

REPORT 9

PATTON STATE HOSPITAL

December 6-10, 2010

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

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

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

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

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

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

SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
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
Tx	Treatment
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan

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

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from December 6-10, 2010 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 CM 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. No ratings of non-compliance were assigned in this report. 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. The facility should confirm the data on several indicators that appear to display marked unusual patterns, such as the numbers of diagnoses of diabetes mellitus and of individuals receiving new generation antipsychotics, which have diverged from their usual relationship for the second consecutive review period.

2. Monitoring, mentoring and self-evaluation

- a. PSH has maintained significant progress in self-assessment and data presentation.
- b. Regarding the process of self-assessment, this monitor has requested the following:
 - i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
 - Comparison of the mean compliance rates for the main indicator in the entire 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.
- c. PSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.
- d. 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.
- e. The CM will accept further reasonable reduction in the self-auditing samples if DMH, with input from the facilities and practitioners, determines that this reduction is needed to ensure that senior clinicians achieve adequate balance in time spent in auditing and time spent in clinical activities and oversight.

3. Implementation of the EP

This tour marks the end of what could be called round nine. At this juncture, it is critical that the CM and DMH have common understanding of what is required in the next and final phase. The following is an overview of the CM's perspective as it applies to all four facilities:

- a. All four facilities have made significant process improvements in most requirements of the EP. However, some of the facilities have lagged behind in the implementation of some of the requirements of the EP that pertain to the safety of individuals. This is unacceptable at this time and jeopardizes the timely achievement of overall compliance with the terms of the EP.

- b. The EP is structured to address all domains of care of individuals: treatment, rehabilitation and enrichment, but the requirements embedded in each cell do not have equal clinical significance. There is in fact a hierarchy of significance that all clinicians would agree with, which is that in any hospital setting, requirements that address individuals' safety and well-being must always have priority over other requirements. For example, if a facility's risk management system doesn't identify and ameliorate a source of harm to an individual, the value is stripped from that individual's top-notch nutritional assessment, spotless By Choice point record and state-of-the-art dental care. These services are all important, but they gain their value from being layered on a foundation of safety.
- c. The CM cautions the facilities not to be exclusively focused on numerical counting of the compliance ratings. If 90% of the cells have a compliance rating of Substantial, but if the 10% of cells that don't are critical to individual safety, a facility cannot be found in substantial compliance with the terms of the EP.
- d. The successful conclusion of this process requires the following:
 - i. The facilities must maintain current progress in the implementation of different requirements of the EP;
 - ii. Compliance with the EP must include, at a minimum, compliance with the requirements that are essential to the safety and well-being of the individuals. One must keep in mind that no facility can guarantee the safety of its individuals and that certain events can be explained by some combination of contributing factors independent of clinical performance. However, all facilities as well as DMH must have an adequate Quality Management function to ensure continuous review of systemic trends and patterns in data, particularly key indicator data that pertain to safety, analysis of factors that contribute to these trends and patterns, a process of formulating data-based recommendations for corrective actions and follow-up of the implementation and effectiveness of these actions.
 - iii. It is critical to establish a self-sustaining system that is driven by formalized, objective processes that:
 - Provide a framework for (but also facilitate) practitioners' performance;
 - Establish a channel for effective dialogue with clinicians; and
 - Ensure that practitioners are invested in this system. If they are not, there is a real risk that progress made thus far will not be self-sustaining. This monitor emphasizes that achieving a reasonable balance between documentation requirements and time spent in direct care and appropriate balance where clinical discipline/protocol meets clinical craft will facilitate the engagement and collaboration of the clinical staff in ensuring that the implementation of the EP will have long-lasting benefits to the system.

The following is an overview of findings regarding PSH:

- e. During the last six months, PSH has maintained progress in many areas of the EP, with the most significant achievement being the recruitment and retention of highly qualified and committed practitioners. The leadership of the facility's Medical

Director, George Christison, MD, has been instrumental in this area. The facility's progress is outlined in each corresponding section of this report.

- f. The facility's quality management system has yet to meet standards. The facility has a Quality Council that did not perform its most essential functions, including strategic planning, and did not seek to obtain the guidance and assistance that is needed from DMH. As a result, there existed a situation in which serious and critical incidents of harm have continued to occur without timely or adequate analysis of trends and patterns, assessment and understanding of factors that contribute to these events and development and implementation of clinical and systemic corrective actions that are needed to improve the safety and well being of individuals. This must be corrected as soon as possible.
- g. The facility has maintained effective training and mentoring programs regarding the process of Wellness and Recovery Planning. However, further work is needed from DMH to streamline both the process and content of the WRP review with input from practitioners. This is necessary to ensure that the WRPTs do not lose focus on the main current needs of the individuals as they adhere to the process steps of the WRPC and to find a reasonable allocation of time between direct care and documentation of this care.
- h. PSH has maintained an effective system of psychiatric and medical leadership as well as leadership of its substance use services program.
- i. The facility has made further progress in the provision of a cognitive remediation program that adequately meets the specialized needs of individuals with cognitive impairments;
- j. PSH has made further progress in ensuring a well-functioning PSR Mall that meets the specific needs of the individuals.
- k. The DMH must complete the analysis that was initiated by the facility's Medical Director, George Christison, MD of trends, patterns and contributing factors in patient-to-staff aggression. This analysis was an excellent start, but more inter-disciplinary work is needed to address additional factors. Informed by this analysis, corrective actions must be developed and implemented.

4. Staffing

The table below shows the staffing pattern at PSH as of October 31, 2010:

Patton State Hospital Vacancy Totals as of October 31, 2010				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0%
Assistant Director of Dietetics	5.00	4.00	1.00	20%

Patton State Hospital Vacancy Totals as of October 31, 2010

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Audiologist I	1.00	1.00	0.00	0%
Chief Dentist	1.00	1.00	0.00	0%
Chief Physician & Surgeon	1.00	1.00	0.00	0%
Chief, Central Program Services	0.00	0.00	0.00	0%
Chief Psychologist	1.00	1.00	0.00	0%
Clinical Dietician/Pre-Reg. Clin Dietician	14.00	14.00	0.00	0%
Clinical Laboratory Technologist	0.00	0.00	0.00	0%
Clinical Social Worker	97.50	96.00	1.50	2%
Coordinator of Nursing Services	1.00	1.00	0.00	0%
Coordinator of Volunteer Services	1.00	1.00	0.00	0%
Dental Assistant	4.00	4.00	0.00	0%
Dentist	2.00	2.00	0.00	0%
Dietetic Technician	4.00	2.50	1.50	38%
E.E.G. Technician	0.00	0.00	0.00	0%
Food Services Technician I and II	101.00	99.50	1.50	1%
Hospital Worker	0.00	0.00	0.00	0%
Health Record Technician I	8.00	8.00	0.00	0%
Health Record Techn II Spec	3.00	3.00	0.00	0%
Health Record Techn II Supv	1.00	1.00	0.00	0%
Health Record Techn III	1.00	1.00	0.00	0%
Health Services Specialist	24.00	21.00	3.00	13%
Institution Artist Facilitator	0.00	0.00	0.00	0%
Licensed Vocational Nurse	68.00	67.00	1.00	1%
Medical Technical Assistant	0.00	0.00	0.00	0%

Patton State Hospital Vacancy Totals as of October 31, 2010

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Medical Transcriber	5.00	5.00	0.00	0%
Medical Transcriber Sup	0.00	0.00	0.00	0%
Sr Medical Transcriber	2.00	1.00	0.00	0%
Nurse Instructor	5.00	5.00	0.00	0%
Nurse Practitioner	5.00	5.00	0.00	0%
Nurse Coordinator	12.00	12.00	0.00	0%
Office Technician	32.00	29.00	3.00	9%
Pathologist	0.00	0.00	0.00	0%
Pharmacist I	15.00	15.00	0.00	0%
Pharmacist II	1.00	1.00	0.00	0%
Pharmacist Services Manager	1.00	1.00	0.00	0%
Pharmacy Technician	11.00	11.00	0.00	0%
Physician & Surgeon	23.00	20.75	2.25	10%
Podiatrist	1.00	1.00	0.00	0%
Pre-Licensed Pharmacist	0.00	0.00	0.00	0%
Pre-Licensed Psychiatric Technician	2.00	2.00	0.00	0%
Program Assistant	8.00	8.00	0.00	0%
Program Consultant (RT,PSW)	0.00	0.00	0.00	0%
Program Director	10.00	8.00	2.00	20%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0%
Psychiatric Technician	688.00	670.00	18.00	3%
Psychiatric Technician Trainee	0.00	0.00	0.00	0%
Psychiatric Technician Assistant	35.00	34.00	1.00	3%
Psychiatric Technician Instructor	1.00	1.00	0.00	0%

Patton State Hospital Vacancy Totals as of October 31, 2010

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Psychologist-HF, (Safety)	71.50	69.75	1.75	2%
Public Health Nurse II	2.00	2.00	0.00	0%
Radiological Technologist	1.00	1.00	0.00	0%
Registered Nurse	379.10	369.00	10.10	3%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0%
Rehabilitation Therapist	89.30	83.75	5.55	6%
Special Investigator	5.00	5.00	0.00	0%
Special Investigator, Senior	3.00	3.00	0.00	0%
Speech Pathologist I	1.00	1.00	0.00	0%
Sr. Psychiatrist (Spvr)	13.20	8.00	5.20	39%
Sr. Psychologist (Spvr and Spec)	24.50	23.00	1.50	6%
Sr. Psych Tech (Safety)	77.00	77.00	0.00	0%
Sr. Radiological Technologist (Specialist)	1.00	1.00	0.00	0%
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor 2	3.00	2.00	1.00	33%
Staff Psychiatrist	93.40	80.00	13.40	14%
Supervising Psychiatric Social Worker	5.00	5.00	0.00	0%
Supervising Registered Nurse	3.00	2.00	1.00	33%
Supervising Rehabilitation Therapist	4.00	3.00	1.00	25%
Teacher-Adult Educ./Vocational Instructor	14.40	12.00	2.40	17%
Teaching Assistant	0.00	0.00	0.00	0%
Unit Supervisor	33.00	31.00	2.00	6%
Vocational Services Instructor (Landscp Gardn) (S)	0.00	0.00	0.00	0%

Key vacancies include senior and staff psychiatrists.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with 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 6-10, 2011.
2. The Court Monitor's team is scheduled to tour Napa State Hospital January 24-28, 2011 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C. Integrated Therapeutic and Rehabilitation Services Planning		
	<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has maintained substantial compliance with the requirements of Section C.1 and maintained an adequate system of mentoring and training of WRPTs in the process of Wellness and Recovery Planning. However, further work is needed to streamline the process (and content) of the WRP review with input from practitioners. This is necessary to ensure that the WRPTs do not lose focus on the main current needs of the individuals as they adhere to the process steps of the WRPC and to find an appropriate balance in the time spent in documentation and auditing and time spent in direct care of the individuals. 2. PSH has maintained substantial compliance with most of the requirements of Section C.2, including assessment and provision of interventions to address the specialized needs of individuals suffering from cognitive, seizure and substance use disorders. However, the facility has to yet to make progress to ensure that the WRP treatment objectives for individuals with other Axis I disorders adequately address the current needs of the individuals.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Daphne Erhart, PsyD, Acting Wellness and Recovery Planning Chief 2. Gari-Lyn Richardson, Director, Standards Compliance 3. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Clinical Chart Auditing Form summary data (May to October 2010) 2. PSH WRP Observation Monitoring summary data (May to October 2010) 3. PSH WRP Team Facilitator Observation Monitoring Form summary data (May to October 2010) 4. PSH data regarding staffing ratios on admissions and long-term units (May to October 2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit U06) for annual review of DEB 2. WRPC (Program I, unit EB11) for monthly review of LGM 3. WRPC (Program I, unit EB04) for quarterly review of BA 4. WRPC (Program III, unit 31) for annual review of PC 5. WRPC (Program VI, unit EB12) for 14-day review of LT 6. WRPC (Program VI, unit EB09) for 14-day review of LMD 7. WRPC (Program VI, unit 75) for quarterly review of RMM 8. WRPC (Program VI, unit 71) for 14-day review of RMV 9. WRPC (Program VII, unit 73) for quarterly review of JVP 10. WRPC (Program VIII, unit 25) for monthly review of RS 11. WRPC (Program VIII, unit 21) for quarterly review of MLB

