTH) found a timely comprehensive assessment of the individual's response in the IDNs in 46 incidents.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.</td>
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<tr>
<td>F.3.b</td>
<td>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Ensure all appropriate documentation omissions are included and reported as medication variances and clearly stated in the facility policy.
• Continue to monitor this requirement.

Findings:
PSH has modified its review system for medication variances. Training provided in June 2009 focused on the importance of generating MVRs without a punitive response. The SRNs and NCs initiated daily rounds to monitor medication administration and MARs. If incorrect procedures are found, the medication nurse will be instructed to generate an MVR.</td>
</tr>
</table>

In addition, any missing initials identified during spot checks are being communicated to the program NCs, who are to follow up by providing additional Medication Administration observations to reinforce the correct medication administration and documentation protocol. All copies of the unit nightly audits that include MAR and Narcotic Log blanks are reviewed daily by the Unit Supervisors and NCs. Also, CNS/the Clinical Review Committee review all the MVRs and identify trends. Reports are sent to the US/NC to ensure that follow-up is completed at the unit level. PSH clearly has a system for identification and follow-up of MAR and Narcotic Log blanks. Encouraging self-reporting and medication nurse reporting of these issues will require on-going training and reinforcement of the premise that medication variance reporting is crucial to analysis of the functioning of the overall medication administration system rather than a means to assign blame to nursing staff.

Findings:
The facility reported the following data:

Key Indicator Data on MVR Documentation Errors							
	5/09	6/09	7/09	8/09	9/09	10/09	Mean
N	22	21	8	11	21	20	17
n	22	21	8	11	21	20	17
%S	100	100	100	100	100	100	100

N = Number of medication variances for missed signatures, titles and/or initials on MTR reported
n = Number followed up to prevent recurrence of signature variances

Although the number of variances for missed signatures and initials on the MARs and Narcotic Logs were low, indicating an issue of under-reporting,, PSH has a system in place to monitor the MARs and Narcotic Logs routinely.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendation:** **Recommendation, June 2009:** See C.2.l. **Findings:** No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.l for findings addressing WRP interventions. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Staff Familiarity Monitoring Audit, PSH assessed its compliance based on an average sample of 48% of the nursing staff: 8. *Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to* — 100%

		discuss the individual's therapeutic milieu interventions as described in the WRP.
		Comparative data indicated improvement in compliance from 59% in the previous review period. A review of the admissions assessments, integrated assessments and/or WRPs of 40 individuals (AH, ALC, AM, BRH, BVV, CB, CEB, DAA, DH, DOJ, DSG, DUA, GEP, IP, JAN, JB, JE, JEM, KJH, LEB, LL, LR, MAM, MC, MIM, MP, MSB, RCQ, REJ, RIJ, RIS, RK, ROM, SA, SHS, SOL, SUJ, SV, SW and YM) found that there was significant overall improvement in the nursing objectives and interventions, especially in alignment with information contained in the Nursing Admission/Integrated Assessments. This progress needs to continue. In all three WRPCs observed, all team members were very familiar with the individual's WRP goals and interventions. Also, from conversations with unit staff, all were familiar with the goals and interventions of the individuals on their units. **Compliance:** Substantial. **Current recommendation:** Continue to current practice.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals'	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Ensure that the auditors for this requirement (Change of Status) are reviewing for quality and not just completion. • Provide real-time review and mentoring for Change of Status situations.

	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.	**Findings:** PSH has initiated periodic real-time review and mentoring by the ACNS, HSS, and SRN for Change of Status. Audits are conducted within 48 hours to ensure compliance with the requirement to integrate the medical transfer information into the WRP. **Recommendation 3, June 2009:** Continue to mentor staff regarding change of shift report. **Findings:** PSH did not address this recommendation. **Recommendation 4, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Medical Transfer Audit, PSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (May-October 2009): 1. *There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* 94% 7. *The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.* 78% Comparative data indicated maintenance of compliance greater than 90% from the previous review period for item 1 and improvement in compliance for item 7:

	Previous period	Current period
Mean compliance rate		
7.	51%	78%

A review of the records of 11 individuals who were transferred to a community hospital/emergency room (ADA, AG, CG, DCV, DLB, DWD, HE, RC, RDS, SBP and YW) found that the documentation was significantly improved in all cases reviewed. Most of the notes contained appropriate and comprehensive assessments upon the onset of change of status and when the individual returned from the ER/hospital. However, there were a number of RN Change of Status forms that were incomplete. Also, there were two WRPs that did not include an update after hospitalization (HE and RDS). Addressing these areas by the next review should put the facility in substantial compliance with this requirement.

Using the DMH Nursing Services Audit, PSH assessed its compliance based on a 77% sample of Change of Shift Reports observed during in the review months (May-October 2009):

10.	*Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.*	100%

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

Observation of shift report on unit EB-02 found that there was a lack of clinical information provided to the on-coming shift. During the report, a number of individuals were noted to be "maintaining stability" without any mention of progress regarding specific goals. Although the shift report observed was an improvement from previous shift reports, efforts

		addressing this requirement need to continue. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement strategies to increase compliance with this requirement. 2. Continue to monitor this requirement
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Substantial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 42% of level of care nursing staff who are licensed and medication-certified: 11. *Nursing staff are knowledgeable regarding each individual's prescribed medications.* 100% Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period. In medication administration on Program I, Unit EB04 observed by this monitor, the medication nurse demonstrated good interaction with the individuals and provided appropriate medication education. The

<table>
<tr><td></td><td></td><td>individuals on the unit were clearly familiar with the nurse and comfortable discussing medication issues with her. A noon medication was not appropriately initialed and the medication nurse was able to identify this as a medication variance.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.ii</td><td>education is provided to individuals during medication administration;</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 42% of level of care nursing staff who are licensed and medication-certified:

<table><tr><td>12.</td><td>Education is provided to individuals during medication administration.</td><td>100%</td></tr></table>
Comparative data indicated improvement in compliance from 87% in the previous review period. See F.3.f.i for observation findings.

Current recommendation:
Continue to monitor this requirement.</td></tr>
<tr><td>F.3.f.iii</td><td>nursing staff are following the appropriate medication administration protocol; and</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:
• Analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data.
• Continue to monitor this requirement.</td></tr>
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Findings:
PSH's 24-Hour NOC audit form and Nursing Policy have been revised to improve the quality of the documentation. Vital signs, pulse and/or blood pressure not documented on the MTR prior to administration of specific medications requires an MVR. Training regarding these issues has been completed.

Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 42% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>13.</td><td>Nursing Staff are following the appropriate medication administration protocol.</td><td>100%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period. See F.3.f.i for observation findings

Current recommendation:
Continue to monitor this requirement.
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<td>F.3.f.iv</td>
<td>medication administration is documented in accordance with the appropriate medication administration protocol.</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
See F.3.b.

Findings:
Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 42% of level of care nursing staff who are licensed and medication-certified:

<table>
<tr><td>14.</td><td>Medication administration is documented in accordance with the appropriate medication</td><td>100%</td></tr>
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		administration protocol. Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period. PSH was able to produce the MVRs for the blanks found on the MARs and Narcotic Logs during the review period. PSH has put a significant amount of effort into reviewing and analyzing the medication administration system and has implemented a system of regular monitoring as well as spot checks. **Current recommendation**: Continue to monitor this requirement.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** There were no bed-bound individuals during this review period. **Compliance:** Not applicable. **Current recommendation**: Continue to monitor this requirement in the event this issue arises.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Substantial.

F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Training rosters indicated that one PT attended new employee orientation class in May 2009 and one RN attended the class in August 2009. Both nursing staff completed and passed the competency-based training for a) Mental Health Nursing Class b) Therapeutic Strategy Interventions (TSI) Training c) PBS and d) Principles of Medication. No nursing staff were hired during the months of June, July, September or October 2009. **Current recommendation**: Continue current practice.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** See F.3.h.i **Current recommendation**: See F.3.h.i
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement.

		Findings: See F.3.h.i **Current recommendation**: See F.3.h.i
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** A review of PSH's training rosters verified that 100% of the medication nurses have attended and passed competency-based training on the completion of the MTR and the controlled medication log. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Chris Keierleber, Acting Senior Rehabilitation Therapist 2. Debra Taylor-Tatum, Acting Senior Rehabilitation Therapist 3. Denise Byerly, POST Coordinator 4. Erin Cross, Rehabilitation Therapist 5. Greg Siples, Chief of Rehabilitation Therapy Services 6. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 7. Mike Gomes, Senior Rehabilitation Therapist 8. Renata Geyer, Acting Senior Rehabilitation Therapist 9. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 10. Stan Hydinger, Acting Senior Rehabilitation Therapist Reviewed: 1. F.4 audit data for May-October 2009 2. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 19 individuals participating in observed PSR Mall groups: AG, AH, AP, CDS, CRG, DW, EH, FW, JA, JEH, JM, KA, LJS, OR, PJJ, RA, RRR, SD and TFH 4. List of individuals who received direct physical therapy services from May-October 2009 5. List of individuals who received direct speech therapy services from May-October 2009 6. List of individuals who received direct occupational therapy services from May-October 2009 7. Records of the following 13 individuals who received direct physical, occupational, and speech therapy from May-October 2009: AJB, AKA, AMC, BZ, CH, CL, CMM, FLH, GWS, JAM, JM, RM and TM 8. List of individuals with 24-Hour Rehabilitation Support Plans 9. Records of the following three individuals with 24-Hour

		Rehabilitation Support Plans: DC, JC and MLR 10. List of the following individuals with Individualized Physical or Occupational Therapy Programs (INPOP) implemented by nursing staff 11. Records for the following two individuals with Individualized Physical or Occupational Therapy Programs (INPOP) implemented by nursing staff: RC and RS <u>Observed</u>: 1. Creative Arts Therapy Coping Skills PSR Mall Group 2. Dance Movement Therapy PSR Mall Group 3. Healthy Relationships PSR Mall Group 4. Music Appreciation PSR Mall Group 5. Music Making PSR Mall Group 6. PSOT Relationships and Sexuality PSR Mall Group 7. Visual Court Competency 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:	**Compliance:** Substantial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Provide quality direct services by Occupational, Physical and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the Present Status section of the WRP.

Findings:
The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during one week of the review period:

	Scheduled	Provided
OT	20	18
PT	9	8
SLP	16	16

The facility reported that some scheduled appointments were not provided due to individual refusals.

Other findings:
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 32% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period May-October 2009:

1.	*The provision of direct services by rehabilitation therapy services staff*	98%

Comparative data indicated improvement in compliance from 54% in the previous review period.

A review of the records of 13 individuals receiving direct occupational, physical and speech therapy treatment to assess compliance with F.4.a.i criteria found 12 records in substantial compliance (AJB, AKA, AMC, BZ, CH, CL, CMM, FLH, JAM, JM, RM and TM) and one record in partial compliance (GWS).

Current recommendation:
Continue current practice.

<table>
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<td>F.4.a.ii</td>
<td>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that the oversight by rehabilitation therapists of individualized Occupational or Physical Therapy programs implemented by nursing staff occurs as needed, and that results are documented in the Present Status section of the WRP.

Findings:
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 67% of plans completed during the review period May-October 2009:

<table>
<tr>
<td>2.</td>
<td>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</td>
<td>100%</td>
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</table>

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of two records of individuals with individualized OT/PT programs implemented by nursing found that both were in substantial compliance with F.4.a.ii requirements.

Current recommendation:
Continue current practice.

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<td>F.4.b</td>
<td>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.</td>
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Current findings on previous recommendation:

Recommendation, June 2009:
Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.

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		Findings: The POST clinician and unit supervisor determine which staff members require competency-based training. The Unit Supervisor and/or shift leader track staff that are trained and send the data to the RT department. According to facility report, 89 out of 89 nurses who required training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation, June 2009:** Ensure that for all individuals receiving Rehabilitation Therapy services, progress towards objectives is documented in the Present Status section of the WRP, and quality foci, objectives, and interventions are aligned and documented in the WRP. **Findings:** Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period May-October 2009: 4. *Each State hospital shall ensure that individuals are* 82%

	provided with timely and adequate rehabilitation therapy services.	
4.a	*There is an appropriate Focus of Hospitalization.*	92%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.*	77%
4.c	*The intervention in the PSR Mall Aligned with this objective states the name of the RT mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT staff to assist the individual in achieving this objective.*	80%
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	88%

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

	Previous period	Current period
Mean compliance rate		
4.	53%	82%
Compliance rate in last month of period		
4.	65%	100%
4.a	72%	100%
4.b	43%	100%
4.c	48%	100%
4.d	44%	100%

The facility initiated a hospital-wide effort (utilizing a team referred to

as the Sixty-Sixers) beginning in July to improve the quality of foci statements, objectives, interventions. In addition, the Supervising RTs performed proactive mentoring to promote improvement in the quality of focus statements, objectives and interventions. Review of the data found an upward trend following the initiation of these performance improvement efforts, which resulted in substantial compliance for item 4 in the months of August, September and October 2009.

A review of the records of 19 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found all records in substantial compliance.

Other findings:
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period May-October 2009:

4.b	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of records of three individuals with 24-hour support plans to assess compliance with F.4.c criteria found all records in substantial compliance.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Voc Rehab during the week of 10/26-10/30/09:

	Scheduled	Provided
RT	471	440
Voc Rehab	11	10

The facility reported that discrepancy between hours scheduled and hours provided was due to staff time off including illness, lockdowns, RT vacancies within the Mall cycle, and mandatory training.

Six PSR Mall groups led by Rehabilitation Therapists were observed. All six groups were found to have lesson plans developed and in use, and more than 90% of individuals were engaged in group activities in all groups observed.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

F.4.d

Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database each month during the review period May-October 2009:

e.	*The individual was assessed for the appropriateness of adaptive equipment by an RT professional*	100%
f.	*The individual was provided with the equipment as per*	100%

	the doctor's order	
g.	*The individual's level of functioning related to independence versus supports needed was assessed.*	100%
h.	*Training for the individual on the use of adaptive equipment was provided.*	100%
i.	*Reassessment of adaptive equipment, if clinically indicated*	100%

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Jeanie Kim, Assistant Director of Nutrition Services 4. Kitchie Miana, Assistant Director of Nutrition Services 5. Tai Kim, Director of Nutrition Services Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from May-October 2009 for each assessment type 2. Records of the following 18 individuals with types a-j.ii assessments from May-October 2009: AP, AVL, DEB, DEH, DML, DS, ERJ, HG, HL, JLF, KLS, MD, MGS, MLR, ORL, PJ, REJ and SS 3. Meal Accuracy Report audit data from May-October 2009 4. Nutrition Care Monitoring Tool audit data from May-October 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. Records for the following three individuals participating in the Win Over Weight PSR Mall group: ELF, JLC and TD Observed: Win Over Weight (WOW) PSR Mall Group
F.5.a	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	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice.

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<td>and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</td>
<td>

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 25% of Nutrition Assessments (all types) due each month from May-October 2009 (total of 587 out of 2368):

<table>
<tr><td>7.</td><td>Nutrition education is documented</td><td>95%</td></tr>
<tr><td>8</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance at or greater than 90% from the previous review period.

A review of the records of 18 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.

Other findings:
According to review of Meal Accuracy Report data, 99% of trays (regular and modified diets) audited from May-October 2009 (total of 2017 out of 9030, for a 22% sample) were 100% accurate.

Compliance:
Substantial.

Current recommendation:
Continue current practice.

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<tr>
<td>F.5.b</td>
<td>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</td>
<td>

Current findings on previous recommendation:

Recommendation, June 2009:
Continue current efforts to achieve compliance.

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</table>

implementation of strategies and methodologies to address such issues.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with WRP integration based on an average sample of 25% of Nutrition Assessments (all types) due each month from May-October 2009 (587 out of 2368):

19.	*The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated*	94%
20.	*The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated*	56%

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

	Previous period	Current period
Mean compliance rate		
19.	84%	94%
20.	34%	56%
Compliance rate in last month of period		
19.	94%	97%
20.	41%	59%

A review of the records of 18 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found nine records in substantial compliance (AP, DEB, HG, HL, JLF, KLS, MLR, REJ and SS), eight records in partial compliance (AVL, DML, DS, ERJ, MD, MGS, ORL and PJ) and one record not in compliance (DEH).

		Other findings: A review of records for three individuals (ELF, JLC and TD) participating in the Weight Management PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found all records in partial compliance. Observation of the Win Over Weight PSR Mall group found that the appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. This procedure should be revised on an ongoing basis to reflect current practice and system changes. **Compliance:** Substantial. **Current recommendation**:

		Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Three new dietitians were hired during the review period and all three were trained to competency on basic issues related to aspiration and dysphagia. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. Currently, no individuals at PSH require enteral nutrition. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. George Christison, MD, Acting Medical Director 2. Laura Yao, Business Manager II 3. Phung Thi Chau, Pharmacy Services Manager 4. Rebecca Kornbluh, MD, Acting Assistant Medical Director 5. Washington Ubillus, Jr., Pharmacist I Reviewed: 1. PSH self-assessment monitoring data 2. Pharmacists' recommendations regarding new psychotropic medication orders and physicians' response to these recommendations during this reporting period
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2009:** • Continue current practice. • Provide monitoring data by specific type of recommendations and comparisons with previous review. **Findings:** PSH presented the following data regarding the recommendations made during the current review period:

		Previous period	Current period
1.	Drug-drug interactions	183	128
2.	Side effects	18	82
3.	Need for laboratory testing	99	139
4.	Dose adjustment	81	73

5.	Indications	0	0
6.	Contraindications	21	18
7.	Need for continued treatment	0	0
8.	Others	76	61
Total number of recommendations*		478	501

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement.

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.

Current findings on previous recommendations:

Recommendations 1 and 2, June 2009:

- Provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review.
- Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale.

Findings:
The facility provided the following data:

	Previous period	Current period
Recommendations followed	367	465
Recommendations not followed, but rationale documented	56	27
Recommendations not followed and rationale/response not documented	55	9

		The facility reported that no individual experienced harm as a result of situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented rationale. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

7. General Medical Services		
		Methodology: <u>Interviewed</u>: 1. A. Sungkakitkorane, MD, Physician and Surgeon 2. Aung Zin, MD, Physician and Surgeon 3. Chinh Pham, MD, Physician and Surgeon 4. Cung Nguyen, MD, Physician and Surgeon 5. Daryl Brown, Medical Services Administrator 6. Dien Mach, MD, Chief Physician and Surgeon 7. Duc Nguyen, MD, Physician and Surgeon 8. Dung Tran, MD, Physician and Surgeon 9. George Christison, MD, Acting Medical Director 10. Javier Diaz, RN, Supervising RN in Medical Services 11. Lidia Lau, RN, Assistant Coordinator, Nursing Services 12. Luzmin Inderias, MD, Physician and Surgeon 13. Mohamed Hafez, MD, Physician and Surgeon 14. My Tran, MD, Physician and Surgeon 15. Nittin Kulkarni, MD Senior Psychiatrist 16. Sandra Doerner, RN, Acting Nurse Administrator 17. Sang Chung, MD, Physician and Surgeon 18. Tim Alder, MD, Staff Psychiatrist <u>Reviewed</u>: 1. The charts of the following 16 individuals: AA, BB, BD, CCB, CL, GB, HH, HMJ, JB, JTD, RC, RMH, SN, TLM, TO and YMW 2. Quality Review Check System of an External Referral Form 3. External Hospitalization Re-Admission Note Template (PSH 7441), June 2009 4. Records Retrieval Report template 5. Treatment Guidelines for COPD, Asthma and Dyslipidemia 6. Hyperprolactinemia section of Pharmacy and Therapeutics Manual 7. List of all individuals admitted to an outside medical facility during

		the review period 8. The charts of the following 12 individuals who were transferred to an outside medical facility during this reporting period: AA, AG, BC, CG, DB, DV, DWD, HE, RC, RS, SP and YW 9. PSH Integration of Medical Conditions into the WRP Auditing summary data (May-October 2009) 10. PSH Medical Transfer Auditing summary data (May-October 2009) 11. PSH Diabetes Mellitus Auditing summary data (May-October 2009) 12. PSH Hypertension Auditing summary data (May-October 2009) 13. PSH Dyslipidemia Auditing summary data (May-October 2009) 14. PSH Asthma/COPD Auditing summary data (May-October 2009) 15. Quality Council Meeting Minutes, December 1, 2009 16. Current protocol regarding management of water intoxication, PSH Pharmacy and Therapeutics Manual, October 10, 2008 17. DMH Joint Medical Nursing Policy and Procedure: Constipation, revised October 2009 18. PSH Guidelines for Prevention and Management of Constipation for Individuals on Clozapine, November 2009
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Implement corrective actions to address the monitor's findings of deficiencies in this report. **Findings:** The following summarizes the facility's corrective actions during the review period: 1. Hired a Chief Physician and Surgeon in August 2009; 2. Hired a Nursing Administrator in July 2009; 3. Hired an Infection Disease Physician as a Public Health Officer in September 2009;

4. Replaced two physicians who transferred to MSH;
5. Recruiting for two vacant physician positions;
6. Held training and discussion during the Joint Department of Medicine and Psychiatry and MOD meetings related to deficiencies identified in the previous report;
7. Initiated involvement of PBS for individuals ingesting foreign bodies; and
8. Developed a draft protocol for water intoxication.

Recommendation 2, June 2009:
Finalize and implement the facility's draft policy, Refusal of Medical Treatment.

Findings:
PSH reported that it developed and implemented Phase 1 of a refusal protocol on October 28, 2009. Phase 1 included refusals deemed to be of high concern. Phase 2 will address other refusals.

Other findings:
This monitor reviewed the charts of 12 individuals who were transferred to an outside medical facility during this reporting period. The following table outlines the episodes of transfer review by date of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

Individual	Date of MD evaluation	Reason for transfer
1	5/29/09	Small bowel obstruction
2	6/13/09	Angina and DVT, by history
3	6/24/09	Gastrointestinal bleeding
4	6/25/09	Hyponatremia with seizure activity
5	7/1/09	Abdominal pain
6	7/12/09	Encephalopathy

7	7/30/09	Unsteady gait
8	8/20/09	Seizure disorder
9	8/29/09	Hyponatremia
10	8/29/09	Lethargy, unsteady gait
11	9/21/09	R/O Neuroleptic Malignant Syndrome
12	10/17/09	Hyponatremia

The review found general evidence of timely and appropriate care to individuals as well as further progress by the facility in the following areas:

1. Attention to factors that contributed to the event requiring outside transfer;
2. The format (and content) of the physician acceptance evaluation upon return from outside hospitalization;
3. The process of quarterly medical reassessments;
4. Nursing documentation of changes in the physical status of individuals, including seizure activity; and
5. Availability of necessary discharge records from the hospital (with a few exceptions, e.g. DB and BC).

This monitor found a few process deficiencies as follows:

1. There was evidence of inadequate justification of the continuation of a high-risk medication (clozapine) in an individual who suffered from repeated small bowel obstruction and was continued on the high-risk medication that appeared to be the main contributing factor (CG).
2. Some individuals who suffered from episodic water intoxication did not receive behavioral interventions to address the behavioral variables contributing to this condition (e.g. DV). The facility is currently in the process of initiating a behavioral program to address water intoxication (in Unit 30).
3. An individual (RC) suffered at least four recurrences of seizure

		activity while having adequate serum levels of the current medication regimen. However, the neurological evaluation did not adequately assess the appropriateness of current treatment. 4. In general, the facility did not document the morphological diagnosis of individuals who suffered from seizure disorders. This information is essential to the selection of an appropriate anticonvulsant medication regimen. 5. The facility did not document reviews of the possible negative impact of treatment with old generation anticonvulsant medications, particularly for individuals suffering from cognitive impairment. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: 1. Implement corrective actions to address the monitor's findings of deficiencies listed above. 2. Provide a summary outline of any changes in the current medical and joint medical nursing ADs, policies and procedures.
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2009:** • Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). • Provide a summary outline of improvements in practice made as a

result of review by the facility of internal monitoring data.

Findings:
Using the DMH Medical Surgical Progress Notes Auditing Form, PSH assessed its compliance based on an average sample of 19% of all individuals with at least one diagnosis on Axis III during the review period (May-October 2009):

1.	*There is a quarterly note that documents reassessment of the individual medical status.*	95%
2.	*Significant conditions for which the individual is at risk for complications are identified.*	99%
3.	*If applicable, the primary care physician (PCP) 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.*	90%

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

	Previous period	Current period
Mean compliance rate		
1.	80%	95%
2.	96%	99%
3.	65%	90%

Other findings:
This monitor reviewed the charts of 16 individuals (AA, BB, BD, CCB, CL, GB, HH, HMJ, JB, JTD, RMH, RS, SN, TLM, TO and YMW). The review focused on the timeliness and overall content of ongoing quarterly reassessments of the individual's medical conditions. In general, this

<table>
<tr><td></td><td></td><td>review found that the reassessments were timely and properly aligned with the individuals' current needs.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement</td></tr>
<tr><td>F.7.b.ii</td><td>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;</td><td>Current findings on previous recommendations:

Recommendation 1, June 2009:
Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.

Findings:
The facility reported that the monitoring tools regarding the medical emergency response system and drills were finalized.

Recommendation 2, June 2009:
Develop and implement a system to assess timeliness and appropriateness of various specialty consultation services.

Findings:
PSH reported that it developed and implemented the Quality Check System for External Clinic Reports during the current review period. Data from this system is summarized below:

<table>
<tr><td></td><td>August 2009</td><td>September 2009</td><td>October 2009</td></tr>
<tr><td>% of external consultation reports timely and appropriate</td><td>79%</td><td>69%</td><td>94%</td></tr>
</table></td></tr>
</table>

Recommendations 3 and 4, June 2009:

- Monitor this requirement using the DMH Medical Transfer Auditing Form, the DMH Integration of Medical Conditions into the WRP Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least 20% samples.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:

Using the DMH Medical Transfer Auditing Form, PSH assessed its compliance based on an average sample of 100% of medical transfers during the review period (May–October 2009):

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	95%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	96%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	80%
4.	*Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.*	87%
5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	90%
6.	*Timely written progress notes by the regular medial physician shall address the treatment provided at the*	98%

	acute medical facility and follow-up treatment provided at the DMH hospital.	
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	78%

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

	Previous period	Current period
Mean compliance rate		
1.	95%	95%
2.	87%	96%
3.	67%	80%
4.	74%	87%
5.	82%	90%
6.	87%	98%
7.	51%	78%
Compliance rate in last month of period		
3.	70%	100%
4.	70%	96%
7.	60%	94%

PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 15% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (May-October 2009). The following is a summary of the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	76%

2.	*The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form*	71%
3.	*There is an appropriate focus statement for each medical condition or diagnosis*	47%
4.	*There is an appropriate objective for each medical condition or diagnosis*	64%
5.	*There are appropriate intervention(s) for each objective*	49%

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

	Previous period	Current period
Mean compliance rate		
1.	61%	76%
2.	57%	71%
3.	11%	47%
4.	41%	64%
5.	25%	49%
Compliance rate in last month of period		
1.	66%	95%
2.	59%	89%
3.	15%	81%
4.	46%	89%
5.	30%	80%

Using the same tool, the facility reviewed a 21% sample of individuals who have refused medical treatment or laboratory tests. The facility reported a mean compliance rate of 30% compared to 34% in the previous review period. The rate for the last month of this review period was 25%

		compared to 22% during the last month of the previous review period. **Recommendation 5, June 2009:** Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** PSH reported that the development and implementation of Form 7441 "External Hospitalization Readmit Note" has improved compliance in this area. Also see discussion of refusal protocols above. **Compliance:** Partial; improved compared to the last review. **Current recommendations**: 1. Provide information based on the Medical Emergency Response Evaluation Form that the facility has implemented. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** PSH reported that physicians' duty statements are aligned with AD 10.52: Provision of Medical Care to Individuals. In addition, ADs 10.25: Medical Emergencies, 10.53: RN & Physician Communication About Physical Status Change, 10.54: Transfer and Return From Another Facility for Evaluation and/or Medical or Surgical Treatment, and Medical Services P&Ps 01.10: History and Physical Examinations, 01.12: Procedures of Off-Site

		Referrals, 01.13: Emergency Medical Response and 01.14: Primary Care Physician Responsibilities are relevant to this requirement. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** PSH indicated that both a Primary Care Physician and a Psychiatrist continue to provide after-hours coverage. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue efforts to improve receipt of records from regional medical centers. **Findings:** PSH indicated that it implemented the Record Retrieval Report Review in May 2009. Each month, the Records Retrieval Courier monitors the

		effectiveness of efforts to retrieve records from off-site medical clinics. **Recommendations 2 and 3, June 2009:** • Monitor this requirement based on a 100% sample. • Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period). **Findings:** The facility presented data based on an 88% sample of individuals returning from outside medical treatment during the review period (May-October 2009). The mean compliance rate was 88%, compared to 40% in the previous review period. The rate for the last month of this review period was 93%, compared to 55% during the last month of the previous review period. **Other findings:** This monitor's chart reviews (see F.7.a) found significant improvement in the availability of discharge summaries and other records from outside hospitals compared to the last review period. **Compliance:** Substantial. **Current recommendation:** Continue to monitor this requirement
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service	**Current findings on previous recommendations:** **Recommendations 1, 2 and 3, June 2009:** • Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized

	plans to address any problematic changes in health status indicators.	tools based on at least 20% samples. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). • Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data. **Findings:** PSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 19% (diabetes mellitus), 19% (hypertension), 19% (dyslipidemia) and 18% (COPD/asthma) of individuals diagnosed with these disorders during the review months (May-October 2009). The following tables summarize the facility's data: <u>Diabetes Mellitus</u>

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	96%
2.	*HgbA1C was ordered quarterly.*	98%
3.	*The HgbA1C is equal to or less than 7%.*	100%
4.	*Blood sugar is monitored regularly.*	100%
5.	*Urinary micro albumin is monitored annually.*	98%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	100%
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	100%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.*	98%
9.	*Blood pressure is monitored weekly.*	92%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood*	98%

	pressure.	
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	95%
12.	*Podiatry care was provided by a podiatrist at least annually.*	96%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	98%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	98%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	96%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 3, 4, 7, 8, 10, and 13-15, and improvement for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	71%	96%
2.	81%	98%
5.	81%	98%
6.	81%	100%
9.	81%	92%
11.	86%	95%
12.	83%	96%

<u>Hypertension</u>

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	94%
2.	*Blood pressure is monitored weekly.*	97%
3.	*Blood pressure is less than 140/90 or there is an*	99%

	appropriate plan of care in place to reduce blood pressure.	
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	92%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	99%
6.	*Focus 6 for Hypertension has appropriate objectives and interventions.*	94%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	96%
8.	*The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.*	98%
9.	*An exercise program has been initiated.*	96%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	100%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 2, 3 and 5, and improvement for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	72%	94%
4.	77%	92%
6.	88%	94%
7.	89%	96%
8.	88%	98%
9.	85%	96%
10.	75%	100%

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	92%
2.	*A lipid panel was ordered at least quarterly.*	96%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	98%
4.	*The LDL level is ≤ 130 or a plan of care is in place.*	98%
5.	*The Triglyceride level is ≤ 200 or a plan of care is in place.*	99%
6.	*Dyslipidemia is addressed in focus 6 of the WRP.*	96%
7.	*Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.*	92%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	97%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	98%
10.	*An exercise program has been initiated.*	94%
11.	*If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.*	99%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for items 4-6 and 11, and improvement for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	76%	92%

2.	82%	96%
3.	86%	98%
7.	86%	92%
8.	89%	97%
9.	88%	98%
10.	86%	94%

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	94%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.*	96%
3.	*If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.*	97%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	98%
5.	*Asthma or COPD is addressed in focus 6 of the WRP.*	95%
6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions.*	91%
7.	*The individual has been assessed for a flu vaccination.*	87%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	85%

Comparative data indicated maintenance of compliance at or greater than 90% from the previous review period for 5 and improvement for the remaining items:

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>73%</td><td>94%</td></tr>
<tr><td>2.</td><td>86%</td><td>96%</td></tr>
<tr><td>3.</td><td>81%</td><td>97%</td></tr>
<tr><td>4.</td><td>72%</td><td>98%</td></tr>
<tr><td>6.</td><td>81%</td><td>91%</td></tr>
<tr><td>7.</td><td>70%</td><td>87%</td></tr>
<tr><td>8.</td><td>69%</td><td>85%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>72%</td><td>100%</td></tr>
<tr><td>8.</td><td>70%</td><td>92%</td></tr>
</table>

Recommendation 4, June 2009:
Monitor preventive care and care of cardiac disease using NSH's indicators.