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Provide an update of WRP training and mentoring activities provided to the WRPTs during the review period. • Continue to monitor this requirement. <p>Findings:</p> <p>During this review period, PSH continued its WRP training and mentoring activities as follows:</p> <ol style="list-style-type: none"> 1. Phase II WRP (program-wide) training was provided to staff who were referred by supervisors or Program-Wide Trainers (PWTs) as described in the previous report. Under the joint supervision of the Standards Compliance department and the Medical Director, six PWTs participated throughout the current review period, a decrease from eight trainers during the previous review period. Those currently being trained were either new employees or employees who required further training. All staff who were referred for training reportedly received the training. The chart below shows the numbers of persons trained during the review period: <table border="1" data-bbox="1024 1003 1894 1344"> <thead> <tr> <th>Module</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> </tr> </thead> <tbody> <tr> <td>Present Status</td> <td>40</td> <td>15</td> <td>0</td> <td>5</td> <td>14</td> <td>7</td> </tr> <tr> <td>Foci, Objectives and Interventions</td> <td>22</td> <td>13</td> <td>0</td> <td>5</td> <td>12</td> <td>6</td> </tr> <tr> <td>Life Goal/Barriers to Discharge</td> <td>29</td> <td>10</td> <td>0</td> <td>5</td> <td>11</td> <td>6</td> </tr> <tr> <td>Focus 6/Care Plans</td> <td>37</td> <td>5</td> <td>11</td> <td>28</td> <td>8</td> <td>5</td> </tr> <tr> <td>Total</td> <td>128</td> <td>43</td> <td>11</td> <td>43</td> <td>45</td> <td>24</td> </tr> </tbody> </table> <p>The facility reported that PWTs reviewed auditing data and</p>	Module	May	Jun	Jul	Aug	Sep	Oct	Present Status	40	15	0	5	14	7	Foci, Objectives and Interventions	22	13	0	5	12	6	Life Goal/Barriers to Discharge	29	10	0	5	11	6	Focus 6/Care Plans	37	5	11	28	8	5	Total	128	43	11	43	45	24
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		<p>provided written and/or verbal feedback regarding needed corrections and then reviewed the changes made by the teams. Additionally, the PWTs acted as resources for WRPT members who had questions regarding the correct completion of the WRP document.</p> <p>2. Computer lab-based training on the WRP documentation requirements and navigation of WaRMSS modules was continued. During this review period, 94 nursing staff who were referred by their supervisors or one of the PWTs were trained. An addition to sample Focus 6 nursing treatment plans, which was initiated during the last review period, was developed during the current review period and posted on the Patton intranet.</p> <p>3. WRPC mentoring was continued during this review period. Nine mentors participated (one MD, three PhDs, three SWs and two RTs). Mentoring was provided under the supervision of Dr. Jason Rowden, Senior Psychologist (May through September 2010) and Dr. Daphne Erhart, Senior Psychologist (October 2010). A total of 14 teams across programs were mentored. The majority of teams selected for mentoring had newly hired psychiatrists (hired since June 2009). One all-mentor meeting occurred during this review period to ensure consistency of approach and standards.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WPRCs held each month (May-October 2010). The following is a summary of the results:</p> <table border="1" data-bbox="982 1222 1879 1409"> <tr> <td data-bbox="982 1222 1075 1372">1.</td> <td data-bbox="1075 1222 1780 1372"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1780 1222 1879 1372">96%</td> </tr> <tr> <td data-bbox="982 1372 1075 1409">2.</td> <td data-bbox="1075 1372 1780 1409"><i>Treatment, rehabilitation and enrichment services are</i></td> <td data-bbox="1780 1372 1879 1409">95%</td> </tr> </table>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	96%	2.	<i>Treatment, rehabilitation and enrichment services are</i>	95%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	96%						
2.	<i>Treatment, rehabilitation and enrichment services are</i>	95%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></p>	
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>Other findings: The monitor and his experts attended 11 WRPCs. The meetings showed that PSH has, in general, maintained its progress in this area. However, the facility needs to ensure that the teams do not lose focus on individuals' main current needs as they adhere to the process steps of the WRPC. Current efforts to streamline the process (and content) of WRP review and documentation of this review can be very helpful in this regard.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the review period. 2. Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners. 3. Continue to monitor this requirement. 	
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>	

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a mean compliance rate of 99% based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 83% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 670 1881 972"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>The team psychiatrist was present.</i></td> <td style="width: 15%;">90%</td> </tr> <tr> <td>2.</td> <td><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 2-4 and improved compliance for item 1 from 87% in the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present.</i>	90%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	99%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%	4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	97%
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C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 99% based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, PSH reported a compliance rate of 96% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.1.e	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 99% based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 98% for the review period, based on a 21% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that PSH has maintained a compliance</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (May-October 2010). The facility reported 100% compliance with the indicator regarding the identification of someone with the responsibility for implementation of this requirement. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Findings: PSH presented core WRPT member attendance data based on an average sample of 21% of quarterly and annual WRPCs held during the review period (May-October 2010):</p> <table border="1" data-bbox="982 376 1745 721"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>88%</td> <td>86%</td> </tr> <tr> <td>Psychiatrist</td> <td>87%</td> <td>90%</td> </tr> <tr> <td>Psychologist</td> <td>89%</td> <td>86%</td> </tr> <tr> <td>Social Worker</td> <td>86%</td> <td>90%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>90%</td> <td>89%</td> </tr> <tr> <td>Registered Nurse</td> <td>98%</td> <td>97%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>96%</td> <td>97%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous review period	Current review period	Individual	88%	86%	Psychiatrist	87%	90%	Psychologist	89%	86%	Social Worker	86%	90%	Rehabilitation Therapist	90%	89%	Registered Nurse	98%	97%	Psychiatric Technician	96%	97%
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C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="982 1276 1667 1427"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> </tbody> </table>		Previous review period	Current review period	Admission Units			MDs	1:15	1:15															
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		<table border="1"> <tr><td>PhDs</td><td>1:15</td><td>1:16</td></tr> <tr><td>SWs</td><td>1:15</td><td>1:15</td></tr> <tr><td>RTs</td><td>1:15</td><td>1:15</td></tr> <tr><td>RNs</td><td>1:6</td><td>1:6</td></tr> <tr><td>PTs</td><td>1:3</td><td>1:3</td></tr> </table>	PhDs	1:15	1:16	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:6	1:6	PTs	1:3	1:3									
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		<table border="1"> <tr><td colspan="3">Long-Term Units</td></tr> <tr><td>MDs</td><td>1:25</td><td>1:25</td></tr> <tr><td>PhDs</td><td>1:26</td><td>1:26</td></tr> <tr><td>SWs</td><td>1:25</td><td>1:25</td></tr> <tr><td>RTs</td><td>1:27</td><td>1:25</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>			Long-Term Units			MDs	1:25	1:25	PhDs	1:26	1:26	SWs	1:25	1:25	RTs	1:27	1:25	RNs	1:8	1:8	PTs	1:3	1:3	
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C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Same as C.1.a through C.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as C.1.a through C.1.f.</p>																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Allen Kilian, PsyD 2. Allison Pate, PhD, Senior Supervising Psychologist 3. Angela Broehl, PT 4. Brian Starck-Riley, Assistant Director of Nutrition Services 5. Chris Keierleber, Senior Rehabilitation Therapist 6. Christy Crespin, CSW 7. Daphne Erhart, PsyD, Acting Wellness and Recovery Planning Chief 8. David Haimson, PhD, Chief of Psychology 9. Delores Otto-Moreno, Assistant Director of Nutrition Services 10. Elise Cheng, PsyD 11. Erica Easterly, PsyD, Program-Wide Trainer 12. Erin Cross, BA, CTRS, Program-Wide Trainer 13. Gari-Lyn Richardson, Director, Standards Compliance 14. Giancarlo Gonzalez, Program Director, Enhancement Services 15. Grace Ferris, Assistant Director of Nutrition Services 16. Greg Siples, Director of Rehabilitation Therapy Services 17. Helga Thordarson, PhD, Senior Supervising Psychologist 18. Hope Marriott, LCSW, Assistant to Clinical Administrator 19. Jeffrey Lawler, MD 20. Jenna Arthurton, RT 21. Jonathan Myer, MD, Staff Psychiatrist, Director Substance Abuse Services 22. Jacquelyn Williams, PsyD, SAFE staff coordinator 23. Kevin Garland, Supplemental Activities Coordinator 24. Maria Carreon, RN 25. Mark Richards, PT, By Choice Assistant Coordinator 26. Mark Williams, PhD, PBS Team member 27. Martin Oswari, RN 28. Melanie Byde, PhD, Senior Psychologist, Mall Director

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		<p>29. Michelle Hernandez, RN 30. Nitin Kulkarni, MD, Assistant Medical Director 31. Rachel Strydom, LCSW, Supervising Social Worker 32. Rebecca Griffin, Acting Senior Rehabilitation Therapist 33. Rebecca Kornbluh, MD, Acting Chief of Psychiatry 34. Renata Geyer, Senior Rehabilitation Therapist 35. Robert Koranda, PsyD, Program-Wide trainer 36. Rufino Co, MD 37. Sabrina Eisner, CSW 38. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 39. Sharon Morrison, PT 40. Stan Hydingler, Senior Rehabilitation Therapist 41. Steve Berman, PhD, By Choice Coordinator 42. Susan Velasquez, PhD, PSSC Coordinator 43. Tai Kim, Director of Nutrition Services 44. Vivian Collins, Acting Assistant Director of Nutrition Services</p> <p><u>Reviewed:</u></p> <p>1. The charts of the following 117 individuals: AA, AAA, AC, AER, AKA, AS, AY, BA, BC, BPH, CG, CGD, CH, CJS, CLG, CS, CT, DCF, DG, DGA, DLG, DRS, DS, DTJ, EB, EEC, EJW, EK, EM, FDH, GL, GR, GRR, GRS, HDM, HLD, HM, HV, JG, JK, JL, JMV, JPF, JRB, JT, JV, JW, KA, KAM, KCY, KG, KHM, KJ, KLS, KR, KRE, LDL, LEL, LG, LL, LM, LMP, LS, MAE, MAM, MB, MDC, MDF, MDF, MEM, MG, MH, MJM, MLR, MM, MM-2, MMB, MPA, MR, MSB, PE, PEL, PH, PS, PT, QH, RA, RAS, RDH, RF, RH, RLC, RLH, RMM, RMO, RRA, RRJ, RS, SA, SC, SH, SLE, SMK, ST, SW, TC, TFH, THE, TJ, TLO, TN, TW, TY, WE, WG, WS and YRR</p> <p>2. One WRP per team for the following 67 individuals: AA, AC, AGM, AJM, ALG, AM, ARB, BKS, CAB, CCH, CDF, CEH, CH, CJS, CWC, DFS, DG, DJV, DNE, DRJ, DW, EEC, ES, FAT, FDW, FS, GIW, GPS, GRR, HG, JAM, JBW, JC, JG, JJT, JLM, JNL, KAI, KAM, KLS, LL, LT, MB, MJV, MLB, MLV, MW, OV, PEL, PP, PS, PSP, RAD, RAE, RC, RH, RMM,</p>
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		<p>SBP, SH, SJA, SML, SRD, TN, VM, WM, ZB, and ZHO</p> <ol style="list-style-type: none"> 3. PSH WRP Observation Monitoring summary data (May-October 2010) 4. PSH Clinical Chart Auditing Form summary data (May-October 2010) 5. PSH Chart Auditing Form summary data (May-October 2010) 6. Summary of three DMH approved streamlining changes to the WRP. 7. Lesson Plans for the following groups: <ul style="list-style-type: none"> • Chains Group for CJS • The Process to Self Empowerment for MAM and TC • Medication Education for MAM and TC • Stress Management for MB • Understanding Mental Health for TC • Creative Arts Therapy for CJS • Cognitive Remediation for TC and RMM • Cognitive Skills Building through Movement and Rhythm for MM-2 • Tone Chimes Choir for DG, DRS, LL, and TN • Face It and Pace It for LL • Crisis Management for TC and MAM • Beginning Relapse Prevention for Co-Occurring Disorders for MB • Medication Awareness for GRR • Depression and Bipolar Support for GRR • Psychotherapy Group and WRP for CH • Functional Rehabilitation Educational Experience (FREE) for JNL, includes course materials 8. Summary of number and hours of cognitive remediation groups current and previous review period 9. Current WRP with corresponding Focus 1 PSR Mall Progress Notes for the following six individuals: CJS, GRR, MAM, MB, SC, and TC 10. Summary data substance abuse process and clinical outcomes 11. PSH Consumer Satisfaction Survey summary data 12. PSH WRP Substance Abuse Auditing Form summary data (May to October 2010) 13. Data regarding Medication Education groups and individuals enrolled 14. Data regarding WRP Education groups and individuals enrolled
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		<ol style="list-style-type: none"> 15. List of individuals assessed to need family therapy 16. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 17. List of individuals who met trigger threshold during this review period 18. List of individuals with aggression to self with major injury 19. List of individuals with high BMI in exercise groups 20. List of individuals with substance disorders 21. List of psychosocial enrichment activities 22. List of scheduled exercise groups 23. List of scheduled vs cancelled medical appointment 24. List of staff trained during New Employee Orientation 25. List showing aggressive incidents (September through November, 2010) 26. Mall non-adherence list 27. PSR Mall Lesson Plans 28. PSR Mall Monthly Progress Note completion database 29. Verification of competency for providing substance abuse groups <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit EB11) for monthly review of LGM 2. WRPC (Program VI, unit 75) for quarterly review of RMM 3. WRPC (Program VI, unit EB09) for 14-day review of LMD 4. Mall Group: Cognitive Remediation 5. Mall Group: Karaoke, Spanish Group 6. Mall Group: Mindfulness Through Laughter 7. Mall Group: RISE, Cognitive Remediation 8. Mall Group: SAFE Program 9. Mall Group: Stress Management 10. Mall Group: Substance Recovery (Stage of Change 1-3) 11. Three groups for Substance Abuse Education, led by Andrei Bryant, Melissa Roskos and Kathy Freeman
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C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 96% based on an average sample of 21% of the WRPCs held each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010). Based on an average sample of 45% of the A-WRPs, the facility reported a mean compliance rate of 97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review</p>

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		<p>period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (AC, CLG, KG, LMP, MAM, MB, MM, RLC, SC, and TC) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 62% of the 7-day WRPs, the facility reported a mean compliance rate of 98% with this requirement. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (AC, CLG, KG, LMP, MAM, MB, MM, RLC, SC, and TC) found compliance in all cases.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>															
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 599 1650 829"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>25%</td> <td>94%</td> </tr> <tr> <td>Monthly</td> <td>19%</td> <td>91%</td> </tr> <tr> <td>Quarterly</td> <td>25%</td> <td>91%</td> </tr> <tr> <td>Annual</td> <td>29%</td> <td>92%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: A review of the charts of 12 individuals (AC, CJS, CLG, GR, KG, LMP, MAM, MB, MM, RLC, SC and TC) found compliance in eight charts (CJS, CLG, GR, KG, MAM, MB, MM and RLC) and partial compliance in four (AC, LMP, SC and TC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	25%	94%	Monthly	19%	91%	Quarterly	25%	91%	Annual	29%	92%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	25%	94%															
Monthly	19%	91%															
Quarterly	25%	91%															
Annual	29%	92%															