Findings:
PSH reported that it intends to develop additional indicators during the next review period.

Compliance:
Partial; improved compared to the last review.

Current recommendation:
Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
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<tr>
<td>F.7.d</td>
<td>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and</td>
<td>Current findings on previous recommendations:</td>
</tr>
</table>

	patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Recommendation 1, June 2009:** Implement a quality performance profile for the physicians and surgeons. **Findings:** PSH indicated that it implemented the Medical Report Card process for primary care physicians in March 2009. In this process, physicians are provided a summary of performance on auditing tools across the following domains: 1. Timeliness; 2. Quality of care; 3. WRP planning and documentation; 4. Appropriate consultations ordered; 5. Appropriate consultations reviewed; 6. Appropriate labs/diagnostic tests ordered; and 7. Appropriate labs/diagnostic tests reviewed. The facility reported that physicians are expected to perform at 90% or greater compliance across all domains. **Recommendation 2, June 2009:** Ensure that the process of reprivileging incorporates indicators and operational instructions that provide an objective evaluation of physicians' performance in the areas of diagnosis/differential diagnosis, admission medical assessment, quarterly reassessments, evaluations upon transfers to an outside facility and upon return to PSH, emergency medical response, integration of medical conditions into the WRPs, and medication management (ADRs, DUEs and MVRs) as clinically appropriate. **Findings:** PSH reported that it maintained the general structure and process of reprivileging from the previous review. During the current review period, the facility added an examination of data from all audits of assessment

		and diagnosis for the previous two years to the reprivileging process. **Recommendation 3, June 2009:** Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated. **Findings:** The facility reported that it completes peer review data analysis through utilization of the Medical Report Cards summarized under Recommendation 1 above. **Recommendation 4, June 2009:** Update practice guidelines guided by current literature and relevant clinical experience. **Findings:** PSH reported that it developed practice guidelines for COPD, asthma and dyslipidemia during the current review period. **Recommendation 5, June 2009:** Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated. **Findings:** The facility indicated that it intends to develop this system during the next review period. **Recommendation 6, June 2009:** Implement current efforts to facilitate data collection in medical risk management. **Findings:** PSH reported that the Risk Manager collects medical risk management

		data through the incident management/risk management WaRMSS software. The facility indicated that data are utilized during Medical Risk Management Committee reviews. **Compliance:** Partial. **Current recommendation**: Develop and implement a formalized system to assess process and clinical outcomes of medical care, utilizing the current monitoring system as well as other relevant data.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Chloe Cummings, PHN II 2. Cindy Blaire, RN 3. Danielle Helmick, PT Auditor 4. Donna Rowe, PHN II 5. Richard Morrissey, MD 6. Sandra Doerner, RN, Acting Nurse Administrator Reviewed: 1. PSH's progress report and data 2. PSH MRSA Data Collection and Reporting Procedure 3. Department of Medicine Meeting minutes for 5/6/09, 6/3/09, 7/1/09, 8/5/09, 9/2/09 and 10/7/09 4. Joint Department of Medicine/Psychiatry Meeting minutes dated 5/27/09, 7/22/09, 8/26/09 and 9/23/09 5. PSH Enhancement Plan of Action Team Leader Meeting minutes dated 5/15/09, 6/19/09, 8/28/09 and 10/16/09 6. Infection Control Committee meeting minutes dated 5/14/09, 7/9/09, 8/13/09, 9/10/09 and 10/8/09 7. Medical records for the following 142 individuals: AA, AAG, ADG, AEE, AH, AI, AIM, ALS, AM, APS, ASB, AV, AVJ, AWM, BGW, BOB, BRH, BV, BW, CAO, CCC, CO, CRB, CS, CTT, CV, DB, DFH, DH, DLJ, DLT, DM, DOJ, DSG, DTP, DVD, DZS, EF, EK, ER, FG, FK, FOM, FV, GD, GF, GTF, HH, HIL, HRG, HS, JAC, JAN, JCF, JDD, JDS, JEM, JF, JHC, JJC, JLZ, JMG, JSL, JTS, KA, KDC, KDM, KE, KJH, KLA, KLS, KNS, LF, LL, LRJ, MAM, MAV, MC, MD, MEM, MHM, MIM, ML, MR, MST, MWS, MZG, MZN, OC, PAH, PC, PEC, PPJ, PQR, PTG, RBA, RD, RDL, REG, REJ, RES, RFV, RHT, RIJ, RJT, RK, RMR, ROM, RQ, RRR, RRW, RS, RTH, RW, RWR, SAS, SBR, SC, SDR, SH, SHS, SHT, SIW, SMR, SNL, SOL, SS, SUH, SUJ, SZ, TB, TDF, TDI, TRD, TW,

		TYD, UDN, VCR, VK, VN, YM and YMH
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Substantial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue collaboration between the Infection Control Department and nursing. **Findings:** Collaboration between the Infection Control Department and the department of Nursing has continued throughout the review period. Since the last review, the Public Health Department has added a third staff member to the Immunization Team, which has improved compliance rates. In addition, PSH hired Dr. Morrissey as the facility's new Public Health Officer when Dr. Bui retired in June 2009. Dr. Morrissey comes with over 25 years of experience as an Infectious Disease Physician working for Kaiser Permanente. The chairmanship of the Infection Control committee was turned over to Dr. Hafez. Also, in June 2009, PSH implemented a new system addressing refusals. The immunization team now records refusals of PPDs and immunizations in the doctor's communication book. The PCP is alerted to open up a Focus 6 for PPD or immunizations refusal. PSH has developed a new Immunization/PPD team refusal log to record all refused PPD or immunizations. The RN liaison nurse uses this log to ensure that refusals are addressed in the WRPs. **Recommendation 2, June 2009:** Continue to monitor this requirement.

Findings (by test/disease):

Admission PPD

Using the DMH IC Admission PPD Audit, PSH assessed its compliance based on an average sample of 77% of individuals admitted to the hospital with a negative PPD in the review months (May-October 2009):

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the admission procedure.*	100%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	99%
4.	*1st step PPDs were read by the nurse within 7 days of administration.*	98%
5.	*2nd step PPDs were read by the nurse within 48-72 hours of administration.*	94%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2, 4 and 5 and improvement in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	59%	100%
3.	87%	99%

F.8.a.ii: Assesses these data for trends

No trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends

In addressing its barriers to compliance, PSH recognized that that an

additional team member was necessary to provide consistent and timely services for infection control.

F.8.a.iv: Identifies necessary corrective action
In May 2009, an additional team member was added to the IC Department.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH's data has demonstrated substantial compliance since June 2009. PSH will continue to monitor this issue for compliance.

A review of the records of 20 individuals admitted during the review period (AH, AM, BRH, DH, DOJ, DSG, JAN, JEM, KJH, LL, MAM, MIM, REJ, RIJ, RK, ROM, SHS, SOL, SUJ and YM) found that all had a physician's order for PPD upon admission and all were timely administered and read.

Annual PPD
Using the DMH IC Annual PPD Audit, PSH assessed its compliance based on an average sample of 32% of individuals needing an annual PPD during the review months (May-October 2009):

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	100%
2.	*PPDs were ordered by the physician during the annual review procedure.*	95%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	98%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	97%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2 and 4 and improvement in

compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
1.	38%	100%
3.	83%	98%

F.8.a.ii: Assesses these data for trends
No trends identified. Also, there were no cases of PPD conversion following admission to the hospital during the reporting period.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 20 individuals requiring an annual PPD during the review period (AI, BV, DFH, DM, DTP, ER, FK, JF, KA, KDC, KDM, KE, MC, MD, MR, RRW, RTH, SC, SIW and TW) found that all had a physician's order for an annual PPD and all PPDs bwere timely given and read.

Hepatitis C
Using the DMH IC Hepatitis C Audit, PSH assessed its compliance based on an average sample of 100% of individuals admitted to the hospital in the review months (May-October 2009) who were positive for Hepatitis C:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	100%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.*	100%
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	100%
5.	*A Focus 6 is opened for Hepatitis C.*	100%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet*	100%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual*	97%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-5 and improvement in compliance for the remaining items:

	Previous period	Current period
Mean compliance rate		
6.	86%	100%
7.	76%	97%

F.8.a.ii: Assesses these data for trends

No trends identified. Also, there were no Hepatitis B conversions following admission during the review period.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 23 individuals who were admitted Hepatitis C positive during the review period (ALS, APS, BGW, BW, CAO, CO, DLJ, GF, GTF, JAN, JDD, JDS, JTS, ML, RQ, SAS, SDR, SS, TDI, TRD, TYD, VK and VN) found that 22 contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and 23 had adequate and appropriate objectives and interventions in the WRPs.

HIV Positive
Using the DMH IC HIV Positive Audit, PSH assessed its compliance based on a 100% sample (four individuals) of individuals who were positive for HIV antibody in the review months (May-October 2009):

1.	*Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.*	100%
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the*	100%

	appropriate clinic.	
5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.*	100%
6.	*A Focus 6 is opened for HIV (unspecified viral illness)*	100%
7.	*Appropriate objective is written to address the progression of the disease.*	100%
8.	*Appropriate interventions are written.*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-6 and 8, and improvement in compliance for item 7 from 83% in the previous review period.

F.8.a.ii: Assesses these data for trends
No trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of four individuals who were admitted during the review period with HIV (MHM, MWS, MZG and SNL) found that all were in compliance regarding clinic referrals and follow-up, and all had appropriate objectives and/or interventions in the WRPs.

Immunizations
Using the DMH IC Immunization Audit, PSH assessed its compliance

based on an average sample of 20% of individuals admitted to the hospital during the review months (May-October 2009):

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	100%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	100%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	100%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	97%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-3 and improvement in compliance for item 4 from 73% in the previous review period.

F.8.a.ii: Assesses these data for trends
No trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 20 individuals (AH, AM, BRH, DH, DOJ, DSG, JAN, JEM, KJH, LL, MAM, MIM, REJ, RIJ, RK, ROM, SHS, SOL, SUJ and YM) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by

the lab, and all were timely administered.

Immunization Refusals

Using the DMH IC Immunization Refusal Audit, PSH assessed its compliance based on a 80% sample (59 individuals) of individuals in the hospital who refused to take their immunizations during the review months (May-October 2009):

1.	*Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s*	100%
2.	*There is a Focus 6 opened for the refusal of the immunization(s).*	90%
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	95%
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	94%
5.	*The unit notified the Infection Control Department when the individual consented and received the immunization(s).*	100%

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

	Previous period	Current period
Mean compliance rate		
1.	90%	100%
2.	53%	90%
3.	32%	95%
4.	27%	94%
5.	N/A	100%

F.8.a.ii: Assesses these data for trends
See F.8.a.i.

F.8.a.iii: Initiates inquiries regarding problematic trends
See F.8.a.i.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.i.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 13 individuals who refused immunizations during the review period (DB, DVD, FG, FV, HIL, KLS, MEM, MZN, PAH, REG, RRR, SH and TB) found that all had an open Focus 6 and appropriate objectives and interventions.

MRSA
Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 60% sample (32 individuals) of individuals in the hospital who tested positive for MRSA during the review months (May-October 2009):

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained*	100%
3.	*The individual is placed on contact precaution per MRSA policy.*	95%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%

5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	100%
6.	*A Focus 6 is opened for MRSA.*	100%
7.	*Appropriate objective is written to include prevention of spread of infection*	98%
8.	*Appropriate interventions are written to include contact precautions.*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1, 2 and 4-8 and improvement in compliance for item 3 from 69% in the previous review period.

F.8.a.ii: Assesses these data for trends
No trends identified. However, see comment in cell F.8.a.ii.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 20 individuals with MRSA (AIM, ASB, AVJ, CRB, CTT, DZS, EF, GD, HRG, JLZ, JMG, JSL, KLA, KNS, LF, OC, RBA, RFV, RHT and RS) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and 18 WRPs contained appropriate objectives and interventions.

Positive PPD
Using the DMH IC Positive PPD Audit, PSH assessed its compliance based

on an average sample of 80% of individuals in the hospital who had a positive PPD test during the review months (May-October 2009):

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and Lateral Chest X-ray.*	100%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	100%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	NA
5.	*If LTBI is present, there is a Focus 6 opened.*	100%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	100%
7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-3 and 5, and improvement in compliance for the remaining items (item 4 was not applicable in either review period):

	Previous period	Current period
Mean compliance rate		
6.	71%	100%
7.	71%	100%

F.8.a.ii: Assesses these data for trends
No trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
A drop in compliance from September 2009 was related to one chart and the staff responsible was notified of the issue.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 25 individuals who had a positive PPD (AA, AAG, AEE, AV, AWM, BOB, CCC, CS, CV, EK, FOM, HH, JCF, JHC, JJC, LRJ, MAV, MST, PC, PTG, RDL, RMR, SZ, TDF and VCR) found that all individuals had the required chest x-rays; 23 records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, PSH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD or annual PPD during the review months (May-October 2009):

1.	*Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.*	100%
2.	*There is a Focus opened for the lab work or PPD refusal*	90%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	98%
4.	*There are appropriate interventions written for the*	98%

	lab work or PPD refusal.	

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

	Previous period	Current period
Mean compliance rate		
1.	31%	100%
2.	52%	90%
3.	25%	98%
4.	32%	98%

F.8.a.ii: Assesses these data for trends
See F.8.a.i.

F.8.a.iii: Initiates inquiries regarding problematic trends
See F.8.a.i.

F.8.a.iv: Identifies necessary corrective action
See F.8.a.i.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this issue for compliance.

A review of the records of 13 individuals who refused admitting or annual labs/diagnostics (ADG, ER, HS, JAC, PEC, PPJ, RD, RES, RW, RWR, SMR, UDN and YMH) found that 11 refusals were adequately addressed in the WRPs.

Sexually Transmitted Diseases
Using the DMH IC Sexually Transmitted Disease (STD) Audit, PSH assessed its compliance based on a 100% sample of individuals in the

hospital who tested positive for an STD during the review months (May-October 2009):

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	100%
3.	*An RPR is ordered during the admission process for each individual.*	100%
4.	*An HIV antibody test is offered to every individual upon admission.*	100%
5.	*A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals*	100%
6.	*If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.*	N/A
7.	*Focus 6 is opened for an individual testing positive for an STD.*	100%
8.	*Appropriate objective(s) are written.*	100%
9.	*Appropriate interventions are written.*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-2 and 7 and 9, and improvement in compliance for item 8 from 79% (items 3-6 were not applicable in the previous review period).

F.8.a.ii: Assesses these data for trends
No trends identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
None required.

F.8.a.iv: Identifies necessary corrective action
None required.