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<p>C.2.c</p>	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 14% to 49% of the relevant population for each sub-indicator during the review period (May-October 2010).</p> <table border="1" data-bbox="991 597 1885 1122"> <tr> <td data-bbox="991 597 1087 784">2.</td> <td data-bbox="1087 597 1791 784"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 597 1885 784">95%</td> </tr> <tr> <td data-bbox="991 784 1087 898">2.a</td> <td data-bbox="1087 784 1791 898"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 784 1885 898">92%</td> </tr> <tr> <td data-bbox="991 898 1087 1011">2.b</td> <td data-bbox="1087 898 1791 1011"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 898 1885 1011">97%</td> </tr> <tr> <td data-bbox="991 1011 1087 1122">2.c</td> <td data-bbox="1087 1011 1791 1122"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 1011 1885 1122">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the following:</p>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	95%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	92%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	97%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	95%
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	95%												
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		<ol style="list-style-type: none"> 1. The WRPs of eight individuals suffering from various cognitive disorders, including Dementia Due to General Medical Condition without Behavioral Disturbance (LL and RAS), Alcohol-Induced Persisting Dementia (KJ), Cognitive Disorder NOS (DGA, DRS and TN) and Borderline Intellectual Functioning (DG, MM-2 and RMM); 2. The charts of six individuals diagnosed with seizure disorders (CH, MG, SA, TW, TY and WG); 3. Lesson plans of groups that offered cognitive remediation (formal or informal) during this review period for six individuals suffering from cognitive disorders (DG, DRS, LL, MM-2, RMM and TN); and 4. PSH Cognitive rehabilitation Update, December 2010. <p>The reviews found that the facility maintained progress in all of the areas that were outlined in the previous report and made further progress in decreasing the number of individuals who are diagnosed with seizure disorders and are prescribed high-risk anticonvulsant medications. The review found a few deficiencies as follows:</p> <ol style="list-style-type: none"> 1. An individual (MG) was diagnosed with seizure disorder on October 1, 2010 and started on phenytoin on October 4, 2010 based on the individual's reported history. However, the most recent WRP (11/29/10) did not include objectives/interventions to address the seizure disorder (the plan included an adequate focus related to this condition). 2. An individual (CH) was diagnosed with Behcet's Syndrome (and seizure disorder) and Cognitive Disorder NOS and received treatment with an older anticonvulsant agent (phenobarbital). Although the WRP included adequate objectives and interventions to address the seizure disorder, the plan did not address the cognitive risks of treatment in this individual. <p>Compliance: Substantial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide a summary of changes in the number, range and content of cognitive rehabilitation interventions during the review period.
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH reported a compliance rate of 99% based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Recommendation 2, June 2010: Continue efforts to streamline the review and presentation of data in the</p>

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		<p>case formulation.</p> <p>Findings: PSH presented a summary of draft facility suggestions to streamline the content of the WRPs. This monitor found that these suggestions were potentially helpful in decreasing the documentation burden for practitioners and focusing the WRPTs on the current relevant needs of the individuals while meeting the requirements of the EP. DMH was in the process of synthesizing initiatives presented by various facilities and developing a plan of implementation.</p> <p>Other findings: This monitor reviewed one WRP per team for the following 67 individuals: AA, AC, AGM, AJM, ALG, AM, ARB, BKS, CAB, CCH, CDF, CEH, CH, CJS, CWC, DFS, DG, DJV, DNE, DRJ, DW, EEC, ES, FAT, FDW, FS, GIW, GPS, GRR, HG, JAM, JBW, JC, JG, JTT, JLM, JNL, KAI, KAM, KLS, LL, LT, MB, MJV, MLB, MLV, MW, OV, PEL, PP, PS, PSP, RAD, RAE, RC, RH, RMM, SBP, SH, SJA, SML, SRD, TN, VM, WM, ZB, and ZHO.</p> <p>The review found general evidence that PSH has maintained substantial compliance with this requirement of the EP. However, the facility has yet to make progress in improving the linkage between the case formulation and the foci and objectives outlined in the WRP (see C.2.e and C.2.f.iii).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that current streamlining efforts facilitate linkage between case formulations and treatment objectives (i.e. treatment objectives adequately address the current status of the individual). 2. Continue to monitor this requirement.
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating	97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.

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	factors; previous treatment history, and present status;	
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	96%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Address and correct this monitor's finding of deficiency as described [in this cell in the previous report]. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the review period and

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		<p>compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH reported a compliance rate of 99% based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed one WRP from each WRPT in the facility (same as in C.2.d.i). This review found that the facility has yet to make progress in improving the linkage between the treatment objectives and the case formulation, and in ensuring that the treatment objectives adequately address the current needs of the individuals. The main reason for this deficiency was that too many objectives were developed for a given focus, primarily focus 1, and that these objectives were essentially the same as those of different groups to which individuals were assigned rather than being focused on the current status of the individual. This finding also applies to the requirement in C.2.f.iii.</p> <p>This monitor also reviewed the records of 11 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.e. Ten records were in substantial compliance (AAA, DG, EB, EJW, JRB, LS, MAE, MPA, WS and YRR) and one record was in not in compliance (RRA).</p> <p>This monitor also reviewed the records of 11 individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p>
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		<p>Finally, this monitor reviewed the records of 14 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.d.i. 2. Continue to monitor this requirement.
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH assessed compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (May-October 2010). The facility reported a compliance rate of 96% for this requirement. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review</p>

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		<p>period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (CJS, GRR, MB, MEM, SC and TC). The review found substantial compliance in five charts and partial compliance in one (CJS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH reported a compliance rate of 100% based on an average sample of 29% of the quarterly and annual WRPs due each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (CJS, GRR, MB, MEM, SC and TC) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Same as in C.2.e.</p> <p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Same as in C.2.d.i and C.2.e. Although these reviews found that most of the objectives were stated in behavioral, observable and/or measurable terms, the deficiency referenced in C.2.d.i and C.2.e is such that these objectives are inadequate to address the current needs of the individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in C.2.d.i. 2. Continue to monitor this requirement.
C.2.f.iv	<p>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

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		<p>Findings: The facility reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Chart reviews found substantial compliance in four charts (GRR, MEM, SC and TC) and partial compliance in two (CJS and MB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (CJS, GRR, MB, MEM, SC and TC) and found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>																																										
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following data for the current review period (May-October 2010) and previous period:</p> <table border="1" data-bbox="991 636 1887 941"> <thead> <tr> <th colspan="3">Hours of Mall Groups Scheduled</th> </tr> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>18</td> <td>11</td> </tr> <tr> <td>6-10 hours</td> <td>15</td> <td>10</td> </tr> <tr> <td>11-15 hours</td> <td>16</td> <td>10</td> </tr> <tr> <td>16-20+ hours</td> <td>1,551</td> <td>1,560</td> </tr> </tbody> </table> <table border="1" data-bbox="991 979 1887 1300"> <thead> <tr> <th colspan="3">Hours of Mall Groups Attended</th> </tr> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>88</td> <td>49</td> </tr> <tr> <td>6-10 hours</td> <td>89</td> <td>52</td> </tr> <tr> <td>11-15 hours</td> <td>122</td> <td>65</td> </tr> <tr> <td>16-20+ hours</td> <td>1,302</td> <td>1,425</td> </tr> </tbody> </table> <p>This monitor reviewed the charts of 10 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent</p>	Hours of Mall Groups Scheduled				Previous period	Current period	Mean number of individuals			0-5 hours	18	11	6-10 hours	15	10	11-15 hours	16	10	16-20+ hours	1,551	1,560	Hours of Mall Groups Attended				Previous period	Current period	Mean number of individuals			0-5 hours	88	49	6-10 hours	89	52	11-15 hours	122	65	16-20+ hours	1,302	1,425
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		<p>WRP and corresponding MAPP data regarding hours scheduled and attended. The following table summarizes the monitor's findings:</p> <table border="1" data-bbox="991 302 1833 760"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>CS</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>CT</td> <td>20</td> <td>17</td> <td>9</td> </tr> <tr> <td>JL</td> <td>17</td> <td>17</td> <td>4</td> </tr> <tr> <td>JT</td> <td>20</td> <td>18</td> <td>13</td> </tr> <tr> <td>KR</td> <td>19</td> <td>19</td> <td>8</td> </tr> <tr> <td>LM</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>PS</td> <td>20</td> <td>20</td> <td>2</td> </tr> <tr> <td>RA</td> <td>20</td> <td>19</td> <td>11</td> </tr> <tr> <td>SA</td> <td>19</td> <td>19</td> <td>3</td> </tr> <tr> <td>SW</td> <td>20</td> <td>20</td> <td>8</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	CS	20	20	12	CT	20	17	9	JL	17	17	4	JT	20	18	13	KR	19	19	8	LM	20	20	12	PS	20	20	2	RA	20	19	11	SA	19	19	3	SW	20	20	8
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours																																											
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RA	20	19	11																																											
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C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>There has been no change AT PSH regarding programming civilly committed individuals for off-site programming. Civilly committed individuals are not programmed for off-site visits due the difficulty in coordinating such events with the Hospital Police. Individuals leaving the facility for off-site programming need to be accompanied by a CDCR Correctional Officer, following the California Welfare and Institutions Code, Section 4107(a). The facility also has faced difficulty with obtaining CDCR approval and supervision. PSH continues to transfer individuals with the potential for off-site visits, when possible, to other State facilities where the option of off-site visits is available.</p>																																												

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		<p>This monitor reviewed four charts of civilly committed individuals. The table below shows that diagnoses and behavioral issues of these individuals, as documented in the WRPs:</p> <table border="1" data-bbox="991 337 1896 901"> <thead> <tr> <th>Individual</th> <th>Diagnoses</th> <th>Behavioral Issues</th> </tr> </thead> <tbody> <tr> <td>CG</td> <td>Schizophrenia, substance abuse, tardive dyskinesia</td> <td>Gravely medically disabled, inability to take medication</td> </tr> <tr> <td>CT</td> <td>Pedophilia, borderline personality disorder, bi-polar, substance abuse</td> <td></td> </tr> <tr> <td>DCF</td> <td>Substance abuse, schizophrenia, tardive dyskinesia, antisocial personality disorder</td> <td>Violent/assaultive</td> </tr> <tr> <td>RDH</td> <td>Schizophrenia, substance abuse</td> <td>Problem communicating, disorganized thought, not participating in groups, challenged cognitive function</td> </tr> </tbody> </table> <p>As the data in the table above show, most of the individuals carry a number of diagnoses and dangerous behaviors that put them and the community at risk.</p>	Individual	Diagnoses	Behavioral Issues	CG	Schizophrenia, substance abuse, tardive dyskinesia	Gravely medically disabled, inability to take medication	CT	Pedophilia, borderline personality disorder, bi-polar, substance abuse		DCF	Substance abuse, schizophrenia, tardive dyskinesia, antisocial personality disorder	Violent/assaultive	RDH	Schizophrenia, substance abuse	Problem communicating, disorganized thought, not participating in groups, challenged cognitive function
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RDH	Schizophrenia, substance abuse	Problem communicating, disorganized thought, not participating in groups, challenged cognitive function															
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 28% of quarterly and annual WRPs due during the review period (May-October 2010), and reported a mean</p>															

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	<p>groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the charts of seven individuals found substantial compliance in all seven (AA, AER, EEC, JMV, KJ, PE and SLE).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>C.2.g</p>	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
<p>C.2.g.i</p>	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the review period and compared to the last period).</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p>

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		<p>Other findings: This monitor reviewed the charts of six individuals (CJS, GRR, MB, MEM, SC and TC). The review found substantial compliance in five charts and partial compliance in one (CJS).</p> <p>This monitor also reviewed the records of 13 individuals receiving direct therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 97% based on an average sample of 68% of individuals placed in seclusion and/or restraints each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. This review focused on the documentation in the Present Status section (and/or the</p>

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		<p>Psychiatric Progress Notes) of the circumstances leading to the use of restrictive intervention and treatment provided to avert the use of the interventions. (The modifications of treatment to decrease the risk of future occurrences are addressed as part of the review of PPNs). The following table outlines these reviews:</p> <table border="1" data-bbox="991 414 1843 756"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> <th>Date of applicable Psychiatric Progress Note</th> </tr> </thead> <tbody> <tr> <td>DLG</td> <td>10/07/10</td> <td>10/14/10</td> <td>10/07/10</td> </tr> <tr> <td>DS</td> <td>11/7/10</td> <td>12/3/10</td> <td>11/8/10</td> </tr> <tr> <td>HDM</td> <td>11/21/10</td> <td>11/30/10</td> <td>11/21/10</td> </tr> <tr> <td>JW</td> <td>10/24/10</td> <td>12/2/10</td> <td>10/24/10</td> </tr> <tr> <td>KAM</td> <td>11/16/10</td> <td>12/2/10</td> <td>11/17/10</td> </tr> <tr> <td>PS</td> <td>10/7/10</td> <td>10/18/10</td> <td>10/7/10</td> </tr> </tbody> </table> <p>The review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	Date of applicable Psychiatric Progress Note	DLG	10/07/10	10/14/10	10/07/10	DS	11/7/10	12/3/10	11/8/10	HDM	11/21/10	11/30/10	11/21/10	JW	10/24/10	12/2/10	10/24/10	KAM	11/16/10	12/2/10	11/17/10	PS	10/7/10	10/18/10	10/7/10
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KAM	11/16/10	12/2/10	11/17/10																											
PS	10/7/10	10/18/10	10/7/10																											
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 98% based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period</p>																												

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		<p>(May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals (CJS, GRR, MB, MEM, SC and TC). The review focused on the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). The review found that four charts (CJS, GRR, MB and MEM) included evidence of discharge criteria that were sufficiently individualized and that all charts included adequate documentation of a discussion of the individual's progress towards achievement of each discharge criterion.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the review period and compared to the last period). • Ensure that Mail notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs. <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH reported a compliance rate of 97% based on an average sample of 21% of the quarterly and annual WRP. Comparative data indicated that PSH has</p>