		F.8.a.v: Monitors to ensure that appropriate remedies are achieved PSH will continue to monitor this issue for compliance. A review of the records of six individuals with diagnosed STDs (DLT, PQR, RJT, SBR, SHT and SUH) found that the appropriate lab work was obtained indicating a positive STD and the STD was adequately addressed in the WRP in all cases. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** A review of PSH's Key Indicator data for MRSA found that it was different than the data presented in PSH's progress report. Specifically, the Key Indicator data for MRSA showed 43 individuals with that diagnosis in May and 97 in June, for an increase of 54 individuals. Additionally, the Key Indicator data showed 12 new diagnoses of MRSA in June. This would imply that 42 individuals were admitted to PSH with an existing diagnosis of MRSA, which seems unlikely. The Medical Risk Management Committee Coordinator was interviewed regarding the problems with the Key Indicator data. He indicated that after the last revision in the WaRMSS software in June 2009, the system would not allow inputting of MRSA data as previously done,

		causing errors in the data. An alternative system has been set up to avoid errors in these data. In addition, it was decided while on-site that Key Indicator data for Infection Control will be reviewed at the Infection Control Committee meetings to ensure its reliability. This system will be implemented during the coming review period and the facility should be in substantial compliance with this requirement by the next tour. **Compliance:** Partial. **Current recommendations**: 1. Implement system to ensure reliability of IC Key Indicator data and review by the Infection Control Department. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendation:**

		Recommendation, June 2009: See F.8.a.i. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Review of the minutes of PSH's meetings verified that IC data are

		discussed monthly at the meetings of the Infection Control Committee, the Joint Department of Medicine and Psychiatry, the Department of Medicine and the Enhancement Plan Committee. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, RN, Nurse Auditor Reviewed: 1. PSH's progress report and data 1. PSH's Dental Appointment logs 2. Medical records for the following 109 individuals: AB, ADA, AEJ, AG, AGW, AI, AJV, ALT, AP, AXG, BB, BEH, BS, BV, CM, CT, DAY, DEB, DEW, DFH, DHH, DJV, DLW, DM, DNB, DTP, DW, ER, FK, GRA, HC, HED, HYC, IMC, ISL, JAP, JCA, JEF, JF, JH, JHR, JJG, JL, JM, JN, JO, JUW, KA, KDC, KDM, KE, KE, KHM, KLD, KLS, KMH, LDS, LEF, LF, LMM, LTH, LW, MAH, MB, MC, MD, MG, MGM, MIR, MLR-1, MLR-2, MMN, MNP, MO, MPC, MR, OS, OVR, PAB, PH, PST, RAR, REK, RJB, RMO, RNC, RP, RRA, RRW, RTH, RU, RVS, SA, SC, SCL, SHJ, SHS, SIW, ST, STM, SW, TEK, TPS, TW-1, TW-2, VAA, VGC, WR and WWI
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Pursue recommendations included in the 2009/2010 Budget Change Proposal. **Findings:** In September 2009, PSH's Executive Director approved a part-time student assistant position for data entry, which has freed up the clinical staff. In October 2009, the Executive Director approved a part-time position for a dentist working 20-24 hours per week. Three applicants are scheduled for interviews on 12/04/09 and 14 more candidates will be

		interviewed in January 2010. **Recommendation 2, June 2009:** Continue to monitor this requirement. **Findings:** The number of full-time dental staff remains unchanged from last reporting period. The 2009/2010 Budget Change Proposal was submitted on 05/20/09 requesting the expansion of the dental clinics and office spaces and addition of dental staff. Due to staff sick leave and vacation time, the Dental Department has not yet attained substantial compliance with some EP requirements. The facility believes that with the addition of staff in early 2010, areas that are currently below substantial compliance will be in substantial compliance by the next review period. **Compliance:** Partial. **Current recommendations**: 1. Pursue recommendations included in the 2009/2010 Budget Change Proposal. 2. Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Implement strategies to increase compliance. **Findings:** The hiring of an additional dentist will facilitate compliance with the EP's

dental requirements.

Recommendation 2, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, PSH assessed its compliance based on a 38% mean sample of individuals scheduled for comprehensive dental exams during the review months (May-October 2009):

1.a	*Comprehensive dental exam was completed*	99%

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of the records of 27 individuals (ADA, AEJ, AJV, ALT, DW, GRA, IMC, JCA, JN, JO, KHM, LF, LW, MB, MGM, MLR-1, MLR-2, MMN, MPC, OVR, PAB, RP, RRA, SCL, SW, TW-1 and WR) found that all individuals received a comprehensive dental exam.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 40% mean sample of individuals who have been in the hospital for 90 days or less during the review period (May-October 2009):

1.b	*If admission examination date was 90 days or less*	77%

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

	Previous period	Current period
Mean compliance rate		
1.b	57%	77%

Compliance rate in last month of period		
1.b	22%	96%

In May 2009, PSH implemented the EagleSoft system. The time spent learning and implementing this system resulted in a temporary decrease in the department's direct clinical service capability. In addition, in June 2009, this cell was impacted by an unusual number of dental staffing absences due to leave, trainings and illness. In August 2009, actual chair time was significantly increased due to the elimination of the practice of automatically rescheduling a second appointment for dental refusals. This resulted in an increase in clinical chair time for admission exams, annual exams and other dental appointments.

A review of the records of 27 individuals (ADA, AEJ, AJV, ALT, DW, GRA, IMC, JCA, JN, JO, KHM, LF, LW, MB, MGM, MLR-1, MLR-2, MMN, MPC, OVR, PAB, RP, RRA, SCL, SW, TW-1 and WR) found that 21 individuals were timely seen for their admission exam.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (May-October 2009):

1.c	*Annual date of examination was within anniversary month of admission*	80%

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

	Previous period	Current period
Mean compliance rate		
1.c	33%	80%

Compliance rate in last month of period		
1.c	44%	96%

A review of the records of 20 individuals (AI, BV, DFH, DM, DTP, ER, FK, JF, KA, KDC, KDM, KE, MC, MD, MR, RRW, RTH, SC, SIW and TW-2) found that 15 annual exams were timely completed.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 76% mean sample of individuals with dental problems identified on admission or annual examination during the review months (May-October 2009):

1.d	*Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner*	100%

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of the records of 47 individuals (ADA, AEJ, AI, AJV, ALT, BV, DFH, DM, DTP, DW, ER, FK, GRA, IMC, JCA, JF, JN, JO, KA, KDC, KDM, KE, KHM, LF, LW, MB, MC, MD, MGM, MLR-1, MLR-2, MMN, MPC, MR, OVR, PAB, RP, RRA, RRW, RTH, SC, SCL, SIW, SW, TW-1, TW-2 and WR) found that all individuals were timely seen for follow-up care.

Using the DMH Dental Services Audit, PSH assessed its compliance based on a 49% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (May-October 2009):

1.e	*Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a*	100%

		timely manner

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of the records of 19 individuals (AG, AGW, CM, DEW, DJV, HED, JEF, JH, JM, JUW, LEF, LMM, LTH, MIR, MO, PH, RU, ST and WWI) found that all individuals received timely follow-up care.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.

F.9.b.ii

documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:

Current findings on previous recommendation:

Recommendation, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, PSH assessed its compliance based on a 29% mean sample of individuals scheduled for follow-up dental care during the review months (May-October 2009):

2.	*Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.*	98%

Comparative data indicated improvement in compliance from 88% in the previous review period.

A review of dental documentation for 47 individuals (ADA, AEJ, AI, AJV, ALT, BV, DFH, DM, DTP, DW, ER, FK, GRA, IMC, JCA, JF, JN, JO, KA,

		KDC, KDM, KE, KHM, LF, LW, MB, MC, MD, MGM, MLR-1, MLR-2, MMN, MPC, MR, OVR, PAB, RP, RRA, RRW, RTH, SC, SCL, SIW, SW, TW-1, TW-2 and WR) found that 45 records were in compliance with the documentation requirements. **Current recommendation**: Continue to monitor this requirement.
F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Dental Services Audit, PSH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (May-October 2009): 3.a — *Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction* — 100% Comparative data indicated improvement in compliance from 33% in the previous review period. A review of the records of 20 individuals (AI, BV, DFH, DM, DTP, ER, FK, JF, KA, KDC, KDM, KE, MC, MD, MR, RRW, RTH, SC, SIW and TW) found that all individuals were provided preventive care. Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (May-October 2009):

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>100%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of the records of 19 individuals (AG, AGW, CM, DEW, DJV, HED, JEF, JH, JM, JUW, LEF, LMM, LTH, MIR, MO, PH, RU, ST and WWI) found that all received restorative care.

Current recommendation:
Continue current practice.
</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (May-October 2009):
<table>
<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. 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.</td><td>100%</td></tr>
</table>

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

		A review of the records of 23 individuals (AXG, BB, BEH, DEB, DLW, ISL, JAP, JHR, KE, KLD, KLS, KMH, MAH, MNP, RJB, RMO, RNC, SA, SHS, TEK, TPS, VAA and VGC) found that all records were in compliance with this requirement. **Current recommendation**: Continue current practice.
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.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (May-October 2009): 5. *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.* 99% Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period. A review of the records of 47 individuals (ADA, AEJ, AI, AJV, ALT, BV, DFH, DM, DTP, DW, ER, FK, GRA, IMC, JCA, JF, JN, JO, KA, KDC, KDM, KE, KHM, LF, LW, MB, MC, MD, MGM, MLR-1, MLR-2, MMN, MPC, MR, OVR, PAB, RP, RRA, RRW, RTH, SC, SCL, SIW, SW, TW-1, TW-2 and WR)

<table>
<tr><td></td><td></td><td>found that 45 records were in compliance with the documentation requirements.

Compliance:
Substantial.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.9.d</td><td>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue to monitor this requirement.

Findings:
Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals scheduled for dental appointments during the review months (May-October 2009):

<table>
<tr><td>6.a</td><td>The individual attended the scheduled appointment</td><td>96%</td></tr>
</table>

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

The facility provided the following data on missed appointments:

<table>
<tr><td>Month</td><td>Refused to come to appt</td><td>Unit staff procedural problem</td><td>Transportation problem</td></tr>
<tr><td>5/09</td><td>74</td><td>26</td><td>0</td></tr>
<tr><td>6/09</td><td>143</td><td>26</td><td>0</td></tr>
<tr><td>7/09</td><td>147</td><td>8</td><td>0</td></tr>
<tr><td>8/09</td><td>145</td><td>3</td><td>1</td></tr>
</table>
</td></tr>
</table>

		9/09 | 122 | 10 | 1 10/09 | 113 | 16 | 1 A review of PSH's missed dental appointments for the review period verified that the majority of missed appointments were due to refusals, not to transportation or staffing issues See F.9.e for findings regarding dental refusals. **Compliance:** Partial. **Current recommendations**: 1. Implement strategies addressing dental refusals. 2. Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals scheduled for but refusing to attend dental appointments during the review months (May-October 2009): 7. *Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments* — 4% 7.a *Refusals are documented in the Present Status section of the Case Formulation in the individual's* — 2%

	WRP.	
7.b	*When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.*	5%

Comparative data indicated no significant change in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
7.	5%	4%
Compliance rate in last month of period		
7.	0%	0%
7.a	0%	0%
7.b	0%	0%

PSH implemented a system for addressing dental refusals in August 2009; however, it did not produce the desired results. The system involved sending e-mails regarding the refusals to the Unit Supervisor, Unit Psychiatrist, and Unit PCP followed by a dental progress note documenting the refusal. At the end of this reporting period, dental refusals were added to the system addressing medical refusals. In addition, if the dentist deems the refusal to be of high concern, the unit PCP or referring physician will be notified and asked to write an order to initiate the "high-concern refusal" protocol. PSH anticipates that this system should produce higher compliance rates with this requirement.

A review of the records of 20 individuals who have refused dental appointments (AB, AP, BS, CT, DAY, DHH, DNB, HC, HYC, JJG, JL, LDS, MG, PST, RAR, REK, ROS, RVS, SHJ and STM) found that none had an open focus with interventions addressing refusals included in their WRPs

		although one did have mention of the refusal in the present status section. **Compliance:** Partial. **Current recommendation**: See F.9.d.

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. PSH continues to make significant progress regarding the documentation requirements for seclusion and restraint. With continued efforts, the facility should be able to attain substantial compliance by the next review. 2. PSH has implemented a system to address in the WRPs individuals who have reached trigger thresholds for seclusion and restraint. 3. PSH continues to be committed to decreasing the use of restraint and seclusion.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. George Christison, MD, Acting Medical Director 2. Harry Oreol, Program Director 3. Lidia Lau, RN, Assistant Coordinator Nursing Services 4. Sandra Doerner, RN, Acting Nurse Administrator 5. Tammy Denny, PT Auditor 6. Willie Harris, DO, Acting Chief of Psychiatry <u>Reviewed</u>: 1. PSH's progress report and data 2. PSH Incident Reports to determine seclusion use 3. DMH Observation Record for Behavioral Seclusion or Restraint form 4. DMH RN Nursing Process for Use of Restraint/Seclusion form 5. PSH training rosters 6. Medical records of the following 19 individuals: AAA, AAB, AC, AR, ATM, DBP, DLG, DOR, ED, GB, HC, LJ, MLB, NC, NM, OR, RK, SAV and TCB

H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendation:** **Recommendation 1, June 2009:** Continue current practice. **Findings:** No incidents of prone restraint, containment or transportation were found during this tour. Since the last tour, PSH has modified the RN Activating Event form to include a prompt for documentation regarding use of the individual's preference plan. In addition, Nursing Services has implemented real-time mentoring by the ACNS/designee for any seclusion or restraint event to ensure correct and appropriate documentation. Also, in October 2009, the facility implemented the new DMH Observation Record for Behavioral Seclusion or Restraint Form to document behavioral observations for anyone in seclusion or restraints. **Compliance:** Substantial. **Current recommendation:** Continue current practice.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (total of five episodes) of initial seclusion orders

each month during the review period (May-October 2009):

1.	*Restraints and seclusion are used in a documented manner.*	100%
2.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	100%
3.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	100%

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1 and 2 and improvement in compliance for item 3 from 89%.

A review of four episodes of seclusion for four individuals (AAA, AR, HC and NC) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 95% mean sample of initial restraint orders each month during the review period (May-October 2009):

1.	*Restraints and seclusion are used in a documented manner.*	98%
2.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	100%
3.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	99%

Comparative data indicated that PSH maintained compliance greater than

		90% from the previous review period for all three items. A review of 35 episodes of restraint for 15 individuals (AAB, AC, ATM, DBP, DLG, DOR, ED, GB, LJ, MLB, NM, OR, RK, SAV and TCB) found that the documentation for 34 episodes supported the decision to place the individual in restraint. In the remaining one episode, there was no documentation of specific circumstances that would justify placement of the individual in restraint. Less restrictive alternatives attempted were documented in 34 episodes and orders that included specific behaviors were found in 34 episodes. **Current recommendation**: Continue current practice.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (May-October 2009): 4. *Seclusion is not used in the absence of, or as an alternative to, active treatment.* 100% 5. *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].* 90% 6. *Staff used and documented the use of information in* 40%

	the Seclusion and Restraint Preference and Family Notification Form (PSH 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.	

Comparative data indicated mixed changes in compliance since the previous review period:

	Previous period	Current period
Mean compliance rate		
4.	93%	100%
5.	81%	90%
6.	44%	40%
Compliance rate in last month of period		
6.	0%	N/A

(There were no episodes of seclusion during the last month of the current review period, thus no compliance data.)

Staff had not been documenting the use of the Preference Plans when an individual was placed in seclusion or restraints. In August 2009, the facility implemented the new DMH Observation Record for Behavioral Seclusion or Restraint, which should prompt the staff to document this issue.