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		<p>maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed the documentation of the individual's attendance and progress in all group interventions that were listed for Focus I in the charts of six individuals (CJS, GRR, MB, MEM, SC and TC). The review found substantial compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Substantial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 28% of quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated</p>

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		<p>that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in all seven WRPs in the charts (AA, AER, EEC, JMV, KJ, PE and SLE).</p> <p>Other findings: This monitor reviewed the records of 11 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility's progress report referred to C.2.f.viii, but that cell is not aligned with this recommendation.</p> <p>A review of the records of seven individuals found that all seven WRPs in the charts contained objectives written in a measurable/observable manner (AA, AER, EEC, JMV, KJ, PE and SLE). The objectives in the same WRPs were directly linked to a relevant focus of hospitalization.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: See C.2.f.viii.</p> <p>Findings: See C.2.f.viii.</p> <p>Current recommendation: See C.2.f.viii.</p>			
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 9% of Mall group facilitators each month during the review period (May-October 2010):</p> <table border="1" data-bbox="991 1081 1890 1157"> <tr> <td>15.</td> <td><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of seven individuals found that all seven specified the strengths of the individual in the functional status section (AA, AER, EEC, JMV, KJ, PE and SLE).</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	100%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation of a mean sample of 28% of quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of seven individuals found that the individual's vulnerabilities were documented in the case formulation section in all seven WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AA, AER, EEC, JMV, KJ, PE and SLE).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Mall Observation Monitoring Form, PSH assessed compliance based on an average sample of 9% of the Mall group</p>

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		<p>facilitators each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 264 1887 342"> <tr> <td data-bbox="993 264 1087 342">16.</td> <td data-bbox="1087 264 1793 342"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 264 1887 342">97%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals (AA, AER, BPH, EEC, JK, JV, PEL and SLE) found that cognitive screening had been conducted in five (AA, AER, JV and PEL, SLE) cases as part of the Integrated Assessment: Psychology Section or as part of a Neuropsychological assessment. Cognitive screening was not completed for the remaining three (BPH, EEC, and JK) due to the individual's mental status or refusal to participate in the screening. Follow-up review found that the dates of completion and results of the five whose cognitive testing were completed were documented in the Present Status section of their WRPs.</p> <p>A review of the Mall groups documented in the WRPs of 10 individuals (DTJ, FDH, JPF, LG, MDF, MSB, QH, RF, RLH and TFH) compared to their documented cognitive levels found that the groups were appropriate to the individuals' cognitive levels.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	97%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	97%			
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported the following data pertaining to Mall Facilitator</p>			

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		<p>Progress Note completion by program, based on a 20% random sample in October 2010:</p> <table border="1" data-bbox="993 305 1854 496"> <thead> <tr> <th></th> <th>P1</th> <th>P3</th> <th>P4</th> <th>P5</th> <th>P6</th> <th>P7</th> <th>P8</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>4009</td> <td>3471</td> <td>3157</td> <td>3253</td> <td>4307</td> <td>4176</td> <td>3405</td> <td>3683</td> </tr> <tr> <td>n</td> <td>802</td> <td>694</td> <td>631</td> <td>651</td> <td>861</td> <td>835</td> <td>681</td> <td>736</td> </tr> <tr> <td>%S</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> <td>20</td> </tr> <tr> <td>%C</td> <td>98</td> <td>91</td> <td>96</td> <td>97</td> <td>96</td> <td>93</td> <td>97</td> <td>95</td> </tr> </tbody> </table> <p>All programs maintained a completion rate of at least 90% since the previous review period.</p> <p>A review of the charts of eight individuals found that all eight contained progress notes (AA, AER, BPH, EEC, JK, JV, PEL and SLE), and the information in the progress notes had been incorporated into the Present Status section of the individual's WRP.</p> <p>Other findings: This monitor reviewed the records of 11 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.vii. All records were in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		P1	P3	P4	P5	P6	P7	P8	Mean	N	4009	3471	3157	3253	4307	4176	3405	3683	n	802	694	631	651	861	835	681	736	%S	20	20	20	20	20	20	20	20	%C	98	91	96	97	96	93	97	95
	P1	P3	P4	P5	P6	P7	P8	Mean																																							
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C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>																																													

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		<p>Findings: PSH continues to provide Mall services five days a week for four hours each weekday. The facility reported the following data:</p> <table border="1" data-bbox="991 339 1451 683"> <thead> <tr> <th></th> <th>Hours of Mall Groups Provided</th> </tr> </thead> <tbody> <tr> <td>May</td> <td>12,916</td> </tr> <tr> <td>Jun</td> <td>13,454</td> </tr> <tr> <td>Jul</td> <td>13,207</td> </tr> <tr> <td>Aug</td> <td>16,049</td> </tr> <tr> <td>Sep</td> <td>12,160</td> </tr> <tr> <td>Oct</td> <td>12,698</td> </tr> <tr> <td>Mean</td> <td>13.414</td> </tr> </tbody> </table> <p>The mean monthly hours of Mall groups provided in the previous period was 9,935.</p> <p>Interview with administrative and clinical staff found that in its desire to address violence, the facility is considering moving to unit-based Mall groups as opposed to central Mall groups on the hypothesis that high rates of violence occur during transition to the central Mall groups and during Mall sessions.</p> <p>Current recommendations: Continue current practice.</p>		Hours of Mall Groups Provided	May	12,916	Jun	13,454	Jul	13,207	Aug	16,049	Sep	12,160	Oct	12,698	Mean	13.414
	Hours of Mall Groups Provided																	
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C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendations:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH has not had any bed-bound individuals during the review period but</p>																

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		<p>continues to have processes in place should a bed-bound individual be admitted.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 711 1896 976"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>8,345</td> <td>8,012</td> <td>8,121</td> <td>9,157</td> <td>7,005</td> <td>8,198</td> <td>8,140</td> </tr> <tr> <td>Groups cancelled</td> <td>1</td> <td>11</td> <td>5</td> <td>14</td> <td>423</td> <td>28</td> <td>80</td> </tr> <tr> <td>Cancellation rate</td> <td><1%</td> <td><1%</td> <td><1%</td> <td><1%</td> <td>6%</td> <td><1%</td> <td>1%</td> </tr> </tbody> </table> <p>As the table above shows, the mean cancellation rate for this review period is 1%, whereas the mean cancellation rate was 7% for the previous review period. However, the cancellation rate needs to be revised as Mall hours held include "alternate course" hours and combined groups held in Mall groups when the regular facilitators and their co-providers were not available. It is encouraging to note that PSH holds alternate course groups instead of cancelling the groups. However, it is only appropriate that these "alternate course" groups be counted as cancelled groups since the course material in these groups do not address the lesson plans or objectives the individuals should be learning. PSH can provide data on the scheduled groups held with and without the "alternate course"</p>		May	Jun	Jul	Aug	Sep	Oct	Mean	Groups scheduled	8,345	8,012	8,121	9,157	7,005	8,198	8,140	Groups cancelled	1	11	5	14	423	28	80	Cancellation rate	<1%	<1%	<1%	<1%	6%	<1%	1%
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groups.

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

Average weekly hours provided by discipline		
	Previous review period	Current review period
Psychiatry ADMIT (4)	2	2.00
Psychiatry L-T (8)	2	2.61
Psychology ADMIT (5)	5	3.58
Psychology L-T (10)	9	7.53
Social Work ADMIT (5)	5	4.83
Social Work L-T (10)	9	8.00
Rehab Therapy ADMIT (7)	9	8.25
Rehab Therapy L-T (15)	13	12.68
Nursing (10)	10	10.00

PSH also provided the following information, based on a 20% audit of scheduled and facilitated hours per discipline:

Discipline	Hours Scheduled/ Week	Hours Provided/ Week	Percentage of Scheduled Hours Fulfilled
Psychiatry	3.30	2.75	83%
Psychology	7.79	6.62	85%
Social Work	7.87	7.37	94%
Rehab Therapy	11.92	11.65	98%
Nursing	10.00	10.00	100%
Other/Admin	3.24	2.68	83%

Since the previous review period, there has been a 30 percentage point

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		<p>increase in scheduled hours fulfilled for psychiatry, but an 11 percentage point decrease for psychology and a 13 percentage point decrease for the administrative staff.</p> <p>According to the Mall Director, she has noted a number of difficulties in aggregating the data, including the difficulty in capturing allocation of staff by the Report Manager, the difficulty in capturing treatment hours provided by clinicians when assisting non-adherent individuals to attend groups, those who are holding mock court, and those whose could not be scheduled in all doses of multiple-dosed groups due to their conflicting schedules. The Mall Director has brought these issues to the attention of the Information Technology Department.</p> <p>Mall staff (coordinators and others) continue to be on a "temporary/acting" status. It appears that a number of them are considering to moving to other positions in the facility because of their impermanency and the absence of vertical movement opportunity in their position and salary. The facility should consider addressing these issues so that the Mall organization does not lose valuable and experienced staff.</p> <p>A number of pieces of equipment for Mall use has worn out or broken. The Mall groups need such equipment to provide the individuals with a quality experience. Individuals in some groups had pointed out such deficiencies during this monitor's visit to the Mall groups. These equipment need to be replenished.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

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		<p>Findings: The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 337 1879 602"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1848</td> </tr> <tr> <td>Hours provided</td> <td>1848</td> <td>1848</td> <td>1848</td> <td>1749</td> <td>1749</td> <td>1848</td> <td>1815</td> </tr> <tr> <td>Completion rate</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>95%</td> <td>95%</td> <td>100%</td> <td>98%</td> </tr> </tbody> </table> <p>PSH continues to provide enrichment activities in the evenings and weekends to ensure that individuals have the opportunity to participate in activities to enhance their quality of life. The number of hours and range of activities offered increased during this review period. According to the Enrichment Activity Coordinator, monthly meetings are held with the leaders of these activities (these are individuals in the facility) for their feedback to further improve the services.</p> <p>Current recommendation: Continue to monitor this requirement</p>		May	Jun	Jul	Aug	Sep	Oct	Mean	Hours scheduled	1848	1848	1848	1848	1848	1848	1848	Hours provided	1848	1848	1848	1749	1749	1848	1815	Completion rate	100%	100%	100%	95%	95%	100%	98%
	May	Jun	Jul	Aug	Sep	Oct	Mean																											
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C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, PSH assessed its compliance based on observations of an average sample of 100% of the a.m. and p.m. shifts on units in the facility. The following table summarizes the facility's data:</p>																																

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		<table border="1"> <tr> <td data-bbox="976 183 1087 305">1.</td> <td data-bbox="1087 183 1793 305"><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td data-bbox="1793 183 1902 305">100%</td> </tr> <tr> <td data-bbox="976 305 1087 378">2.</td> <td data-bbox="1087 305 1793 378"><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td data-bbox="1793 305 1902 378">100%</td> </tr> <tr> <td data-bbox="976 378 1087 418">3.</td> <td data-bbox="1087 378 1793 418"><i>There is evidence of a unit recognition program.</i></td> <td data-bbox="1793 378 1902 418">100%</td> </tr> <tr> <td data-bbox="976 418 1087 492">4.</td> <td data-bbox="1087 418 1793 492"><i>The posted unit rules reflect recovery language and principles.</i></td> <td data-bbox="1793 418 1902 492">100%</td> </tr> <tr> <td data-bbox="976 492 1087 565">5.</td> <td data-bbox="1087 492 1793 565"><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td data-bbox="1793 492 1902 565">100%</td> </tr> <tr> <td data-bbox="976 565 1087 678">6.</td> <td data-bbox="1087 565 1793 678"><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td data-bbox="1793 565 1902 678">99%</td> </tr> <tr> <td data-bbox="976 678 1087 751">7.</td> <td data-bbox="1087 678 1793 751"><i>Staff is observed actively engaged with the individuals.</i></td> <td data-bbox="1793 678 1902 751">100%</td> </tr> <tr> <td data-bbox="976 751 1087 824">8.</td> <td data-bbox="1087 751 1793 824"><i>Staff interacts with individuals in a respectful manner.</i></td> <td data-bbox="1793 751 1902 824">100%</td> </tr> <tr> <td data-bbox="976 824 1087 898">9.</td> <td data-bbox="1087 824 1793 898"><i>Situations involving privacy occurred and they were properly handled.</i></td> <td data-bbox="1793 824 1902 898">100%</td> </tr> <tr> <td data-bbox="976 898 1087 1019">10.</td> <td data-bbox="1087 898 1793 1019"><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td data-bbox="1793 898 1902 1019">99%</td> </tr> </table> <p data-bbox="976 1060 1902 1133">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="976 1174 1902 1424">Other findings: A review of the charts of eight individuals found that all eight contained milieu interventions appropriate to the active intervention (AA, AER, BPH, EEC, JK, JV, PEL and SLE). The milieu interventions were aligned with the individual's active interventions (e.g. active treatment for SLE was court competency and the corresponding milieu intervention was that unit staff will discuss with the individual talking with his attorney).</p>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	100%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	100%	3.	<i>There is evidence of a unit recognition program.</i>	100%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	100%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	100%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	99%	7.	<i>Staff is observed actively engaged with the individuals.</i>	100%	8.	<i>Staff interacts with individuals in a respectful manner.</i>	100%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	100%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	99%
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		<p>Current recommendation: Continue to monitor this requirement.</p>																																																							
C.2.j	<p>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="991 636 1896 902"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>226</td> <td>226</td> <td>226</td> <td>150</td> <td>150</td> <td>156</td> </tr> <tr> <td>Number of groups needed</td> <td>75</td> <td>76</td> <td>75</td> <td>74</td> <td>74</td> <td>73</td> </tr> <tr> <td>Offered/needed</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> <td>>100%</td> </tr> </tbody> </table> <p>As the table above shows, PSH continues to offer more than sufficient exercise groups for all individuals to have the opportunity to participate in them.</p> <p>The facility also presented the following data:</p> <table border="1" data-bbox="991 1161 1873 1390"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>621</td> <td>598</td> <td>96%</td> </tr> <tr> <td>31 - 35</td> <td>344</td> <td>328</td> <td>95%</td> </tr> <tr> <td>36 - 40</td> <td>156</td> <td>152</td> <td>97%</td> </tr> <tr> <td>>40</td> <td>76</td> <td>75</td> <td>99%</td> </tr> </tbody> </table>	Exercise Groups Offered vs. Needed								May	Jun	Jul	Aug	Sep	Oct	Number of groups offered	226	226	226	150	150	156	Number of groups needed	75	76	75	74	74	73	Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	621	598	96%	31 - 35	344	328	95%	36 - 40	156	152	97%	>40	76	75	99%
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		<p>A review of the records of five individuals (AA, AER, JV, KJ and SLE) found that all five were enrolled in exercise groups (e.g. Armchair Aerobics for KJ, Tae Bo and walking for SLE, and Walking for Fitness and Roadways for Health Living for AA).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>									
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH C2k 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:</p> <table border="1" data-bbox="991 1003 1890 1414"> <tr> <td data-bbox="991 1003 1087 1154">1.</td> <td data-bbox="1087 1003 1793 1154"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1793 1003 1890 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1377">2.</td> <td data-bbox="1087 1154 1793 1377"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1793 1154 1890 1377">98%</td> </tr> <tr> <td data-bbox="991 1377 1087 1414">3.</td> <td data-bbox="1087 1377 1793 1414"><i>Discharge: There is documentation in the Medical</i></td> <td data-bbox="1793 1377 1890 1414">100%</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	98%	3.	<i>Discharge: There is documentation in the Medical</i>	100%
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3.	<i>Discharge: There is documentation in the Medical</i>	100%									