A review of four episodes of seclusion for four individuals (AAA, AR, HC and NC) found documentation in all four WRPs addressing behaviors, objectives and interventions. Documentation in three episodes indicated that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance

based on a 95% mean sample of initial restraint orders each month during the review period (May-October 2009):

4.	*Restraint is not used in the absence of, or as an alternative to, active treatment.*	94%
5.	*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].*	94%
6.	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 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.*	91%

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

	Previous period	Current period
Mean compliance rate		
4.	93%	94%
5.	89%	94%
6.	21%	91%

A review of 35 episodes of restraint for 15 individuals (AAB, AC, ATM, DBP, DLG, DOR, ED, GB, LJ, MLB, NM, OR, RK, SAV and TCB) found documentation in 15 WRPs addressing behaviors, objectives and interventions. Documentation in 32 episodes indicated that the individual was released when calm.

		Current recommendations: 1. Continue to implement strategies to increase compliance with this requirement. 2. Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** See F.2.c.iv. **Findings:** See F.2.c.iv. **Current recommendation**: See F.2.c.iv.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of seclusion each month during the review period (May-October 2009): 7. *Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.* 89% 7.a *The individual was released from seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the seclusion order.* 60%

7.b	*The individual did not continue to be in seclusion after remaining calm for 15 minutes.*	60%
7.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	100%
7.d	*The individual did not continue to be in seclusion because he/she was unable to agree to cease using offensive language.*	100%
7.e	*The individual did not continue to be in seclusion because he/she did not cease making verbal threats.*	100%
7.f	*The individual did not continue to be in seclusion because he/she was not able to say he/she recognizes what behavior prompted the seclusion episode.*	100%
7.g	*The individual did not continue to be in seclusion because he/she was unable to say he/she is sorry for his/her actions.*	100%

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

	Previous period	Current period
Mean compliance rate		
7.	79%	89%
Compliance rate in last month of period		
7.	86%	N/A
7.a	67%	N/A
7.b	33%	N/A
7.c	100%	N/A
7.d	100%	N/A

7.e	100%	N/A
7.f	100%	N/A
7.g	100%	N/A

See chart review findings, barriers to compliance and plan of action in H.2.b.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 95% sample of episodes of restraint each month during the review period (May-October 2009):

7.	*Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.*	92%

Comparative data indicated improvement in compliance from 85% in the previous review period. See H.2.b for chart review findings.

Current recommendations:
1. Continue to implement strategies to increase compliance with this requirement.
2. Continue to monitor this requirement.

H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (May-October 2009): 8. *Each State Hospital shall comply with 42 C.F.R.,* 93%

	483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.	

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of four episodes of seclusion for four individuals (AAA, AR, HC and NC) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in three episodes.

Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 95% mean sample of initial restraint orders each month during the review period (May-October 2009):

8.	*Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.*	93%

Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period.

A review of 35 episodes of restraint for 15 individuals (AAB, AC, ATM, DBP, DLG, DOR, ED, GB, LJ, MLB, NM, OR, RK, SAV and TCB) found that the RN conducted a timely assessment in 34 episodes and that the individual was timely seen by a psychiatrist in 33 episodes.

PSH's training rosters indicated that at the end of this reporting period (October 2009), 93% of staff had received and passed TSI/PMAB training.

		Compliance: Substantial. **Current recommendations**: 1. Continue to implement strategies to increase compliance with this requirement. 2. Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** Since April 2009, PSH has fully implemented the MedSelect throughout the facility. This system captures PRN and Stat data by unit, individual, time and user. This data is compared to the HSS reports and CIS databases to ensure accuracy. A review of PRN/Stat medications and seclusion and restraint episodes found no incidents that were not included in the PSH databases. However, due to issues with the WaRMSS system, a number of discrepancies were found regarding the seclusion and restraint data provided by the facility. This was particularly concerning when it was difficult to identify a small sample of individuals (five) who were placed in seclusion during the review period. There had been no review by the facility of the data regarding seclusion and restraints to ensure accuracy. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a system to ensure accuracy of seclusion and

		restraint data if the WaRMSS system continues to be inaccurate. 2. Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** There have been no incidents of seclusion four or more times in a four-week period during this review period. Using the DMH Seclusion/Restraint Audit, PSH 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 (May-October 2009): 9. *Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate* — 77% 9.a *The review was held within three business days for any individual who had four or more episodes of restraint within the last 30 days* — 70% 9.b *The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done* — 80% 9.c *If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case* — 80%

	Formulation Section of the WRP	

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

	Previous period	Current period
Mean compliance rate		
9.	35%	77%
Compliance rate in last month of period		
9.	100%	55%
9.a	100%	33%
9.b	100%	33%
9.c	100%	100%

Any problematic issue and the small number of individuals with four or more episodes of restraint in 30 days significantly impact the compliance data. The lack of an automated system that documents restraint episodes in real time has been a barrier for teams being alerted to an individual who has triggered. The CNS Office will be providing the Executive Committee, the Programs and the Medical Director a 24-hour daily report for any seclusion or restraint episodes. Upon notification of a trigger, the Medical Director will designate staff to convene a meeting with the WRPT to review, discuss and document the necessary actions within the required timeframe.

A review of the records of four individuals who were in restraint more than three times in 30 days during the review period (AC, AR, MLB and OR) found that three WRPs included documentation within three business days.

Compliance:
Partial.

		Current recommendations: 1. Continue to implement strategies to increase compliance with this requirement. 2. Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** See F.1.b.
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, June 2009:** 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, June 2009:** 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, June 2009:** See F.1.b. **Findings:** See F.1.b. **Current recommendation:** See F.1.b.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, June 2009:** See F.3.a.iii. **Findings:** See F.3.a.iii. **Current recommendation**: See F.3.a.iii.
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.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.

H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** See F.3.h.i. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
H.8	Each State hospital shall:	**Compliance:** Not applicable.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement. **Findings:** There was no use of side rails during this review period. **Current recommendation**: Continue to monitor this requirement.
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	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue to monitor this requirement.

	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.	**Findings:** See H.8.a. **Current recommendation**: See H.8.a.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. Review of selected incidents in the WaRMSS Incident Management module found that the errors that had been noted on the original SIRs had been corrected. The facility has designated resources specifically to review and correct each SIR. 2. The Standards Compliance Directors have agreed upon uniform SIR coding instructions. This should improve the validity of any SIR comparison data among the facilities. 3. PSH is now using the Incident Management and Risk Management modules of WaRMSS exclusively, meaning they are not running redundant or back-up systems. The facility is identifying problems in WaRMSS and communicating these to DMH, as are the other facilities. DMH is triaging the work to correct the problems identified. 4. The conversion to WaRMSS (direct input into the data system by unit staff) triggered a substantial training effort wherein trainers provided training on the units to staff needing assistance. 5. PSH has maintained the improvement in the quality of investigations. Asking staff and individuals about additional witnesses and addressing the question of possible retaliation or enticement to drop an allegation are examples. 6. The facility has provided annual A/N training for staff and guidance to individuals in signing the statement of rights each year by airing a presentation on individuals' rights. 7. Review of the Quality Council minutes found that trending data on violence was provided to the members on a regular basis. Aggression/ violence was a topic of discussion at each meeting. The facility continued to implement measures to reduce violence. These included implementation of the Risk Management review committee recommendations, improvements in WRPs, increased recreational activities to reduce down time, and establishment of a facility-wide committee on violence reduction.

		8. The MIRC reviews of deaths evidence thoughtful review of available material and recommendations for improvement. 9. The environment on the three units visited was generally clean. The Central Council minutes state that the individuals have also seen an improvement in the cleanliness of the environment. 10. The facility continues to make those changes that improve the safety of the environment as resources become available. The design of the new lockers is a prime example. 11. DMH has agreed to finalize a Special Order dealing with searches of individuals.

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. B. Sherer, Hospital Administrator 2. C. Brown, Standard Compliance/Risk Manager 3. G. Richardson, Director of Standards Compliance 4. J. Olive, Supervising Senior Investigator Reviewed: 1. Fourteen Investigation Reports 2. Incident Review Committee minutes 3. Fifteen SIRs 4. IRC task tracking form 5. All materials provided related to the deaths of three individuals 6. Data for variables related to abuse/neglect incidents 7. Ten Headquarters Reportable Briefs 8. Graphed aggression data 9. Quality Council minutes
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial; improved compared to last review. The facility needs to ensure action on failures to report abuse/neglect to attain substantial compliance.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice.

		Findings: See I.1.a.v for instances in which there was no report of any action taken in response to staff members' failure to report abuse/neglect. **Current recommendation**: Follow DMH guidelines for addressing staff members' failure to report abuse allegations.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Review SIRs to identify and correct coding errors. **Findings:** Review of the SIR incident list found apparent errors in the involvement codes, e.g. an individual listed as the aggressor in an allegation of physical abuse, a staff member identified as the victim, and the involvement of the individual alleging verbal abuse coded as unknown. Further review of the database online indicated that the errors had been corrected. The printout provided was apparently run before the corrections were made. **Recommendation 2, June 2009:** Undertake staff training efforts in preparation for electronic SIR entry as planned. **Findings:** The facility reports five Student Assistant positions were allocated to provide training 24/7 to all levels of staff, instructing staff at their worksite on how to use the WaRMSS module for SIR entry. **Recommendation 3, June 2009:** DMH should ensure that all facilities are using the same SIR coding business rules, so that the new Statewide Incident Management System will have

		comparable data across all the facilities. **Findings:** The facility reported that it has hired 4.5 full time positions to review SIRs and ensure they are coded in a manner consistent with the statewide coding instructions agreed upon by the facilities' Standards Compliance Directors prior to June 2009. **Current recommendation**: Continue current practice.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Consistently document in the investigation report whether the named staff person(s) was removed from contact with the alleged victim. **Findings:** With two exceptions (#2821 and #2305), the sampled investigations documented whether or not the named staff person was removed following an allegation of abuse/neglect. Several investigation reports noted that the named staff member was not reassigned with the approval of the Clinical Administrator. During the investigation of the allegation of sexual abuse made by JA, the named staff member was not reassigned, but JA was guested on another unit with the approval of the Clinical Administrator. HQ briefs also address the reassignment of staff named in an incident. **Other findings:** In each of the incidents reviewed, the individual's physical needs were attended to in a timely manner through nursing and/or medical assessments and treatment as needed.

		Current recommendation: Continue current practice of monitoring the implementation of procedures seeking the approval of the Clinical Director for decisions not to reassign a named staff member.
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;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure the staff member cited [in this cell in the previous report] and any other staff with no record of A/N training attend the training as soon as possible. **Findings:** As indicated in the table below, 11 of the 14 staff members whose training records were reviewed during the tour had participated in Abuse/Neglect training within the last year. **Recommendation 2, June 2009:** If not already a practice, make attendance at mandatory annual trainings part of performance evaluations. **Findings:** The facility reports that attendance at mandatory training is part of annual performance evaluations as required by AD 5.05: Orientation/Mandated Training. **Other findings:** As presented in the table below, three of the 14 staff members whose A/N training records were reviewed had not completed the required training within the past year.

<table>
<tr>
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<tr><td></td><td colspan="4">Date of:</td></tr>
<tr><td>Staff member*</td><td>Hire</td><td>Background clearance</td><td>Signing of Mandatory Reporter</td><td>Most recent A/N training</td></tr>
<tr><td>_L</td><td>12/16/05</td><td>10/27/05</td><td>11/5/08</td><td>10/29/09</td></tr>
<tr><td>_O</td><td>4/3/06</td><td>3/23/06</td><td>7/3/08</td><td>9/3/09</td></tr>
<tr><td>_O</td><td>9/2/08</td><td>6/12/08</td><td>9/2/08</td><td>8/6/09</td></tr>
<tr><td>_B</td><td>8/1/89</td><td>1/26/89</td><td>8/11/08</td><td>6/25/09</td></tr>
<tr><td>_G</td><td>12/16/05</td><td>12/15/05</td><td>1/4/08</td><td>5/7/09</td></tr>
<tr><td>_B</td><td>7/3/00</td><td>6/28/00</td><td>3/20/08</td><td>4/16/09</td></tr>
<tr><td>_B</td><td>3/2/06</td><td>2/23/06</td><td>4/11/08</td><td>4/10/09</td></tr>
<tr><td>_K</td><td>7/1/08</td><td>6/30/08</td><td>7/1/08</td><td>2/26/09</td></tr>
<tr><td>_A</td><td>1/31/07</td><td>8/1/08</td><td>9/2/08</td><td>2/19/09</td></tr>
<tr><td>_E</td><td>9/2/97</td><td>8/8/97</td><td>10/17/08</td><td>1/20/09</td></tr>
<tr><td>_L</td><td>10/31/97</td><td>10/1/97</td><td>12/9/08</td><td>12/9/08</td></tr>
<tr><td>_M</td><td>10/31/08</td><td>9/18/08</td><td>10/31/08</td><td>11/12/08</td></tr>
<tr><td>_H</td><td>1/31/07</td><td>11/2/06</td><td>6/19/08</td><td>6/19/08</td></tr>
<tr><td>_M</td><td>1/3/05</td><td>11/12/04</td><td>1/3/05</td><td>3/7/08</td></tr>
</table>
*Only last initials are provided to protect confidentiality.

Current recommendation:
Continue current practice.
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<tr>
<td>I.1.a.v</td>
<td>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</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
As presented in the table in the preceding cell, ten of the 14 staff members sampled signed the Mandatory Reporter acknowledgement form after the
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<td>recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</td>
<td>date of hire. This includes staff members hired as recently as 2006 and 2007.

Other findings:
Two of the sampled staff members had been found during an investigation to have failed to report allegations of abuse/neglect as required by policy. The HR department reported no completed or pending disciplinary action for the two staff. This is in apparent violation of AD 15.13, which states that failure to report will result in progressive corrective or disciplinary action. The staff members were involved in the 7/5/09 and 7/3/09 allegations of verbal abuse.

Current recommendations:
1. Follow AD 15.13 regarding corrective and disciplinary action for failure to report.
2. Ensure that staff members sign the Mandatory Reporter acknowledgement form and understand the responsibilities associated with it before they begin working in contact with individuals.</td>
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<tr>
<td>I.1.a.vi</td>
<td>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
At annual WRPCs, discuss rights and responsibilities with individuals and request they sign the form.

Findings:
As shown below, eight of the nine individuals sampled had signed the statement of rights within the last year—most on 12/3/09 following a presentation by the Patient Rights Advocate.

<table>
<tr><th>Individual</th><th>Date of most recent signing</th></tr>
<tr><td>DH</td><td>12/3/09</td></tr>
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<td></td>
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<table>
<tr><td>DG</td><td>12/3/09</td></tr>
<tr><td>WM</td><td>12/3/09</td></tr>
<tr><td>TN</td><td>12/3/09</td></tr>
<tr><td>HG</td><td>12/3/09</td></tr>
<tr><td>ZC</td><td>12/3/09</td></tr>
<tr><td>RH</td><td>12/2/09</td></tr>
<tr><td>KB</td><td>2/12/09</td></tr>
<tr><td>ST</td><td>12/26/07</td></tr>
</table>

Current recommendation:
Continue current practice.
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<tr>
<td>I.1.a.
vii</td>
<td>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;</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
The statement of rights with directions for contacting the Patient Rights Advocate was present in a common area on the units reviewed.

Current recommendation:
Continue current practice.</td>
</tr>
<tr>
<td>I.1.a.
viii</td>
<td>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue to improve the referral process.