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		<table border="1" data-bbox="991 188 1885 378"> <tr> <td data-bbox="991 188 1087 378"></td> <td data-bbox="1087 188 1793 378"> <p><i>Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></p> </td> <td data-bbox="1793 188 1885 378"></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of eight individuals with assessed need for family therapy services (AA, DCF, JT, KA, KHM, KLS, RAS and SH) found documentation in the Present Status section of all eight WRPs indicating the receipt of family therapy services and/or contact between SW staff and the individual's family members (e.g. SW has arranged for parenting from a distance for KHM, and conducted relationship-building activities for JT). In other cases, the family or the individual was not able to participate or declined to participate (e.g. KLS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>		<p><i>Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></p>	
	<p><i>Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></p>				
C.2.1	<p>Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Continue to develop and implement a system addressing this requirement that includes a system to track this specific population. • Continue to monitor this requirement. <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, PSH</p>			

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		<p>assessed its compliance based on a 22% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (May-October 2010):</p> <table border="1" data-bbox="993 337 1887 716"> <tr> <td data-bbox="993 337 1087 412">1.</td> <td data-bbox="1087 337 1793 412"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1793 337 1887 412">97%</td> </tr> <tr> <td data-bbox="993 412 1087 487">2.</td> <td data-bbox="1087 412 1793 487"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1793 412 1887 487">97%</td> </tr> <tr> <td data-bbox="993 487 1087 561">3.</td> <td data-bbox="1087 487 1793 561"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1793 487 1887 561">95%</td> </tr> <tr> <td data-bbox="993 561 1087 636">4.</td> <td data-bbox="1087 561 1793 636"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1793 561 1887 636">99%</td> </tr> <tr> <td data-bbox="993 636 1087 716">5.</td> <td data-bbox="1087 636 1793 716"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1793 636 1887 716">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the WRPs of 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JJT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that PSH has continued to make improvements in this area from ongoing training and mentoring since the last review. The majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions, which comports with PSH's data.</p> <p>PSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 2% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p> <table border="1" data-bbox="993 1382 1887 1421"> <tr> <td data-bbox="993 1382 1087 1421">6.</td> <td data-bbox="1087 1382 1793 1421"><i>Each State hospital shall ensure that interdisciplinary</i></td> <td data-bbox="1793 1382 1887 1421">83%</td> </tr> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	97%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	97%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	95%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	99%	5.	<i>There are appropriate interventions for each objective.</i>	98%	6.	<i>Each State hospital shall ensure that interdisciplinary</i>	83%
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		<p><i>teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></p>	
<p>Comparative data indicated that compliance decreased from 98% in the previous review period.</p> <p>PSH implemented the WRP Manual Addendum for Individual Refusal of Appointments and/or procedures in October 2010. This policy outlined staff's responsibility in addressing an individual's refusal for a procedure or appointment using the Daily Appointment Refusal Tracking Log. In addition, the individual's PCP determines a risk level of the refusal and depending on the risk level assigned, the WRPTs will have 14 days to conduct a treatment refusal review for low or moderate risks levels and for refusals deemed high risk, a psychologist will have one week to complete an evaluation with a plan to address the refusal. The facility reported that identified barriers to compliance included the lack of assigned responsibility for addressing the refusals by the WRPTs and that the current appointment tracking forms were not equipped for tracking refusals. PSH provided additional training in November 2010 and designated the Case Managers as the responsible persons for tracking refusals and the reasons for the refusals. The Conference Facilitators are responsible to prompt the WRPTs to develop plans addressing the refusals. Data for this requirement will be reviewed monthly by the facility.</p> <p>A review of records of 18 individuals (ACM, ANA, AV, DJC, DM, DRM, FGC, JTL, KLR, KRE, LEM, LS, OD, RC, SC, TT, TY and YHR) whose appointment refusals were designated by the facility as high risk found that all had documentation of the refusals noted in the Present Status section of the WRPs and an open focus addressing refusals. However, the WRPs were basically a generic template and did not address the reason for the refusal such as the individual having a fear of needles. In addition, information found in the sections addressing psychological</p>			

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		<p>tests, cognitive functioning, and interventions when noted by the psychologist was not used to develop the WRP interventions addressing refusals, especially with severe memory and attention issues. PSH's data from the High Concern Medical Refusers by Month tracking sheet did indicate that after interaction with a psychologist, a number of individuals agreed and completed the needed test/procedures. The current system implemented by the facility is very promising, but since individuals are being designated at high risk due to their refusals, it is imperative that the documentation reflects timely and appropriate interventions and follow-up.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementing facility-wide system addressing and tracking non-adherence issues. 2. Ensure that WRPs addressing refusals are individualized, address the reason for refusals, and incorporate appropriate interventions in alignment with the individual's functioning. 3. Increase sample size addressing individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months. 4. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	

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C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The facility has maintained its practice (see C.2.o).</p> <p>Other findings: PSH reported that during this review period, an additional 108 providers of Substance Abuse groups were trained and certified to provide treatment in the Mall, based on the transtheoretical model of stages of change.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Provide summary of both process and clinical outcome data regarding delivery of substance use services.</p> <p>Findings: The following is a summary of PSH's process outcome data:</p>

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		<table border="1"> <thead> <tr> <th>Process Outcomes</th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individuals with Substance Abuse Dx</td> <td>1027</td> <td>1038</td> </tr> <tr> <td>Individuals screened by SAS</td> <td>955</td> <td>972</td> </tr> <tr> <td>Hours of SAS treatment offered/wk</td> <td>450</td> <td>432</td> </tr> <tr> <td>SAS sessions scheduled</td> <td>322</td> <td>311</td> </tr> <tr> <td>%SAS sessions held</td> <td>97%</td> <td>98%</td> </tr> <tr> <td>AA/NA (hours per month)*</td> <td>77</td> <td>79</td> </tr> <tr> <td>%AA/NA sessions held</td> <td>91%</td> <td>94%</td> </tr> <tr> <td>Individuals enrolled in SAS Tx</td> <td>955</td> <td>972</td> </tr> </tbody> </table> <p>*This outcome was erroneously labeled "Individuals enrolled in AA/NA" in the previous report.</p> <p>PSH also evaluated the clinical outcomes of the services provided during this review period. As mentioned in the previous report, the data were derived from a database that was established in March 2010 using the Readiness Ruler (RR) instrument instead of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). The table below shows the summary of the data:</p> <table border="1"> <thead> <tr> <th>Clinical Outcomes</th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Advanced at least one stage of change or sustained in maintenance.</td> <td>N/A</td> <td>42.7%</td> </tr> <tr> <td>Refused treatment or regressed at least one stage of change.</td> <td>N/A</td> <td>28.5%</td> </tr> <tr> <td>Did not advance in stage of change</td> <td>N/A</td> <td>28.8%</td> </tr> <tr> <td>Out to Court/Other/Discharged</td> <td>N/A</td> <td>258</td> </tr> </tbody> </table> <p>In addition to the above outcome data, PSH is considering the extent to which the pre-discharge Stage of Change for substance use disorders is</p>	Process Outcomes	Previous review period	Current review period	Individuals with Substance Abuse Dx	1027	1038	Individuals screened by SAS	955	972	Hours of SAS treatment offered/wk	450	432	SAS sessions scheduled	322	311	%SAS sessions held	97%	98%	AA/NA (hours per month)*	77	79	%AA/NA sessions held	91%	94%	Individuals enrolled in SAS Tx	955	972	Clinical Outcomes	Previous review period	Current review period	Advanced at least one stage of change or sustained in maintenance.	N/A	42.7%	Refused treatment or regressed at least one stage of change.	N/A	28.5%	Did not advance in stage of change	N/A	28.8%	Out to Court/Other/Discharged	N/A	258
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Clinical Outcomes	Previous review period	Current review period																																										
Advanced at least one stage of change or sustained in maintenance.	N/A	42.7%																																										
Refused treatment or regressed at least one stage of change.	N/A	28.5%																																										
Did not advance in stage of change	N/A	28.8%																																										
Out to Court/Other/Discharged	N/A	258																																										

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		<p>correlated with revocation of CONREP status due to substance abuse relapse. PSH reported plans to analyze this research question in order to highlight areas in which the facility can improve its services to minimize relapses that result in revocation of CONREP and readmission to PSH.</p> <p>The facility's consumer satisfaction surveys summary data is as follows based on a sample of 200 individuals:</p> <table border="1" data-bbox="989 487 1906 1399"> <thead> <tr> <th data-bbox="989 487 1491 565">Consumer Satisfaction Survey</th> <th data-bbox="1491 487 1701 565">Previous review period</th> <th data-bbox="1701 487 1906 565">Current review period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 565 1491 678">1. Overall Satisfaction with the information and skills provided by the group</td> <td data-bbox="1491 565 1701 678"></td> <td data-bbox="1701 565 1906 678"></td> </tr> <tr> <td data-bbox="989 678 1491 716">• Excellent</td> <td data-bbox="1491 678 1701 716">49%</td> <td data-bbox="1701 678 1906 716">49%</td> </tr> <tr> <td data-bbox="989 716 1491 753">• Good</td> <td data-bbox="1491 716 1701 753">36%</td> <td data-bbox="1701 716 1906 753">35%</td> </tr> <tr> <td data-bbox="989 753 1491 790">• Adequate</td> <td data-bbox="1491 753 1701 790">12%</td> <td data-bbox="1701 753 1906 790">10%</td> </tr> <tr> <td data-bbox="989 790 1491 828">• Minimal</td> <td data-bbox="1491 790 1701 828">2%</td> <td data-bbox="1701 790 1906 828">4%</td> </tr> <tr> <td data-bbox="989 828 1491 865">• Poor</td> <td data-bbox="1491 828 1701 865">2%</td> <td data-bbox="1701 828 1906 865">2%</td> </tr> <tr> <td data-bbox="989 865 1491 943">2. The instructor demonstrated knowledge of the course subject</td> <td data-bbox="1491 865 1701 943"></td> <td data-bbox="1701 865 1906 943"></td> </tr> <tr> <td data-bbox="989 943 1491 980">• Excellent</td> <td data-bbox="1491 943 1701 980">55%</td> <td data-bbox="1701 943 1906 980">54%</td> </tr> <tr> <td data-bbox="989 980 1491 1018">• Good</td> <td data-bbox="1491 980 1701 1018">29%</td> <td data-bbox="1701 980 1906 1018">30%</td> </tr> <tr> <td data-bbox="989 1018 1491 1055">• Adequate</td> <td data-bbox="1491 1018 1701 1055">14%</td> <td data-bbox="1701 1018 1906 1055">12%</td> </tr> <tr> <td data-bbox="989 1055 1491 1092">• Minimal</td> <td data-bbox="1491 1055 1701 1092">2%</td> <td data-bbox="1701 1055 1906 1092">2%</td> </tr> <tr> <td data-bbox="989 1092 1491 1130">• Poor</td> <td data-bbox="1491 1092 1701 1130">1%</td> <td data-bbox="1701 1092 1906 1130">2%</td> </tr> <tr> <td data-bbox="989 1130 1491 1208">3. The group resulted in change of the way I see substance use</td> <td data-bbox="1491 1130 1701 1208"></td> <td data-bbox="1701 1130 1906 1208"></td> </tr> <tr> <td data-bbox="989 1208 1491 1245">• Excellent</td> <td data-bbox="1491 1208 1701 1245">50%</td> <td data-bbox="1701 1208 1906 1245">45%</td> </tr> <tr> <td data-bbox="989 1245 1491 1282">• Good</td> <td data-bbox="1491 1245 1701 1282">25%</td> <td data-bbox="1701 1245 1906 1282">38%</td> </tr> <tr> <td data-bbox="989 1282 1491 1320">• Adequate</td> <td data-bbox="1491 1282 1701 1320">17%</td> <td data-bbox="1701 1282 1906 1320">11%</td> </tr> <tr> <td data-bbox="989 1320 1491 1357">• Minimal</td> <td data-bbox="1491 1320 1701 1357">4%</td> <td data-bbox="1701 1320 1906 1357">4%</td> </tr> <tr> <td data-bbox="989 1357 1491 1399">• Poor</td> <td data-bbox="1491 1357 1701 1399">4%</td> <td data-bbox="1701 1357 1906 1399">2%</td> </tr> </tbody> </table>	Consumer Satisfaction Survey	Previous review period	Current review period	1. Overall Satisfaction with the information and skills provided by the group			• Excellent	49%	49%	• Good	36%	35%	• Adequate	12%	10%	• Minimal	2%	4%	• Poor	2%	2%	2. The instructor demonstrated knowledge of the course subject			• Excellent	55%	54%	• Good	29%	30%	• Adequate	14%	12%	• Minimal	2%	2%	• Poor	1%	2%	3. The group resulted in change of the way I see substance use			• Excellent	50%	45%	• Good	25%	38%	• Adequate	17%	11%	• Minimal	4%	4%	• Poor	4%	2%
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		<p>4. The group resulted in change of the way I see myself</p> <ul style="list-style-type: none"> • Excellent • Good • Adequate • Minimal • Poor 	<p>50%</p> <p>24%</p> <p>17%</p> <p>6%</p> <p>4%</p>	<p>48%</p> <p>35%</p> <p>10%</p> <p>4%</p> <p>3%</p>
		<p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Substance Abuse Auditing Form, PSH assessed its compliance with this requirement based on an average sample of 20% of individuals with a current diagnosis of substance abuse (May-October 2010):</p>		
		<p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p>	<p><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></p> <p><i>There is an appropriate focus statement listed under Focus 5.</i></p> <p><i>There is at least one objective related to the individual's stage of change.</i></p> <p><i>There are interventions that are appropriately linked to the active objective(s).</i></p> <p><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></p> <p><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></p>	<p>99%</p> <p>94%</p> <p>97%</p> <p>97%</p> <p>99%</p> <p>98%</p>
		<p>Comparative data indicated that PSH has maintained a compliance rate of</p>		