Findings:
A question has arisen about the proper procedure to follow when it appears that an individual has committed a crime. It was reported that a state statute prohibits the investigator from asking the psychiatrist whether the</td>
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</table>

		individual's actions resulted from mental illness. Investigators have reportedly been advised to ask the psychiatrist if the individual should go to jail. If this is an accurate account of the situation, guidance is needed from DMH on how investigators should proceed. **Current recommendation**: DMH should investigate the circumstances described above, determine the accuracy and provide guidance to investigators on how to proceed if it appears that an individual has committed a crime.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice of investigating all allegations of retaliation or fear of retaliation and alerting staff to possibly dangerous situations, so that they can take appropriate action. **Findings:** There was evidence in the investigations reviewed that investigators remain mindful of the need to question the possibility of retaliation. Specifically, in a first interview pertaining to an allegation of sexual battery, the victim (JL) said he wanted to drop his charge. The investigator asked him why he was making this request. JL responded that he did not believe anything would change. Similarly, in the investigation of the allegation of sexual abuse by JA, he acknowledged the allegation was false. The investigator questioned him specifically, asking if he had been threatened or promised anything to rescind the allegation. He answered he had not been threatened or enticed to rescind. **Current recommendation**: Continue current practice.

I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial; improved compared to last review. Work is needed to complete investigations within 30 business days and in ensuring that disciplinary actions are implemented in a timely manner.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Implement Special Order 205.05: Mortality Review with specific attention to carrying forward for discussion and approval at the MIRC meetings all recommendations or findings of fact that would reasonably imply recommendations for corrective actions made during other reviews. Write MIRC-approved recommendations in clear terms and identify the persons responsible for effecting implementation and reporting results back to the MIRC. **Findings:** This recommendation has been implemented as reflected in the MIRC minutes and task tracking form. **Other findings:** The facility's review of the death of RL (unexpected death on 2/7/09) resulted in the following corrective actions: • Medical Executive Committee will be addressing the adequacy of CPR training for clinical staff. • Emergency Care Committee members will check to be sure that Medical Emergency call number stickers are on each phone and will be checking emergency medical equipment. • The need for more frequent mock code blue drills will be answered by conducting one drill a month on each shift on each unit. A listing of drills for 2009 documented 99 drills completed in each of the second and

		third quarters and 79 completed in the fourth quarter through December 9, 2009. A drill was conducted on each shift on each unit in the second and third quarters. • An audit of dysphagia screenings completed in November 2009 found that 48% of the individuals had a current screening. The plan was to raise the issue with the Quality Council in December for development of a Plan of Corrective Action. • Internal death reviews will be completed by physicians with particular expertise in the issues under review. The reviews of the unexpected death of AS on 1/8/09 (suicide by hanging) resulted in the following corrective actions. • Change in policy to clarify procedures for notifying the unit when an individual does not come to a destination (e.g. Mall group) when expected. • The addition of one staff member for each two units in the N building to make security rounds during Mall times to ensure no one is left behind/ unaccounted for. • Psychological care was provided for the staff members who found AS, for the individuals who knew of his plan beforehand and for all staff and individuals on his unit. • The recommendation for safer clothing lockers has resulted in a newly designed locker with a sloping top and no lock and chain. Production of these lockers should begin shortly. • A proposal was submitted to change all the bedroom doorknobs. This was not approved due to budgetary constraints. • A proposal for a therapy clinic within the intern program has been advanced with the objective of increasing the availability of 1:1 therapy. The death of RK on 8/31/09 was not unexpected. He was receiving hospice services in a community SNF.

		Current recommendation: Continue to track all MIRC recommendations through to completion.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** All incidents that could involve criminal behavior are initially investigated by trained members of the hospital police. Specific types of incidents, including allegations of abuse/neglect, are further investigated by the Office of Special Investigations. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** In the investigation of exploitation (7/30/09), the plastic bags used to hold quarters and stuffed into white socks were sent out for fingerprint analysis, indicating close attention to the safeguarding of evidence. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures	**Current findings on previous recommendation:**

	and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Recommendation, June 2009:** Ensure that DPS practice is changed, so that officers conducting preliminary A/N investigations interview the named staff member(s). **Findings:** Review of the preliminary investigations conducted by hospital police prior to the OSI investigation found that in many instances, the named staff member was not interviewed because he/she was not on the unit or had left the facility. Examples include the preliminary investigation of the allegation of sexual abuse in which the police officer was not able to interview the named staff because he had ended his shift and left the facility and the preliminary investigation of the allegation of verbal abuse in which the named staff was not interviewed because he was absent from the unit. **Other findings**: The IRC minutes of October 27 state that an investigation of verbal and physical abuse was not sustained "as the allegations were unable to be proved beyond a reasonable doubt." The Department standard for making determinations in these cases is "preponderance of evidence." **Current recommendations**: 1. Ensure that all investigators use the preponderance of evidence standard in making determination. 2. Request that preliminary investigators be mindful of the need to interview the named staff member as expeditiously as possible.
I.1.b. iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue current practice of beginning investigations within 24 hours of the report of an incident.

Findings:
PSH continues to ensure that investigations begin within 24 hours of the report of the incident.

Recommendation 2, June 2009:
Ensure that interviews are conducted in a timely manner.

Findings:
As presented below, in two instances in which the incident did not reach OSI until several weeks after it was reported, the interviews of relevant parties were delayed. Nonetheless, overall the time between the report of an incident and OSI assignment shows improvement compared to earlier review periods.

In the investigation of July 7 allegation of verbal abuse, the complaint was received from the Patient Rights Advocate and logged on the Hospital Policy Daily Activity Report on 7/7/09, but the SIR was not completed until 9/16/09. The staff member responsible for completing the SIR was cited for failure to report an allegation of abuse as required by policy.

Incident type	Date reported	Date to OSI
Physical abuse allegation	6/11/09	6/15/09
Neglect allegation	7/1/09	7/29/09
Verbal abuse allegation	7/5/09	7/13/09
Verbal abuse allegation	7/7/09	8/5/09
Physical abuse allegation	7/9/09	7/11/09
Exploitation	7/30/09	7/30/09
Sexual abuse allegation	8/3/09	8/6/09
Sexual assault allegation	8/4/09	8/4/09
Verbal abuse allegation	8/4/09	8/5/09
Verbal abuse allegation	8/6/09	8/7/09
Physical abuse allegation	8/27/09	8/28/09

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue efforts to pass incidents onto OSI in as timely manner as possible so that the investigations can begin.</td></tr>
<tr><td>I.1.b.
iv.2</td><td>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</td><td>Current findings on previous recommendations:

Recommendation 1, June 2009:
Follow the plan outlined [in this cell in the previous report] to limit OSI A/N investigations to those allegations which, if true (after the initial DPS investigation), would meet the SIR definitions. Include the IRC review of the cases in question.

Findings:
This monitor's review did not find investigations of allegations which, if true, did not meet the SIR definition of the incident type. Allegations which raise this question, after preliminary investigation, are reviewed by the IRC (as documented in the minutes) and a determination is made whether further investigation is warranted.

Recommendation 2, June 2009:
Continue other efforts to complete investigations in a timely manner.

Findings:
Of the 14 investigation reports reviewed, nine were completed within the 30 business days required by the EP.

<table>
<tr><td>Incident type</td><td>Date incident reported</td><td>Date investigation closed</td></tr>
<tr><td>Physical abuse allegation</td><td>6/11/09</td><td>7/9/09</td></tr>
<tr><td>Neglect allegation</td><td>7/1/09</td><td>8/3/09</td></tr>
<tr><td>Verbal abuse allegation</td><td>7/5/09</td><td>8/13/09</td></tr>
<tr><td>Verbal abuse allegation</td><td>7/7/09</td><td>8/18/09</td></tr>
<tr><td>Physical abuse allegation</td><td>7/9/09</td><td>8/6/09</td></tr>
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<table>
<tr><td>Exploitation</td><td>7/30/09</td><td>Not provided, but after 10/27</td></tr>
<tr><td>Sexual abuse allegation</td><td>8/3/09</td><td>9/2/09</td></tr>
<tr><td>Verbal abuse allegation</td><td>8/4/09</td><td>9/15/09</td></tr>
<tr><td>Sexual assault allegation</td><td>8/4/09</td><td>8/17/09</td></tr>
<tr><td>Verbal abuse allegation</td><td>8/6/09</td><td>8/14/09</td></tr>
<tr><td>Physical abuse allegation</td><td>8/11/09</td><td>10/22/09</td></tr>
<tr><td>Physical abuse allegation</td><td>8/13/09</td><td>Not provided</td></tr>
<tr><td>Verbal abuse allegation</td><td>8/26/09</td><td>11/30/09</td></tr>
<tr><td>Physical abuse allegation</td><td>8/27/09</td><td>10/8/09</td></tr>
</table>

Other findings:
The OSI list of 40 August and September open/closed cases indicates that 21 open cases had been opened more than 30 business days earlier.

The Supervising Special Investigator agreed to monitor a 100% sample of completed investigations during the next review period to thwart any questions about the selection of cases. In September, for example, 17 investigations were closed and four were audited—all of which were completed within 30 business days. In August, 19 cases were closed and all were audited. Ninety percent of the 19 cases met the EP timeline.

Current recommendation:
Continue efforts to complete investigations within the timeframe required by the Enhancement Plan.
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<td>I.1.b. iv.3</td>
<td>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2009:
The IRC should review investigations with the objective of identifying any additional programmatic recommendations.
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	separately:	**Findings:** The IRC minutes document the consideration of policy and procedural changes necessary in light of an incident. The change requiring Mall providers to notify the unit when an individual does not attend as expected and enhanced staffing to conduct unit searches during Mall time to ensure no one is left unaccounted for are examples. **Other findings:** See also I.1.c. **Current recommendation**: Determine the factors that impede timeliness in implementing disciplinary action and take action where possible.
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Complete the investigation of the 2/11/09 allegation of neglect of RB. **Findings:** The facility reports this investigation was completed. **Other findings:** The investigations reviewed and the IRC minutes demonstrate investigators' attention to violations of Department standards, facility policies and department policies, including failure to report. **Current recommendation**: Continue current practice.
I.1.b. iv.3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:**

		Recommendation, June 2009: Continue current practice. **Findings:** Several of the investigation reports reviewed documented the investigator's attempts to identify witnesses other than those identified in the initial report. For example, the investigator asked HC, the victim in the alleged physical abuse allegation, if any other individuals might have seen the incident. HC replied, "No." In the investigation of the allegation of verbal abuse made by MR, the investigator asked both the individual witness and the staff witness if anyone else could have witnessed the incident. In the investigation of the sexual abuse incident involving JL, the investigator interviewed JL's roommates and a close friend to find out if JL had told any of them about the incident. **Current recommendation**: Continue current practice.
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** All investigation reports reviewed identified the names of the alleged victim(s) and perpetrator(s). **Current recommendation**: Continue current practice.
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:**

		Recommendation, June 2009: Continue current practice. **Findings:** All investigation reports reviewed identified the names of all persons interviewed and provided a summary of the interview. **Current recommendation**: Continue current practice.
I.1.b. iv.3(v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Each investigation report reviewed identified the date of the interview, stated if it was taped, and provided a summary of the contents. An explanation for the delay was provided when an interview was conducted later than one would expect. For example, in the report of the investigation of the allegation of verbal abuse made by MH, the interview of the named staff member was delayed because the staff member was on vacation for three weeks. **Current recommendation**: Continue current practice.
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice.

		Findings: All of the investigation reports reviewed listed the documents reviewed as part of the investigation. Several cited documents particularly relevant to the investigation. For example, in the investigation of the verbal abuse allegation by MR, the named staff member said he wrote an IDN and made an entry in the Grounds Book to pull the alleged victim's privileges for 30 days. The investigator checked and found neither note. The allegation was sustained and additionally the named staff member was determined to have been dishonest during the investigation. In the investigation of the allegation of sexual abuse, the investigator reviewed the individual's clinical record to determine when 1:1 observation was initiated and whether it was continued without interruption. **Current recommendation**: Continue current practice.
I.1.b. iv.3 (vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, June 2009:** Document the findings of the review of the incident history of both the individuals and named staff members in all A/N investigation reports. **Findings:** The investigation reports reviewed consistently note whether the individual has made prior abuse allegations and whether any were sustained. The reports do not document the incident history of the named staff member(s). Periodically, the Hospital Administrator runs a report of all persons involved in incidents. From this report, one can identify those staff members involved in multiple incidents and their role in the incidents. **Current recommendation**: DMH needs to provide guidance to the facilities on its expectations for how the facilities should comply with this section of the EP, since at this time

		there is no consistency among the facilities.
I.1.b. iv.3 (viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** All investigations reviewed included a statement clearly identifying whether the allegation was sustained or not. See also I.1.b.iv requesting that investigators use the preponderance of evidence standard in making determinations. **Current recommendation**: Use the preponderance of evidence standard in making determinations at the close of investigations.
I.1.b. iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** Although frequently not able to reconcile the disparate accounts, the investigations reviewed were forthright in identifying conflicting testimony and attempting to understand the source, often by conferring with the individual's psychiatrist. **Current recommendation**: Continue current practice of close review of investigations by the Incident Review Committee.

I.1.b. iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** All investigation reports reviewed were signed by the Supervising Special Investigator. Additionally, the IRC minutes document additional questions for the investigator and occasionally the need to send the investigation back for further work, as was done with the investigation report of the 6/4/09 allegation of psychological abuse. **Current recommendation**: Continue current practice.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendation:** **Recommendation, June 2009:** Provide meaningful data that identifies the number of investigations completed each month in which programmatic or disciplinary action was recommended and the number in which the actions recommended were completed. **Findings:** This recommendation is being implemented through the IRC task tracking form for programmatic actions and actions related to an individual. Recommendations to send investigation findings to HR for action are not consistently put on the task tracking form. **Other findings:** A review of the disciplinary actions taken in response to a sample of <u>sustained</u> cases, as reported by Human Resources, yields the finding that

these actions are not consistently implemented in a timely manner, as represented below.

Investigation type	Date investigation closed	Response
Physical abuse	6/8/09	No action to date
Psychological abuse	7/6/09 (incident date 2/22/09)	Counseling delivered 2/25/09
Neglect	7/13/09	No action to date
Sexual abuse	7/31/09	No action to date
Failure to report A/N/E	8/18/09 9/23/09	No action to date
Verbal abuse	8/26/09	Discipline pending
Verbal abuse	10/23/09	Will go to HR on 11/30/09
Verbal abuse	(Incident date 5/22/09)	Discipline pending
Verbal abuse	(Incident dates 7/3 and 7/5/09)	Discipline pending
Abuse	(Incident date 7/13/09)	Terminated 7/14/09

Compliance:
Partial.

Current recommendations:
1. Determine the factors that impede timeliness in implementing disciplinary action and take action where possible.
2. Add disciplinary action to the IRC task tracking sheet in a manner that protects staff member's privacy but which ensures review of required actions to ensure timeliness.

I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial. Timely (current) tracking and trending should include types of incidents beyond abuse allegations.
I.1.d.i	type of incident;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Implement plans to provide tracking and pattern reports regarding incidents to the Quality Council. **Findings:** Review of the Quality Council minutes found that aggression/violence was a topic of discussion at each meeting. Trending data was provided to the members on a regular basis. The most recent trending data covered the period through May 2009. No analysis of this data was provided. See I.2.a.iii. **Other findings:** Data gathered from RMS for adult abuse incidents reported during the May-October 2009 review period finds nearly the same total number as during the prior reporting period, but differences in the types of abuse. Specific counts were provided.