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		<p>at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed the charts of six individuals to assess the proper identification of the individual's stage of change regarding substance use treatment and the development of objectives and interventions that are appropriately linked to the stages. As mentioned in C.2.f.iv, this review found substantial compliance in four charts (GRR, MEM, SC and TC) and partial compliance in two (CJS and MB).</p> <p>This monitor and an expert on the court monitoring team observed three substance use education groups that were provided to individuals in different stages of change. In general, the groups met generally accepted standards as demonstrated by knowledge of the leader, relevance of the topics to the stage of change, use of materials to facilitate learning and engagement and participation of the individuals.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide summary of both process and clinical outcome data regarding delivery of substance use services. 2. Continue to monitor this requirement.
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form. PSH assessed its compliance based on an average sample of 9% of Mall group</p>

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	<p>and receive regular, competent supervision.</p>	<p>facilitators during the review period (May-October 2010):</p> <table border="1" data-bbox="991 266 1883 496"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>97%</td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>90%</td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>94%</td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>96%</td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the DMH Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on observation of a 9% sample of all facilitators during the review months (May-October 2010):</p> <table border="1" data-bbox="991 790 1883 1386"> <tbody> <tr> <td>1.</td> <td><i>The session starts and ends within 5 minutes of the designated starting and ending time.</i></td> <td>86%</td> </tr> <tr> <td>2.</td> <td><i>The facilitator greets participants to begin the session.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The facilitator reviews work from the prior session.</i></td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>The facilitator introduces the day's topic and goals.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>The facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>The facilitator makes an attempt to engage each participant during the group.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>The facilitator attempts to keep all participants "on task" during the session.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>The facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i></td> <td>100%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	97%	99%	2.	<i>Course structure</i>	90%	96%	3.	<i>Instructional techniques</i>	94%	100%	4.	<i>Learning process</i>	96%	100%	1.	<i>The session starts and ends within 5 minutes of the designated starting and ending time.</i>	86%	2.	<i>The facilitator greets participants to begin the session.</i>	100%	3.	<i>The facilitator reviews work from the prior session.</i>	95%	4.	<i>The facilitator introduces the day's topic and goals.</i>	99%	5.	<i>The facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	99%	6.	<i>The facilitator makes an attempt to engage each participant during the group.</i>	99%	7.	<i>The facilitator attempts to keep all participants "on task" during the session.</i>	100%	8.	<i>The facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	100%
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C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p data-bbox="989 1133 1577 1162">Current findings on previous recommendation:</p> <p data-bbox="989 1203 1894 1310">Recommendation, June 2010: Ensure that training is provided so that all providers and co-providers are certified.</p> <p data-bbox="989 1351 1829 1421">Findings: Staff interview and documentation review found that all Substance</p>																		

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		<p>Abuse Recovery Mall groups at PSH have at least one certified Substance Abuse Recovery provider. Noncertified providers act as co-facilitators. According to the Mall Director, non-certified providers usually are new employees who have not completed the Substance Abuse provider training. As of September 2010, PSH has included Substance Abuse Provider Certification training as part of the New Employee Orientation. Current staff who are not certified will complete the certification training during the Annual Update Training.</p> <p>PSH presented the following data regarding the certification of Substance Abuse facilitators as of October 2010:</p> <table border="1" data-bbox="991 634 1896 787"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>144</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>132</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>92%</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	144	Number of certified SAR providers/co-providers	132	Percentage of SAR providers/co-providers who are certified	92%
Number of Substance Abuse Recovery (SAR) providers/co-providers	144							
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C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility provided the following data on scheduled and cancelled appointments:</p>						

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Missed Appointments Monitoring - Medical Services					
	Appointments		Reasons for Cancellation		
	Sched- uled	Cancelled	Staffing	Transpor- tation	Other
May 10	2153	684	10	22	652
Jun 10	2208	709	33	17	659
Jul 10	1938	571	17	22	532
Aug 10	2596	754	27	33	694
Sep 10	2706	746	77	15	654
Oct 10	2595	682	36	17	629
Total	14,196	4146	200	126	3820

The data in the table above show that a mean of 29% of scheduled medical appointments were cancelled during this review period. Eight percent of the cancellations were due to staffing and transportation issues. PSH did not analyze the data on factors contributing to the cancellations, especially those pertaining to staffing and transportation. The facility also did not identify corrective actions to address the issues.

Compliance:
Substantial.

Current recommendation:
Monitor this requirement, analyze cancellation data, and take remedial actions to reduce cancellations.

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<p>C.2.s</p>	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for eight individuals found that all eight WRPs assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (BA, BC, GL, JG, MDC, RMO, TY and YRR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>C.2.t</p>	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual</p>

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		<p>WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 94%. Comparative data indicated improvement in compliance from 86% in the previous review period.</p> <p>A review of the WRPs for eight individuals found that six of the WRPs met the elements of this requirement (AER, BPH, EEC, JMV, PEL and SLE) and the remaining two (AA and KJ) did not satisfy the criteria of this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																				
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the numbers of individuals needing and receiving WRP education is a summary of the facility's data:</p> <table border="1" data-bbox="991 1079 1822 1383"> <thead> <tr> <th colspan="5">Individuals in need of WRP Education during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sep 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>264</td> <td>285</td> <td>380</td> <td>283</td> </tr> <tr> <td>Receiving service</td> <td>264</td> <td>285</td> <td>380</td> <td>283</td> </tr> </tbody> </table>	Individuals in need of WRP Education during the current and previous three Mall terms						Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010	With identified need	264	285	380	283	Receiving service	264	285	380	283
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		<p>The table above shows that PSH has provided Wellness and Recovery Education groups to all individuals in need of the program.</p> <table border="1" data-bbox="991 305 1873 646"> <thead> <tr> <th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (May-October 2010, mean)</th> </tr> </thead> <tbody> <tr> <td>Sessions scheduled</td> <td>84</td> </tr> <tr> <td>Sessions held</td> <td>70</td> </tr> <tr> <td>% held</td> <td>83</td> </tr> <tr> <td>Individuals scheduled</td> <td>123</td> </tr> <tr> <td>Individuals attended at least one group per month</td> <td>118</td> </tr> <tr> <td>% attended</td> <td>96%</td> </tr> </tbody> </table> <p>As the table above shows, PSH has scheduled and held a significant number of Wellness and Recovery Groups, and attendance at these groups was high.</p> <p>A review of the WRPs for eight individuals found that six of the individuals were enrolled in Wellness and Recovery Education groups (AER, AS, BPH, EEC, JV and SLE) and the remaining two (KJ and PEL) were not.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (May-October 2010, mean)		Sessions scheduled	84	Sessions held	70	% held	83	Individuals scheduled	123	Individuals attended at least one group per month	118	% attended	96%
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C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a</p>														

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		<p>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.</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 451 1873 751"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>4Q09</th> <th>1Q10</th> <th>2Q10</th> <th>3Q10</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>1,062</td> <td>1,067</td> <td>1,057</td> <td>1,206</td> </tr> <tr> <td># of individuals receiving service</td> <td>959 (90%)</td> <td>957 (90%)</td> <td>968 (92%)</td> <td>1,118 (93%)</td> </tr> </tbody> </table> <p>Other findings: As mentioned in the previous report, the facility used an adequate system of assessing the needs of the individuals for medication education.</p> <p>Compliance: Substantial.</p> <p>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.</p>	Individuals Needing and Provided Medication Education Groups						4Q09	1Q10	2Q10	3Q10	# of individuals needing service	1,062	1,067	1,057	1,206	# of individuals receiving service	959 (90%)	957 (90%)	968 (92%)	1,118 (93%)
Individuals Needing and Provided Medication Education Groups																						
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C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's	Current findings on previous recommendations:																				

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>barriers to participation in therapeutic and rehabilitation services.</p>	<p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. • 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 <p>Findings: According to the Mall Director, PSH has improved its data collection and analysis system to ensure that the non-adherence data is accurate. PSH now identifies trigger data through the WaRMMS (Crystal Reports system) for every day of each month, and extracted the names of those individuals who did not attend a Mall group for 30 days.</p> <p>The table below indicates the number of individuals who were non-adherent to treatment for 30 or more days during the review period:</p> <table border="1" data-bbox="991 857 1740 954"> <thead> <tr> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>4</td> <td>2</td> <td>1</td> <td>5</td> <td>0</td> <td>1</td> <td>2</td> </tr> </tbody> </table> <p>As the table above shows, non-adherence at PSH is low with the newly defined criteria of not attending Mall groups for 30 days. However, the facility did not present data to show each individual's reason for non-attendance and the type of intervention(s) matching the cause for non-attendance.</p> <p>According to the Mall Director, non-attendance data are presented to the WRPT psychologists for attention and intervention. This appears to be a delayed action on PSH's part. It is recommended that WRPTs and Mall staff address non-attendance on an ongoing basis when it is realized that the individual is not attending the groups for more than a week</p>	May	Jun	Jul	Aug	Sep	Oct	Mean	4	2	1	5	0	1	2
May	Jun	Jul	Aug	Sep	Oct	Mean										
4	2	1	5	0	1	2										

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		<p>without valid reasons (e.g. illness) by making appropriate changes to the schedule, type of groups, etc. (this is being done by some WRPTs). A more formal intervention should be undertaken when the individual fails to improve and meets trigger threshold.</p> <p>According to facility report, interventions for individuals meeting non-adherence trigger included the following: Motivational Interviewing; cognitive therapies; behavioral techniques; clinical interviewing and encouragement; medication adjustments; Enhancing Motivation Group; changing of Mall groups to groups that are more aligned with individuals' interests and which individuals perceive as safer and/or more comfortable; improving tolerance for being around other individuals; family education and support; consultation with PBS; and realignment of By Choice points. According to the Mall Director, these techniques are also being used in the Recovery Enhancement Rooms.</p> <p>PSH should identify reasons for non-attendance and try to match appropriate interventions based on the reason(s) for non-attendance, rather than randomly fitting the individual to the available interventions. Data presentation should include the reasons for non-attendance and the specific intervention for such reasons.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. PSH has maintained substantial compliance with most of the requirements in this section, including significant progress in the assessment of risks and benefits of treatment as part of the psychiatric reassessments. However, the facility has yet to implement corrective actions to improve the violence risk assessment for individuals who are readmitted within 90 days of discharge and to address the unnecessary documentation of irrelevant laboratory findings and of theoretical side effects of treatment (at the expense of actual side effects, in some cases). 2. PSH (and DMH) streamlined the format of the inter-unit transfer assessment. The new format has resulted in assessments that are more concise and meaningful and have better clinical flow than the previous format. 3. PSH continued its practice of providing CME activities that adequately address the facility's needs. <p>Summary of Progress on Psychological Assessments: As of this tour, PSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on Nursing Assessments: PSH has maintained substantial compliance with the requirements of Section D.3.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments: PSH has maintained substantial compliance with the requirements of Section D.4.</p>

Section D: Integrated Assessments

		<p>Summary of Progress on Nutrition Assessments:</p> <ol style="list-style-type: none">1. PSH has maintained substantial compliance with the requirements of Section D.5.2. PSH has hired two new dietitians, which has resulted in full staffing. <p>Summary of Progress on Social History Assessments:</p> <p>PSH has maintained substantial compliance with the requirements of Section D.6.</p> <p>Summary of Progress on Court Assessments:</p> <p>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 is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Nitin Kulkarni, MD, Assistant Medical Director 2. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 37 individuals: AC, AW, CH, CJS, CLG, DF, DLG, DR, DS, GIW, GR, HDM, JDM, JMP, JNL, JW, KAM, KG, LMP, LSC, MAM, MB, MC, MDF, MLR, MM, PAG, PS, RAC, RAD, RLC, RPL, SC, TC, VCD, VRB, and VW 2. Monthly Psychiatric Progress Note for the following 45 individuals: ADG, AG, AM, AP, BS, BV, CA, CB, CC, CG, CG(2), CH, CTH, DB, DC, DDF, DLW, DMG, DVS, ER, ETR, GDL, GRO, HG, JEP, JHM, JM, JP, KLA, KS, LJP, MBJ, MM, MM(2), MSB, NJD, NS, NJK, PP, SC, SP, SR, TCS, WAH, and WR 3. PSH Admission Psychiatric Assessment summary data (May to October 2010) 4. PSH Integrated Assessment: Psychiatric Section summary data (May to October 2010) 5. PSH Admission Medical Assessment Auditing summary (May to October 2010) 6. PSH Monthly PPN Audit summary data (May to October 2010) 7. PSH Weekly PPN Auditing summary data (May to October 2010) 8. PSH Physician Transfer Note Auditing summary (May to October 2010) 9. PSH Framework for an Action Plan in Response to a Sentinel Event (on October 4, 2010) 10. PSH Report of the Assault Reduction Team (Sentinel Event of October 4, 2010)

Section D: Integrated Assessments

D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010). The average samples were 25% of admission assessments, 28% of integrated assessments and 20% of monthly notes on individuals who have been hospitalized for more than 90 days. The facility reported compliance rates of 100% for admission and integrated psychiatric assessments and 97% for monthly psychiatric progress notes. Comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review period.</p> <p>Other findings: See this monitor's findings in D.1.c and FD.1.f.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p>

Section D: Integrated Assessments

	<p>Accreditation Counsel for Graduate Medical Education accreditation program, and</p>	<p>Findings: The facility's report on the number and type of positions is summarized below:</p> <table border="1" data-bbox="991 375 1883 623"> <thead> <tr> <th>Psychiatric positions</th> <th>Previous Period</th> <th>Current Period</th> </tr> <tr> <td></td> <th>Filled</th> <th>Filled</th> </tr> </thead> <tbody> <tr> <td>Direct care</td> <td>74</td> <td>71</td> </tr> <tr> <td>Supervisory</td> <td>11</td> <td>14</td> </tr> <tr> <td>Board-certified</td> <td>50</td> <td>53</td> </tr> <tr> <td>Board-eligible</td> <td>34</td> <td>31</td> </tr> </tbody> </table> <p>As mentioned in previous reports, only one psychiatrist who provides direct care to individuals is not board-eligible in psychiatry. This psychiatrist is board-certified in Family Practice and assigned as the attending physician at the medically ill unit. This psychiatrist is supervised by a Senior Psychiatrist, who has the responsibility of ensuring that practice comports with standards of care.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Psychiatric positions	Previous Period	Current Period		Filled	Filled	Direct care	74	71	Supervisory	11	14	Board-certified	50	53	Board-eligible	34	31
Psychiatric positions	Previous Period	Current Period																		
	Filled	Filled																		
Direct care	74	71																		
Supervisory	11	14																		
Board-certified	50	53																		
Board-eligible	34	31																		
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Provide summary regarding status of implementation of the current process of reprivileging.</p>																		

Section D: Integrated Assessments

		<p>Findings: The process of using DMH audit data for reprivileging was fully implemented on March 1, 2010 in the Department of Psychiatry. As mentioned in the previous report, this process is based on adequate indicators. Since March 2010, all psychiatrists who were scheduled for reprivileging, as per the facility's policy, have been repriviledged using the new format.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Provide summary regarding status of implementation of the current process of reprivileging, including the number (and percentage) of psychiatrists who have been repriviledged.</p>
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:	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, PSH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 26% of admissions each month during the review period (May-October 2010). The facility reported 100% compliance with this requirement. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period. The facility's compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are listed for each corresponding cell below. The</p>

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		<p>comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (AC, CLG, KG, LMP, MAM, MB, MM, RLC, SC and TC) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.1.c.i.1	a review of systems;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.2	medical history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.3	physical examination;	<table border="1"> <tr> <td>4.</td> <td><i>A physical examination</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>A rectal and genital examination</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	4.	<i>A physical examination</i>	98%	5.	<i>A rectal and genital examination</i>	100%
4.	<i>A physical examination</i>	98%						
5.	<i>A rectal and genital examination</i>	100%						
D.1.c.i.4	diagnostic impressions; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.5	management of acute medical conditions	<table border="1"> <tr> <td>7.</td> <td><i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary</i></td> <td>100%</td> </tr> </table>	7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary</i>	100%			
7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary</i>	100%						

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		<table border="1"> <tr> <td data-bbox="989 191 1087 228"></td> <td data-bbox="1087 191 1793 228"><i>care physician.</i></td> <td data-bbox="1793 191 1921 228"></td> </tr> <tr> <td data-bbox="989 228 1087 380">8.</td> <td data-bbox="1087 228 1793 380"><i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i></td> <td data-bbox="1793 228 1921 380">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>		<i>care physician.</i>		8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	100%
	<i>care physician.</i>							
8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	100%						
D.1.c.ii	<p>within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Admission Psychiatric Assessment Audit, PSH reported a compliance rate of 100% based on an average sample of 25% of admissions each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for this requirement.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p> <p>Other findings: This monitor reviewed of the charts of 10 individuals admitted during the review period (AC, CLG, KG, LMP, MAM, MB, MM, RLC, SC and TC). The review found substantial compliance in the charts of KG, LMP, MAM, MB, RLC, SC and TC. There was evidence of partial compliance in three charts due to inadequate description of the content of significant perceptual abnormalities (AC), discrepancy between mental status examination and established diagnosis without clarification (MM), and generic reference</p>						

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		<p>to the individual's insight and judgment (CLG).</p> <p>In addition, this monitor reviewed the admission assessment of an individual (JL) who was readmitted to the facility less than 90 days after discharge and who was involved in a sentinel event approximately two weeks following his readmission. This review found inadequate violence risk assessment upon readmission. This was a significant deficiency given the individual's recent history of violence after discharge from the facility. The facility conducted an adequate review and analysis of the sentinel event as documented in the PSH Framework for an Action Plan in Response to a Sentinel Event and Report of the Assault Reduction Team. These documents included evidence that PSH identified this deficiency as a systemic issue and developed adequate corrective actions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide an update on the status of implementation of corrective actions identified in the facility's Report of the Assault Reduction Team (Sentinel Event of October 4, 2010)
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	99%. Comparative data indicated that PSH has maintained a compliance

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		rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.6	consultations ordered; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, PSH reported a compliance rate of 98% based on an average sample of 28% of Integrated Assessments due each month during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for this requirement.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: This monitor reviewed of the charts of 10 individuals admitted during the review period (AC, CLG, KG, LMP, MAM, MB, MM, RLC, SC and TC). The review found substantial compliance in nine charts and partial compliance in one (AC). The integrated assessment of AC did not include an</p>

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		<p>elaboration on significant perceptual abnormalities.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 6	diagnostic formulation;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 7	differential diagnosis;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.	psychopharmacology treatment plan; and	99%. Comparative data indicated that PSH has maintained a compliance

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9		rate of at least 90% from the previous review period.																
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from 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;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: 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.</p> <p>Findings: The following table summarizes live CME presentations during this review period:</p> <table border="1" data-bbox="989 935 1917 1414"> <thead> <tr> <th data-bbox="989 935 1129 1008">Date</th> <th data-bbox="1129 935 1451 1008">Title</th> <th data-bbox="1451 935 1755 1008">Speaker/ affiliations</th> <th data-bbox="1755 935 1917 1008">Attendees (MDs)</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1008 1129 1122">5/26/10</td> <td data-bbox="1129 1008 1451 1122">Psychopharmacological Educational Experience at Patton, Part 1</td> <td data-bbox="1451 1008 1755 1122">George Proctor, MD and Michael A. Cummings, MD, PSH</td> <td data-bbox="1755 1008 1917 1122">37</td> </tr> <tr> <td data-bbox="989 1122 1129 1268">7/7/10</td> <td data-bbox="1129 1122 1451 1268">Fast Dissociation and Antipsychotic Actions at Dopamine D2 Receptor</td> <td data-bbox="1451 1122 1755 1268">Jonathan Meyer, MD, George Proctor, MD and Michael A. Cummings, MD, PSH</td> <td data-bbox="1755 1122 1917 1268">43</td> </tr> <tr> <td data-bbox="989 1268 1129 1414">7/28/10</td> <td data-bbox="1129 1268 1451 1414">Atypical Antipsychotics as Multifunctional Drugs: Differential Pharmacologic Actions</td> <td data-bbox="1451 1268 1755 1414">Stephen M. Stahl, MD, Adjunct Professor of Psychiatry, University of</td> <td data-bbox="1755 1268 1917 1414">82</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	Attendees (MDs)	5/26/10	Psychopharmacological Educational Experience at Patton, Part 1	George Proctor, MD and Michael A. Cummings, MD, PSH	37	7/7/10	Fast Dissociation and Antipsychotic Actions at Dopamine D2 Receptor	Jonathan Meyer, MD, George Proctor, MD and Michael A. Cummings, MD, PSH	43	7/28/10	Atypical Antipsychotics as Multifunctional Drugs: Differential Pharmacologic Actions	Stephen M. Stahl, MD, Adjunct Professor of Psychiatry, University of	82
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5/26/10	Psychopharmacological Educational Experience at Patton, Part 1	George Proctor, MD and Michael A. Cummings, MD, PSH	37															
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7/28/10	Atypical Antipsychotics as Multifunctional Drugs: Differential Pharmacologic Actions	Stephen M. Stahl, MD, Adjunct Professor of Psychiatry, University of	82															

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			in Psychosis, Mania, Bipolar Depression and Treatment-Resistant Depression	California San Diego	
		8/4/10	Antipsychotics and the 5HT-1A (Serotonin 1A) Receptor	Michael A. Cummings, MD, Jonathan Meyer, MD and George Proctor, MD, PSH	47
		8/18/10	From Metabolic Syndrome to Type 2 Diabetes Mellitus: Pathogenesis, Prevention, and Treatment	Chinh Pham, MD, PSH	44
		8/25/10	Antipsychotic Metabolism	Jonathan Meyer, MD, Michael A. Cummings, MD and George Proctor, MD, PSH	58
		9/1/10	Switching Antipsychotics	George Proctor, MD, Jonathan Meyer, MD and Michael A. Cummings, MD, PSH	58
		9/15/10	Skin Laceration Management at Patton State Hospital	Hum Bui, MD, PSH	56
		10/6/10	Atypical Antipsychotics: Clozapine	George Proctor, MD, Jonathan Meyer, MD and Michael A. Cummings, MD, PSH	52
		<p>In addition, the following relevant video presentations were provided during this review period (all speakers were supported by CME Outfitters):</p>			

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		<ol style="list-style-type: none"> 1. Improving the Care of People with Mental Illness in Rural Areas; 2. Assessing and Managing the Patient with Bipolar Mania, Part 2; 3. Epilepsy in the New Millennium: Emerging Treatments and Guidelines for Effective Diagnosis and Disease Management (Encore); 4. A Case of Connecting the Dots: Improving Diagnosis and Management of Fibromyalgia; 5. Clinical Chart Review, Part 2: Assessing and Managing the Patient with Bipolar Mania; 6. ADHD Case Challenge, Parts 1-7 and 7. The Nurse's Pivotal Role in Identifying and managing Symptoms of Multiple Sclerosis <p>The above presentations were appropriate in content and range and relevant to the facility's needs.</p> <p>Recommendation 2, June 2010: Provide stratified data regarding the number of individuals who have had diagnoses listed as NOS, Deferred, and/or R/O for three or more months during the review period compared with the last period.</p> <p>Findings: The facility reported that during the current review period, 210 individuals had diagnoses listed as Rule Out, Deferred or NOS, compared to 167 individuals in the previous review period. In view of the facility's census, these data do not suggest inappropriate practice in this area.</p> <p>Other findings: This monitor reviewed the charts of the following 11 individuals who have received diagnoses listed as NOS for three or more months:</p> <table border="1" data-bbox="991 1295 1879 1408"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>AW</td> <td>Dementia NOS</td> </tr> <tr> <td>CH</td> <td>Cognitive Disorder NOS</td> </tr> </tbody> </table>	Initials	Diagnosis (NOS)	AW	Dementia NOS	CH	Cognitive Disorder NOS
Initials	Diagnosis (NOS)							
AW	Dementia NOS							
CH	Cognitive Disorder NOS							

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		<table border="1" data-bbox="991 190 1881 574"> <tr> <td>DF</td> <td>Cognitive Disorder NOS changed to Dementia NOS</td> </tr> <tr> <td>GIW</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>JDM</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>JMP</td> <td>Impulse Control NOS</td> </tr> <tr> <td>JNL</td> <td>Dementia NOS</td> </tr> <tr> <td>MC</td> <td>Mood Disorder NOS finalized to Schizophrenia, Paranoid Type</td> </tr> <tr> <td>MLR</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>RAD</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>VCD</td> <td>Dementia NOS</td> </tr> </table> <p>The review found substantial compliance in nine charts and partial compliance in two (CH and VCD).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. 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. Provide stratified data regarding the number of individuals who have had diagnoses listed as NOS, Deferred, and/or R/O for three or more months during the review period compared with the last period. 	DF	Cognitive Disorder NOS changed to Dementia NOS	GIW	Depressive Disorder NOS	JDM	Psychotic Disorder NOS	JMP	Impulse Control NOS	JNL	Dementia NOS	MC	Mood Disorder NOS finalized to Schizophrenia, Paranoid Type	MLR	Psychotic Disorder NOS	RAD	Depressive Disorder NOS	VCD	Dementia NOS
DF	Cognitive Disorder NOS changed to Dementia NOS																			
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MLR	Psychotic Disorder NOS																			
RAD	Depressive Disorder NOS																			
VCD	Dementia NOS																			
D.1.d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Same as in D.1.d.i.</p>																		