Abuse type	November 2008 - April 2009	May 2009 - October 2009
Physical	48	58
Verbal	32	21
Psychological	15	14
Sexual	0	15
Neglect	21	6
Exploitation	1	0
Other	NA	2
Total	117	116

		Current recommendation: Provide analysis of the violence data presented to the Quality Council.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Identify how this information is used to improve the safety of the individuals and staff. **Findings:** It is less clear how the periodic listing of all parties involved in incidents (see cell below) as related to staff (in contrast to individuals) is used to improve the safety of the environment, as it is not clearly documented that this data was analyzed and discussed. **Other findings:** The Hospital Administrator ran a report of all parties involved in three or more incidents during the period 5/1/09 to 10/31/09. Review of this list found that ten staff members were identified as suspects (named staff) in more than one abuse allegation during the report period. **Current recommendation**: Provide an analysis of the data regarding staff involvement in incidents and document discussion of this material.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, June 2009:** See recommendation in I.1.d.ii [in the previous report]. **Findings:** There are mechanisms in place to identify and direct treatment toward

		individuals involved in incidents: the abuse history of individuals is reported in investigation reports, investigators consult the individual's psychiatrist for guidance about the individual's mental health status, and the Risk Management Committees review serious and repeated incidents. **Other findings:** A list of individuals named as victims in three or more alleged abuse incidents during the May-October time period contained the names of eight individuals—five identified as victims in three incidents, two individuals as victims in four incidents and one individual (CM) identified as victim in seven alleged abuse incidents. **Current recommendation**: Continue current practice.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Implement plans to provide useful data and analysis on incidents to the Quality Council during the next review period. This would include the type of incidents matched with their location. **Findings:** The facility produced data on the location of abuse incidents but not on other incident types. **Other findings:** Adult abuse incident data for the May-October 2009 period indicates that more of these incidents were reported on Unit 32 than on any other unit. With a count of 18, Unit 32 exceeded the next highest unit (Unit 71) by 10. Excluding Unit 32, the other units of the facility averaged 0.53 reports of alleged abuse each month during the report period. In contrast, Unit 32 averaged three incidents per month. The Quality Council meeting minutes

		for October 6 identify plans for restructuring Unit 32 in light of the safety issues on that unit. **Current recommendation**: Expand the location data to include other types of incident, particularly those involving aggression toward self and others.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Provide analyses of the data as an aid to the bodies reviewing the data to identify possible explanations and recommendations for addressing the issues identified. **Findings:** In response to questions about the data, some findings were explained during the Quality Council meeting. No analysis was included with the data distributed. **Other findings:** Data generated by the facility reveals that during the May-October 2009 period, more incidents identified as allegations of abuse were reported on Thursdays (27) and Tuesdays and Fridays (24 each). Saturday saw the fewest reports with eight. This same data identifies 9:00 AM, 5:00 PM and midnight as the hours with the highest number of abuse incidents reported. **Current recommendation**: Expand this data to include other incident types.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendations:** **Recommendations 1 and 3, June 2009:** • Continue with plans to have the IRC review HQ briefs to identify the

causes and contributing factors for incidents.

- Review HQ Briefs for accuracy and timeliness.

Findings:
The facility reported that the WaRMSS Incident Management module contains all of the elements for completing the HQ briefs. Standards Compliance reviews each HQ reportable incident to ensure each element is completed.

Recommendation 2, June 2009:
Implement the Incident Management WaRMSS module as soon as testing proves its reliability.

Findings:
The facility began using the WaRMSS Incident Management module in June 2009. Many problems have been identified by the facilities and reported to DMH. Fixes to the system are prioritized based on the problem's impact and the ability of the IT staff to correct the problem.

Other findings:
Review of 10 HQ briefs from early in the year revealed that half had not been finalized at the time of this review:

Incident date	Incident type	Comment
1/8/09	Sexual assault	Not finalized
1/14/09	Physical abuse alleg.	Not finalized
1/15/09	Verbal/physical abuse allegation	Finalized 3/30/09 Aggressor reassigned.
1/10/09	Verbal abuse alleg.	Finalized 1/30/09 Aggressor reassigned.
2/11/09	Physical abuse alleg.	Finalized but not dated.
3/5/09	Verbal abuse alleg.	Finalized 3/27/09 Individual moved on his request.

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<tr><td>3/4/09</td><td>Physical abuse alleg.</td><td>Finalized but not dated.
Staff reassigned.</td></tr>
<tr><td>3/7/09</td><td>Psychological abuse</td><td>Finalized 4/26/09.
No mention of reassignment.</td></tr>
<tr><td>6/7/09</td><td>Use of pepper spray</td><td>Finalized 11/2/09.</td></tr>
<tr><td>6/8/09</td><td>Sexual assault</td><td>Finalized but not dated.</td></tr>
</table>

Current recommendation:
Continue working to complete HQ briefs as required by the Incident Management Special Order.
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<tr><td>I.1.d.
vii</td><td>outcome of investigation.</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Continue current practice.

Findings:
All investigations clearly state the disposition/outcome of the investigation. Most provide a short rationale for the decision.

Other findings:
Facility data indicates that approximately 15% of the abuse investigations closed during the period May-October 2009 were sustained.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>I.1.e</td><td>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</td><td>Current findings on previous recommendation:

Recommendation, June 2009:
Ensure investigation reports state whether the named staff member was removed from the unit.</td></tr>
</table>

	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.	**Findings:** As reported in I.1.a.iii, all but two of the investigations reviewed stated whether the named staff person was reassigned. In addition, HQ briefs contain this information. In none of the investigations reviewed where the staff member was not removed did there appear to be imminent risk of harm to the individual. **Other findings:** See findings in I.1.a.iv regarding criminal background checks of 14 sampled staff members, which show that only one was working prior to clearance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** <u>Interviewed</u>: 1. Anca Chiritescu, MD, Unit N-23 psychiatrist 2. B. Sherer, Hospital Administrator 3. C. Brown, Standards Compliance, Risk Manager 4. Cammie Davis, Unit EB-12 psychiatric technician 5. Carrie Anaforian, PhD, Unit EB12 psychologist 6. G. Christison, MD, Acting Medical Director 7. G. Richardson, Director of Standards Compliance 8. Luzmin Inderias, MD, Unit N-23 physician and surgeon 9. Mario Gonzalez, Unit EB-12 clinical social worker 10. Michael Leoni, Unit N-23 RN 11. Rodale Magsino, Unit N-23 senior psychiatric technician 12. Silfat Morohunfola, Unit EB-12 RN 13. Stephane Johnson, MD, Unit EB12 psychiatrist 14. Teresa Lai Leung, Unit EB-12 music therapist <u>Reviewed</u>: 1. Quality Council meeting minutes (March-December 2009) 2. MRMC Case Review and Minutes 8/14/09 3. September ETRC minutes 4. Facility Review Committee Meeting Minutes, November 17, 2009 5. WRPs for 11 individuals tracking incidents/triggers 6. WRPs for 12 individuals tracking risk factors 7. Implementation of September ETRC recommendations for xx individuals 8. Aggregate trigger data 9. The charts of two individuals (JPW and SA) to review implementation of the process and clinical application of Special Order 262 10. List of glucose test strip results for JPW 11. List of triggers for SA 12. ETRC Recommendations for SA

		Observed: Facility Review Committee
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial; improved compared to last review.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue the implementation of initiatives to reduce the level of violence on the campus. **Findings:** Dr. Christison confirmed that he is expanding the medical staff subcommittee on violence reduction to a facility-wide committee. This committee will continue his work with Napa State Hospital researching effective methods of violence reduction. The present plan is to use a study model whereby the violence reduction initiatives will be implemented on one of two sister units and the outcomes compared. In addition, staff in leadership positions noted other efforts to reduce violence. These include: • Individuals are being held to "community standards," meaning that if their violent actions do not result from mental illness, they will be held responsible and criminal charges will be filed. • A continuing conversation with individuals about violence, to keep at the forefront the benefits of reducing violence. • Increased recreational opportunities to fill downtime and develop positive relationships between individuals.

- The SAFE program, which provides a specialized treatment environment for individuals admitted to the program.
- Addition to the Mall schedule of a group entitled "Peaceful Living/Non-Violent Communication."
- Improvements in the development of the WRPs.

Review of the Quality Council minutes found that violence is discussed at nearly every meeting, often in response to violence data, graphed to show trends. For example, the May 12 minutes cite the increase in physical aggression in April 2009 compared to April 2008.

Recommendation 2, June 2009:
See the [previous] recommendation in I.2.a.ii regarding implementation of the Risk Management Special Order.

Findings:
See I.2.a.ii.

Other findings:
As the table below indicates, key indicator data shows a reduction of 18%-43% in the number of aggressive incidents in this review period compared to the previous review period for four of five aggression indicators. (Aggression to staff showed an increase of 38%).

	Nov 2008 - April 2009	May 2009 – October 2009
Peer-to-peer aggression resulting in major injury	40	25
Aggression to staff resulting in major injury	66	91
Individuals with two or more aggressive acts in 7 days	159	117
Individuals with four or more	60	34

		aggressive acts in 30 days Homicide threats 65 53 **Current recommendation**: Produce timely data with analysis. Document discussion of the data in the Quality Council and other appropriate forums.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Ensure full implementation of the Risk Management Special Order and solicit feedback from facilities regarding any operational refinements that may be necessary. **Findings:** This work continues. All Risk Management Review Committees are functioning at the facility. PSH was the first facility to convert totally to use of the WaRMSS. It and the other facilities have identified and reported to DMH problems in the system. DMH is addressing these on a priority basis. **Recommendation 2 and 4, June 2009:** • Ensure that reviews at the second level (ETRC, PSCC, MRMC) include adequate clinical review and rationale for each recommendation. • Ensure appropriate referrals for assessments throughout each level of risk management review. **Findings:** This monitor and his experts interviewed two WRPTs who supported individuals who had crossed established risk management triggers. The following summarizes these episodes:

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<table>
<tr><th>Individual</th><th>Unit</th><th>Indicator</th><th>Trigger</th><th>Date(s)</th></tr>
<tr><td>JPW</td><td>N-23</td><td>Blood sugar above 250</td><td>Two episodes in a two-week period</td><td>7/17/09, 7/22/09</td></tr>
<tr><td>SA</td><td>EB-12</td><td>Aggressive act to self</td><td>Aggressive act to self with major injury</td><td>10/17/09</td></tr>
</table>

Appropriate referrals were made to each of the various risk management review levels. The MRMC reviews included adequate clinical review and rationale for each recommendation. The ETRC failed to provide a documented rationale for each recommendation.

Recommendation 3, June 2009:
Ensure that the second level review generates a clinical document that is filed within the individual's record.

Findings:
The facility reported that Committee recommendations are incorporated into the Psychiatrist Progress Note and the WRP, as appropriate.

Current recommendation:
The ETRC should document a rationale for each of its recommendations.
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<td>I.2.a.iii</td>
<td>identification of systemic trends and patterns of high risk situations.</td>
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Current findings on previous recommendation:

Recommendation, June 2009:
See [previous report] recommendations in I.2.a.i.

Findings:
The Quality Council minutes document presentation of the trends and patterns related to violence that show the rate per 1000 patient days for physical aggression to peers, physical aggression toward staff, verbal aggression to peers and verbal aggression to staff from June 2007 through
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		May 2009. Additional data presented the number of these incident types for the same period. No analysis accompanied the data. **Current recommendation**: Provide data for the period under review as well as analysis of the figures presented.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial; improved compared to last review.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Ensure that individuals suffering serious injury are provided psychological as well as physical services. **Findings:** The facility reports that the psychological as well as physical needs of the individual are addressed in the review of serious injuries by the Program Review Committee. **Other findings:** The facility has implemented the Risk Management system, thus ensuring the review of individuals whose behaviors indicate a need for further clinical attention. **Current recommendation**: Continue current practice.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and	**Current findings on previous recommendations:**

patterns;

Recommendation 1, June 2009:
Continue implementation of measures aimed at reducing violence on campus.

Findings:
See I.2.a.i.

Recommendation 2, June 2009:
Develop, as agreed, a plan for addressing illicit drug use on campus.

Findings:
Positive drug screen data showed a substantial reduction in the number of positive screens in the period May-September (30) as compared with the five month period December 2008-April 2009 (73). In the most recent period, 13% of the positive drug screens were for illicit drugs other than marijuana. In the earlier period, the "other" illicit drugs accounted for 16%.

Other findings:
Review of the WRPs of 11 individuals following discussion at September ETRC meetings found documentation of implementation or progress toward implementation of the ETRC recommendations in eight cases:

Individual	Recommendation	Implementation status
AC	Provide individual therapy during periods of high stress, e.g., anniversaries.	WRP cites increased attention from the social worker.
GB	Follow up with audiologist for hearing aid.	WRP 12/5/09. Hearing aids received.
HA	Consider involuntary med hearing. Get further psych testing.	Determination made not to pursue involuntary med hearing. Psych testing being conducted.
JB	Get psychopharmacology consult.	No consult documented.

MB	Transfer to a non-1370 unit.	Transfer completed.
MH	Get psychopharmacology consult re: meds with no axis diagnosis to support the medication.	WRP 10/20/09. No mention of psychopharmacology consult. No change in diagnosis or meds.
RC	Update assault risk. Consider use of long-acting injectable.	Assault risk changed to moderate. Meds reviewed and changed.
RJ	Get psychopharmacology consult. Prepare behavior guidelines.	Neither completed.
SS	Refer for full neuropsych evaluation. Get EEG.	Referrals in progress.
TS	Follow-up on neuropsych testing. Refer for possible 7301.	Follow-up completed. Referal made and evaluation determined 7301 not recommended.
WH	Review previous psych testing and update diagnosis.	Both recommendations implemented.

This monitor and his experts interviewed WRPTs who supported individuals who had crossed established risk management triggers (see I.2.a.ii for summary). In regards to process, the interviews revealed that the WRPTs were knowledgeable about the first, second and third levels of the risk management procedures, including how to access these interventions.

In regards to clinical care, some areas of progress were noted:

1. Documentation of a timely review of the incident by a psychiatrist was completed consistently. This review included a review of current psychopharmacology regimen and behavioral supports as appropriate.
2. The Present Status section of the case formulation was updated to reflect the trigger event.

		However, for one individual (SA), limited clinical oversight in the implementation of behavioral treatment strategies was discovered. **Current recommendation**: Continue to expand the monitoring by Standards Compliance of implementation of recommendations.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** The facility has met this requirement. WRPTs are notified of incidents using WaRMSS and are expected to review these incidents at the weekly Program Review Committee meeting. This is facilitated by Standards Compliance, which produces an agenda for the PRCs that lists the individual and the incident under review. The minutes of the PRC document the WRPT's response. A similar system is in place for triggers. WRPTs are notified of triggers through WaRMSS and Standards Compliance compiles a schedule of individuals being reviewed each week at the Enhanced Trigger Review Committee. At the meeting, Standards provides a packet of information on each individual that includes the individual's WRP and incident and trigger history. **Current recommendation**: Continue current practice. v
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** As planned, begin using the WaRMSS system as soon as it is operational to

track WRPTs' responses to triggers.

Findings:
The facility began using the WaRMSS system in June 2009.

Recommendation 2, June 2009:
Continue current practice of tracking review committee recommendations.

Findings:
The facility reports that it tracks the implementation of review committee recommendations. Its findings are not inconsistent with this monitor's findings.

PSH findings include:

Trigger	Number of trigger responses returned to SC	Number of responses found by SC to have been implemented	Implementation rate
Aggressive act to self	51	46	90%
Aggressive act to others	267	240	90%
Alleged A/N/E	131	118	90%
Restraint	46	41	89%
Suicide attempt/ threat	97	87	90%
Illicit substances	33	30	91%

Other findings:
As presented below, the WRPs of 10 of 11 individuals sampled acknowledged the incident/trigger under review.

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<table>
<tr><th>Individual</th><th>Approximate date of trigger</th><th>Addressed/cited in WRP?</th></tr>
<tr><td colspan="3">Trigger: Aggression to self resulting in major injury</td></tr>
<tr><td>AP</td><td>9/20/09</td><td>Addressed in 10/16 WRP. SIB listed in risk factors.</td></tr>
<tr><td>DK</td><td>10/28/09</td><td>Incident cited in 11/9 WRP.</td></tr>
<tr><td>HH</td><td>10/26/09</td><td>Incident cited in 11/4 WRP.</td></tr>
<tr><td>NM</td><td>9/29/09</td><td>Listed in triggers in 10/2 WRP.</td></tr>
<tr><td>RK</td><td>9/3 and 9/4/09</td><td>Listed in triggers in 9/8 WRP.</td></tr>
<tr><td>SA</td><td>10/17 and 10/24/09</td><td>Both incidents addressed in 10/27 WRP. SIB also listed in risk factors.</td></tr>
<tr><td>SS</td><td>9/19/09</td><td>Addressed in 9/21 WRP. SIB listed in risk factors.</td></tr>
<tr><td colspan="3">Trigger: Suicide attempt</td></tr>
<tr><td>AC</td><td>10/18/09</td><td>Cited in 11/23 WRP. Risk factors: Suicide=low.</td></tr>
<tr><td>DA</td><td>9/8/09</td><td>Listed in triggers in 9/29 WRP. Suicide Risk=low.</td></tr>
<tr><td>EH</td><td>9/1/09</td><td>Not cited in 10/6/09 WRP. Risk factors: Suicide=high.</td></tr>
<tr><td>MB</td><td>10/13/09</td><td>Addressed in 11/2 WRP. SIB listed in risk factors.</td></tr>
</table>

Current recommendation:
Ensure that suicide risk assessments are reviewed and appropriate action taken following suicide attempts.
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<td>I.2.b.v</td>
<td>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2009:
Undertake the planned monitoring of implementation of recommendations</td>
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<td>and proposed actions in response to incidents and triggers when the statewide WaRMSS incident and risk management module becomes operational.

Findings:
See findings in I.2.b.iv.

Other findings:
Half of the WRPs of 12 sampled individuals that were developed following the most recent risk profile update cited the current risk factor.
<table>
<tr><th>Individual</th><th>High Risk Category</th><th>Addressed/ Cited in WRP?</th></tr>
<tr><td>AO</td><td>Victimization</td><td>No</td></tr>
<tr><td>DJ</td><td>Victimization</td><td>No</td></tr>
<tr><td>JM</td><td>Victimization</td><td>No</td></tr>
<tr><td>RS</td><td>Victimization</td><td>Yes</td></tr>
<tr><td>TB</td><td>Victimization</td><td>Yes</td></tr>
<tr><td>YG</td><td>Victimization</td><td>Yes</td></tr>
<tr><td>BA</td><td>Illicit substances</td><td>No</td></tr>
<tr><td>DA</td><td>Illicit substances</td><td>Yes</td></tr>
<tr><td>GA</td><td>Illicit substances</td><td>Yes</td></tr>
<tr><td>JA</td><td>Illicit substances</td><td>No</td></tr>
<tr><td>KA</td><td>Illicit substances</td><td>Yes</td></tr>
<tr><td>TB</td><td>Illicit substances</td><td>No</td></tr>
</table>

Current recommendation:
Clarify the expectation that WRPs should reflect the individual's current risk profile.</td>
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<tr>
<td>I.2.c</td>
<td>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess</td>
<td>Current findings on previous recommendation:</td>
</tr>
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	and address the facility's compliance with its identified service goals.	**Recommendation, June 2009:** Continue implementation of plans to use the WaRMSS Incident and Risk Management components to advance the facility's achievement of its service goals. **Findings:** The facility reports that full implementation of the Incident Management and Risk Management modules of WaRMSS was completed in June with training for staff continuing as needed. The MAPP II training and implementation project was completed in September 2009. The WRP Realignment project was completed in October 2009, with training for WRPT members by Master Trainers continuing. As reported earlier, the facilities continue to identify problems with WaRMSS and DMH triages the requests for assistance/fixes. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. B. Ray, Health and Safety Officer 2. B. Sherer, Hospital Administrator 3. E. Halsell, Chief of Plant Operations 4. M. Mosk, PhD, Psychologist on Unit EB-10 5. R. Catt, Business Manager Reviewed: 1. Facility documentation regarding environmental inspections and work orders 2. WRPs of eight individuals with the problem of incontinence 3. Clinical records of eight individuals involved in sexual incidents Toured/Observed: 1. Three units: 32, 31 and EB-10 2. Prototype of new locker
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, June 2009:** Continue current practice of improving the safety of the environment as resources are made available. **Findings:** Feedback from facility staff has been incorporated into the design of the new lockers. Construction of the new lockers is expected to begin in January 2010. This locker has a sloping top (one cannot stand on it), the lock will not support weight and the locker will be flush-mounted to the wall of the bedroom. The facility expects to spend $1.6 million for 1500 lockers.

		During the review period, the project of replacing shower valves and heads in Building 70 was completed. The facility reported that during the review period, Health and Safety Environmental Inspections were completed in 44 areas occupied by individuals. Nine programs were notified of areas in need of improvement and all responded. **Recommendation 2, June 2009:** Repair or replace the plumbing access shields on Unit 70 noted above. **Findings:** The facility reported that these plumbing access shields were repaired. **Recommendation 3, June 2009:** Complete the review of the suicide death of AS. Identify, implement and monitor implementation of the recommendations forthcoming from the review. **Findings:** The facility completed the review of the suicide death of AS. See I.1.b.i for discussion of the outcome of this death investigation. **Other findings:** This monitor's tour of three units yielded the following observations: • Bedroom doors on Unit 32, which houses 50 female individuals, are solid. Doors are opened at night and flashlights used to check sleeping individuals. Flashlights were available and working. The three bedrooms reviewed were clean and odor-free. Old lockers with a lock and chain were still in use. Bathrooms were generally clean, but the hot water did not reach appropriate temperature and the Chief of Plant Operations agreed it should be raised five degrees. (Reportedly, there had been no

		complaints from individuals, however.) Showers were equipped with push-button valves. Replacement of the vents is on the list of upcoming improvements. • The water temperature on Unit 31 also needed to be raised. Lighting in the bathroom was adequate, this being a significant improvement. The facility will be enclosing the sink plumbing with a new material and the vents will be replaced. Push-button showers were operational, as were the flashlights. Individuals interviewed said they had all the personal hygiene supplies they needed. • EB-10 is a co-ed unit specifically for individuals with hearing impairments and had a census of 14 at the time of the visit. Some staff are fluent in American Sign Language (ASL); others are attending classes twice weekly. DMH approved the 20 hours of Mall groups for these individuals, some of which are integrated with hearing individuals. These groups include ceramics, weight lifting, art and drumming. The staff reported that interpreters are provided for hearing-impaired individuals who attend ward government meetings, NA, AA, and religious observances. Unit staff were aware of the complaint that there was an unnecessary degree of segregation of hearing-impaired individuals and that called for more inclusion. They noted that about the same time, there was general discontent on the unit when grounds time in the morning was cut by 40 minutes. Individuals on the unit were friendly and welcoming, engaged us in conversation, and said that unit staff were terrific. Review of the responses from individuals on this unit to the August 2009 Individuals Survey found several that noted the need for ASL-proficient staff on the evening shift. The environment was clean with the exception of the windows. The Lexan has to be removed in order to clean the windows. This work has begun in the N and 30 buildings. There was a ceiling leak in one four-bed bedroom. Individuals indicated they had the personal hygiene supplies they needed. The water temperature on this unit needed to be reduced by five degrees. • The Central Council 2010 Roadmap notes that the "cleanliness of the units is generally improving."

		Compliance: Substantial. **Current recommendation**: Determine if evening staff on EB-10 have sufficient signing skills to communicate effectively with individuals.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue current practice. **Findings:** The facility reports that all of the Urgent Request work orders received during the review period were completed by the following working day at the latest, as required by facility policy. Similarly, 98% of all work orders related to hot indoor temperatures were completed within the same time frame. All work orders related to cold indoor temperatures met the same time limit. This level of performance was also reported for the prior reporting period. **Other findings:** The units toured were comfortable. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and	**Current findings on previous recommendation:**

practices so that individuals who are incontinent are assisted to change in a timely manner;

Recommendation, June 2009:
Monitor performance and report the monitoring data for the next review period.

Findings:
PSH reported that in the period May-October 2009, it monitored incontinence care for individuals on 65 occasions. Compliance was reported as follows:

Criterion	Compliance rate
Incontinence status is addressed in Present Status	91%
Incontinence identified in Focus 6	99%
Objectives promote dignity and self-reliance	96%
Individual is clean, dry and odor-free.	100%
Nursing staff explain how they assist the individual	100%

Other findings:
As presented below, six of the eight individuals sampled from the list of individuals with the problem of incontinence prepared by PSH had an open Focus 6 addressing the problem and objectives and interventions to assist the individual in coping with the problem.

Individual	Dx or on Medical Problem list?	Focus 6	Objective and Interventions
FB	No	Yes	Yes
GG	No	Yes	Yes
JC	No	Yes	Yes
KM	Yes	Yes	Yes
KM-2	Yes	No	No
ML	No	Yes	Yes
VY	No	No	No
NG	No	Yes	Yes

		Compliance: Partial; improved compared to last review. **Current recommendation**: Continue to ensure that individuals with the problem of incontinence are provided care and assistance appropriate to their needs.
I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendation:** **Recommendation, June 2009:** Begin auditing the response of WRPTs to sexual contact incidents in order to provide necessary guidance and corrective measures. **Findings:** The facility reported that it monitored the response to 12 sexual incidents during the review period. No analysis was provided regarding the findings from PSH's review of the sexual incidents. **Other findings:** Review of the response to sexual incidents involving eight individuals revealed variable findings.

Individual Incident date	Incident type	WRPT response
AB 6/15/09	Sex between adults	No physician note. No mention in monthly nursing note.
EA 6/15/09	Sex between adults	IDN states EA (and other individual) were "verbally redirected and separated." Monthly note cites the incident.
EB 10/2/09	Sex between adults	IDN states EB was counseled on the behavior and its possible

				consequences. No acute physical or behavioral distress noted. Monthly note by psychiatrist cites the incident. Medication adjusted.
		AJ 10/2/09	Sex between adults	Note by psychologist who discussed the incident with AJ and reviewed safe sex precautions.
		RB 9/5/09	Sex between adults-propositioner	Denied making proposition. Advised to stay away from individual making the complaint.
		VG 9/5/09	Sex between adults-propositioned	Advised to maintain distance from individual who allegedly made the proposition.
		AR 6/8/09	Sexual assault-aggressor	Angry when found. Medicated. Monthly psychiatrist's note addresses the incident.
		NS 6/8/09	Sexual assault-victim	"Emotional support is available with psychologist upon request." Counseling and education provided.
		Compliance: Partial. **Current recommendation**: Provide the findings from monitoring of WRPTs' responses to sexual incidents.		
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are	**Current findings on previous recommendation:** **Recommendation, June 2009:** Continue ensuring that non-clinical Mall providers receive the designated training.		

likely to intervene in incidents are properly trained to work with individuals with mental health concerns.

Findings:
As indicated in the table below, PSH has increased the percentage of facilitators who have completed the complement of required courses.

Course	Nov 2008 - Apr 2009	May 2009 - October 2009
PMAB	94%	97%
CPR	88%	92%
First Aid	94%	94%
Recovery (chapter 1)	79%	86%
By Choice	87%	90%
Patients Rights	88%	92%
Neglect and Abuse	94%	97%
Mean Compliance Rate	87%	93%

Compliance:
Substantial.

Current recommendation:
Continue current practice ensuring the availability of and monitoring training for Mall facilitators.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. For 19 of the 20 questions in the August 2009 Individual Survey, the desired (positive) response improved compared to the prior survey. Fourteen of the 20 questions received desired responses above 65%. 2. The individuals continue to have a representative on the Quality Council. The minutes of the Central Council document the representative's briefing to the individuals attending regarding issues raised in the QC. 3. Quality Council minutes document its request that the individuals assist the facility through the Central Council and other bodies in identifying causes of violence and responses that will make the facility safer. 4. The minutes of the Central Council clearly document questions raised by individuals and the response from administration at the time or at a subsequent meeting from administration. A partial listing of the issues handled is presented in the cell below. 5. The Central Council identifies issues of importance to its members that it will work on in the upcoming months. Progress on some of these issues is evident from year to year. 6. In its minutes and in the Roadmap for 2010, the Central Council acknowledges and expresses appreciation for opportunities to participate in decision-making as well as for issues resolved.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: Several individuals during unit tours <u>Reviewed</u>: 1. Individual Survey results 2. Central Council Minutes for July, August and September 3. Central Council Roadmap for 2010

J

Current findings on previous recommendation:

Recommendation, June 2009:
Investigate methods for broadening telephone communication, such as the use of calling cards that have been found acceptable in other facilities.

Findings:
DMH undertook a survey of the five facilities related to the use of phone cards. The survey results indicate that at the time of the survey in mid-August, none of the facilities sells phone cards; only one facility (NSH) allows individuals to keep phone cards in their possession; and one allows individuals to record the pin number, but not keep possession of the card. PSH changed to a new telephone carrier during the last year. The same eight-mile restriction on local calls ($0.50 charge) remains in effect, but the collect call rates have been reduced.

Other findings:
The August 2009 Individual Survey saw an increase in positive responses.

	Percentage of positive responses	
Item	February 2009	August 2009
Feel safe?	60%	71%
Treated with respect?	70%	72%
Environment clean?	68%	72%
Encouraged to be of service to others?	58%	55%
Staff make sure rules are followed?	74%	76%
Unit's rules are fair?	61%	69%
Staff believe I can get better?	71%	82%
I have input into hospital rules and policies.	52%	55%

		The Central Council minutes document questions from individuals and replies from administrators attending the meeting or reported in later minutes. The Council minutes frequently express appreciation for the sharing of timely information and for issues resolved. Among the issues raised and resolved or in the process of being resolved are improvement in the timely distribution of packages; the installation of software on unit computers to permit individuals to use flash drives; the extension of evening grounds when weather permits; MedPass malfunctioning that created serious backup; clarifications of the purpose of NEMO rooms (New Enhancement Motivational Opportunities) for individuals who do not attend Mall groups; and library hours. The representative of the individuals on the Quality Council reports information from the QC to his peers on the Central Council. This included a request from the QC for input from individuals on the causes of violence and suggestions for making the facility safer. Recent minutes note that representatives of the Senate were asked to participate in the selection of a vendor for the hospital canteen. The Central Council Roadmap for 2010 lists the top eight concerns identified by the Senate. These are, in rank order beginning with the highest concern (the number in parentheses following an item is its rank in the 2009 listing of concerns): • Unchecked violence continues to affect the quality of life at the facility. (1) • Quality of Mall treatment groups. This has been one of the top two concerns for the five years we've been creating these lists. (2)* • Telephone system with fewer or no restrictions. (8) • The facility should designate one time slot per week during afternoon mall for Ward Government meetings facility-wide. • Staff are so preoccupied with the Enhancement Plan that they have no time for us to address our human need for contact or to simply be

		friendly and caring. • We ought to be able to spend our own money as and when we choose. (9) • The growing frequency and poor quality of "alternative mall" treatment. (2)* • Concerns related to medical care in outside facilities: appointment cancellations with little or no notice, the manner of transportation to and conditions while waiting, including wearing shackles and being forced to sit on the floor of the waiting area often without access to a bathroom. (5) *Both ranked 2 in previous year; may have been a single item last year and separated into two items this year. The Roadmap also identifies the issues where progress has been made in the past year. These include: • Positive changes in the Visiting Center after the facility took over most of the process from CDCR. • Positive changes in the Package Room. Packages are processed all day long and are reaching the recipients much more quickly. • By Choice points are being posted daily instead of once a week. • Individuals report being asked during WRPT meetings about their By Choice point allocations and being able to make adjustments. • The Supplemental Activity Program was described as wonderful, valuable and fun. • Treatment conferences have increased in frequency and improved in quality. • The Distance Learning Program via Coastline College is "a wonderful thing." **Compliance:** Partial; improved compared to last review.

		Current recommendations: 1. Continue to work toward a telephone system that reduces impediments to maintaining communication with family, friends and legal representatives. 2. Investigate the conditions that individuals describe enduring during outside medical appointments. Take measures to correct any conditions that unnecessarily compromise an individual's dignity. The first provision of the Protection from Harm section of the EP requires a humane environment.