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

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		<p>Other findings: Chart reviews by this monitor found no evidence of any individual receiving "No Diagnosis" on Axis I.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p>
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, PSH reported a compliance rate of 98% based on an average sample of 21% of individuals with length of stay less than 60 days during the review period (May-October 2010). Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>PSH also used the DMH Monthly PPN Audit to assess compliance, reporting a compliance rate of 100% based on an average sample of 20% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>Other findings: This monitor reviewed the charts of 12 individuals (AC, CJS, CLG, GR, KG, LMP, MAM, MB, MM, RLC, SC and TC). The review focused on the timeliness of the notes. Regarding the weekly notes for individuals hospitalized fewer than 60 days and monthly notes for individuals hospitalized for 90 or more days, the review found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.f	<p>Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 20% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed the most recent monthly Psychiatric Progress notes for the following 45 individuals: ADG, AG, AM, AP, BS, BV, CA, CB, CC, CG, CG-2, CH, CTH, DB, DC, DDF, DLW, DMG, DVS, ER, ETR, GDL, GRO, HG, JEP, JHM, JM, JP, KLA, KS, LJP, MBJ, MM, MM-2, MSB, NJD, NS, NJK, PP, SC, SP, SR, TCS, WAH and WR. In general, the review found that the facility has maintained substantial compliance with the requirements in this section, including significant progress in the</p>

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		<p>documentation of risks and benefits of treatment. However, further corrective actions are needed to address the unnecessary documentation of irrelevant laboratory findings and of theoretical side effects of treatment (at the expense of actual side effects, in some cases).</p> <p>This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period (DLG, DS, HDM, JW, KAM and PS) to assess the use of PRN/Stat medications prior to seclusion and/or restraint (as documented in the orders and progress notes). The review found substantial compliance in five charts (DLG, DS, HDM, KAM and PS). In the case of JW, there was evidence of some delay in the adjustment of regular antipsychotic regimen in response to a significant event given the level of psychotic symptoms at the time of this event as well as discrepancy between emergency psychiatric assessment by the covering psychiatrist and the assessment by the attending psychiatrist. In addition, the review of the administration of a stat medication (olanzapine) was incomplete. This review is also relevant to the requirements in D.1.f.vi and F.1.b.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Implement corrective actions to address the unnecessary documentation of irrelevant laboratory findings and of theoretical side effects of treatment (at the expense of actual side effects). 3. Implement corrective actions to address the occasional discrepancy between emergency psychiatric assessment by the covering psychiatrist and the assessment by the attending psychiatrist.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.

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	follow up;				
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1"> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%			
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<table border="1"> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	96%
5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	96%			

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D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Ensure correction of the deficiencies listed [in this cell in the previous report]. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the review period and compared to the last period). <p>Findings: PSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 16% of the individuals who experienced inter-unit transfer per month during the review period (May-October 2010):</p>

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		<table border="1" data-bbox="991 228 1887 459"> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>100%</td> </tr> </table> <p data-bbox="991 500 1902 570">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 613 1892 902">During this review period, PSH (and the Medical Directors Committee of DMH facilities) streamlined the format of the inter-unit transfer assessments. Following DMH approval, the facility implemented the new format in October 2010. The streamlined format was intended to minimize duplicative documentation between the WRP and the inter-unit transfer assessment. The self-audit tool was recently revised to correspond to the new format (e.g. the barriers to discharge section will be addressed only as part of the WRP audit for C.2.g.iii).</p> <p data-bbox="991 943 1188 971">Other findings:</p> <p data-bbox="991 979 1864 1117">This monitor reviewed the charts of eight individuals who experienced inter-unit transfers during the review period and whose assessments were completed using the streamlined format (the assessment of PAG used a mixture of the old and the new formats):</p> <table border="1" data-bbox="991 1157 1476 1424"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>DR</td> <td>10/8/10</td> </tr> <tr> <td>LSC</td> <td>10/21/10</td> </tr> <tr> <td>MDF</td> <td>10/15/10</td> </tr> <tr> <td>PAG</td> <td>11/16/10</td> </tr> <tr> <td>RAC</td> <td>10/21/10</td> </tr> <tr> <td>RPL</td> <td>10/18/10</td> </tr> </tbody> </table>	1.	<i>Psychiatric course of hospitalization,</i>	100%	2.	<i>Medical course of hospitalization,</i>	100%	3.	<i>Current target symptoms,</i>	100%	4.	<i>Psychiatric risk assessment,</i>	100%	5.	<i>Current barriers to discharge,</i>	98%	6.	<i>Anticipated benefits of transfer.</i>	100%	Initials	Date of transfer	DR	10/8/10	LSC	10/21/10	MDF	10/15/10	PAG	11/16/10	RAC	10/21/10	RPL	10/18/10
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		VRB	10/13/10
		VW	10/8/10
<p>This review found substantial compliance in seven charts and partial compliance in one (VW). In general, there was evidence that implementation of the new streamlined format resulted in transfer assessments that were more concise and easier to follow, that the content was more meaningful and the clinical flow of data was much improved.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure full implementation of the streamlined format of the transfer assessment. 			

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2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Allison Pate, PhD, Senior Supervising Psychologist 2. David Haimson, PhD, Chief of Psychology 3. Gari-Lyn Richardson, Director of Standards Compliance 4. Helga Thordarson, PhD, Senior Supervising Psychologist 5. Joseph Melancharuvil, PhD, ABPP, Clinical Administrator 6. Melanie Byde, PhD, Mall Director 7. Steve Berman, By Choice Coordinator 8. Susan Velasquez, PhD, PSSC Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 40 individuals: AB, AG, AR, BC, BLZ, BM, CC, DG, DJ, DP, EC, EG, FS, FV, GH, GL, GS, HLG, JC, JD, JDC, JG, JID, JNT, KA, LJ, LM, MC, MD, MK, NK, NP, PA, REP, RG, RJ, RS, SD, TY and YL 2. Psychology Assessment Monitoring Form summary data, May-October 2010 3. Psychology staff roster 4. Psychologist assignments list 5. List of individuals aged 22 and under 6. List of individuals whose primary/preferred language is other than English 7. Integrated Psychological Assessments: Psychology Section completed during this review period 8. Focused Psychological Assessments completed during this review period 9. Structural and Functional Assessments <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit EB11) for monthly review of LGM

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		<ol style="list-style-type: none"> 2. WRPC (Program VI, unit 75) for quarterly review of RMM 3. WRPC (Program VI, unit EBO9) for 14-day review of LMD 4. Mall Group: Substance Recovery (Stage of Change 1-3) 5. Mall Group: Cognitive Remediation 6. Mall Group: RISE, Cognitive Remediation 7. Mall Group: SAFE Program 8. Mall Group: Mindfulness Through Laughter 9. Mall Group: Stress Management 10. Mall Group: Karaoke, Spanish Group
D.2.a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: All manuals (DMH Psychology, PBS and By Choice) have been completed and aligned across DMH hospitals. Manuals are revised regularly to reflect updated processes and protocols.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

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		<p>Findings:</p> <p>This monitor's documentation review found that PSH had admitted a total of 30 individuals below 23 years of age. Twenty-seven of them were found to be ineligible for assessment and/or Special Education services for a variety of reasons including refusal, possession of high school diploma, possession of GED, and absence of prior Special Education classes.</p> <p>Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on a 100% sample of individuals below 23 years of age during this review period (May-October 2010):</p> <table border="1" data-bbox="991 636 1890 896"> <tr> <td data-bbox="991 636 1087 896">1.</td> <td data-bbox="1087 636 1793 896"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></td> <td data-bbox="1793 636 1890 896">33%</td> </tr> </table> <p>The compliance rate is less than 100% because legally required consents were unavailable, and testing could not be conducted. The facility had made numerous attempts to contact and obtain the required consent. Mailed requests to the legal guardians were not returned. Requests from the courts for surrogate appointees to provide consent for release of needed documents and testing was not responded to.</p> <p>PSH's compliance rate was 100% in the previous review period.</p> <p>This monitor reviewed the records of the three individuals who met eligibility for testing (AJR, EH and SRG). The required assessments had been completed in a timely fashion for one individual (EH). The required assessments for the remaining two were not completed in a timely fashion</p>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	33%
1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	33%			

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		<p>due to the difficulty in obtaining parental consent. PSH's court motion for surrogate appointees to provide consent remained unresolved. Both had been attending school at PSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
D.2.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The following table describes PSH's psychology staffing pattern as of [date]:</p> <table border="1" data-bbox="991 894 1852 1049"> <thead> <tr> <th></th> <th>Filled positions</th> <th>Vacant positions</th> </tr> </thead> <tbody> <tr> <td>Unit psychologist</td> <td>85</td> <td>2</td> </tr> <tr> <td>Senior psychologist</td> <td>8</td> <td>0</td> </tr> <tr> <td>Neuropsychologist</td> <td>5</td> <td>0</td> </tr> </tbody> </table> <p>PSH reported that 98% of psychology positions were filled, with a 2% vacancy rate. During this review period, two psychologists left state employment and six were hired. Data also showed that seven psychologists were assigned to non-psychology positions (e.g. Clinical Administrator, Mall Director, Standards Compliance, I.T., and SAFE Program Director). Thus, the Psychology "working" vacancy rate is 11%.</p> <p>Other findings: The following table shows the number of staff involved in performing</p>		Filled positions	Vacant positions	Unit psychologist	85	2	Senior psychologist	8	0	Neuropsychologist	5	0
	Filled positions	Vacant positions												
Unit psychologist	85	2												
Senior psychologist	8	0												
Neuropsychologist	5	0												

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		<p>evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:</p> <table border="1" data-bbox="991 339 1887 677"> <tr> <td data-bbox="991 339 1087 451">1.a</td> <td data-bbox="1087 339 1793 451"><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td data-bbox="1793 339 1887 451">98</td> </tr> <tr> <td data-bbox="991 451 1087 527">1.b</td> <td data-bbox="1087 451 1793 527"><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td data-bbox="1793 451 1887 527">98</td> </tr> <tr> <td data-bbox="991 527 1087 604">2.a</td> <td data-bbox="1087 527 1793 604"><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td data-bbox="1793 527 1887 604">5</td> </tr> <tr> <td data-bbox="991 604 1087 677">2.b</td> <td data-bbox="1087 604 1793 677"><i>Number observed to be verifiably competent in assessment procedures</i></td> <td data-bbox="1793 604 1887 677">5</td> </tr> </table> <p>As the table above shows, PSH only observed five psychologists while undertaking psychological assessments. It appears that the psychology department only observes the admissions psychologists who primarily conduct the Initial Integrated Assessment: Psychology Section. Observation and feedback to all practicing psychologists will be of benefit to the psychologists, and should be made a practice at PSH.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	98	1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	98	2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	5	2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	5
1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	98												
1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	98												
2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	5												
2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	5												
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Substantial.</p>												

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D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: According to the facility, 160 focused psychological assessments were completed this monitoring period (103 FPAs and 57 NFAs).</p> <p>Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six contained clear and concise statements with a rationale for the referral (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 100%.</p>

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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six 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 (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 98%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six indicated if the individual would benefit from individual and/or group therapy (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.d.v	<p>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at</p>

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		<p>least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six indicated whether the individual would benefit from behavioral guidelines or required Positive Behavior Support (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six contained documentation of the implications of the findings for PSR and other interventions (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review,	<p>Current findings on previous recommendation:</p>

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	<p>interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>D.2.d. viii</p>	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 87% of the Focused Psychological Assessments due each month for the review period (May-October 2010), and reported a mean compliance rate of 98%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found</p>

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		<p>that all six had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (EG, GS, HLG, JDC, NK and REP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>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.</p> <p>Compliance: Substantial.</p>
D.2.f	<p>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</p>	<p>Compliance: Substantial.</p>
D.2.f.i	<p>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

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		<p>Findings: Staff report and documentation review found that PSH admitted 466 individuals during this review period. A number of factors including, absences, bereavement leave, jury duty, illness, and vacations are said to have contributed to less than 100% timely completion of the IAPS.</p> <p>Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 52% of the Integrated Assessments: Psychology Section (IAPS) due each month for the review period (May-October 2010), and reported a mean compliance rate of 95%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period. A number of factors including, absences, bereavement leave, jury duty, illness, and vacations are said to have contributed to less than 100% timely completion of the IAPS.</p> <p>A review of the IAPs for six individuals found that all six were conducted in a timely manner (AR, EC, FS, JNT, KA and MC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the Integrated Assessments: Psychology Section (IAPS) completed each month for the review period (May-October 2010), and reported a mean compliance rate</p>

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		<p>of 94%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for six individuals found that all six documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AR, EC, FS, JNT, KA and MC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.f.i.2	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (May-October 2010), and reported a mean compliance rate of 94%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for six individuals found that all six provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (AR, EC, FS, JNT, KA and MC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: All 17 Positive Behavior Support Plans and Behavioral Guidelines were developed following the completion of structural and functional assessments (AG, AR, BC, BM, CC, DG, DJ, DP, GH, GL, JG, LJ, MK, RJ, RS, SD and TY)</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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) with differential diagnoses due each month during the review period (May-October 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 1227 1890 1421"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>98%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>98%</td> </tr> </table>	16.	<i>Differential diagnosis</i>	100%	17.	<i>Rule-out</i>	98%	18.	<i>Deferred</i>	100%	19.	<i>No diagnosis</i>	100%	20.	<i>NOS diagnosis</i>	98%
16.	<i>Differential diagnosis</i>	100%															
17.	<i>Rule-out</i>	98%															
18.	<i>Deferred</i>	100%															
19.	<i>No diagnosis</i>	100%															
20.	<i>NOS diagnosis</i>	98%															

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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed the records of seven individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all seven of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AB, BLZ, CC, JD, JID, NP and PA).</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Information and documentation review found that the Psychology Department has 24 bilingual psychology staff. The facility reported the following data from the DMH Psychology Assessment Monitoring Form for the period May-October 2010:</p> <table border="1" data-bbox="991 1079 1887 1416"> <tr> <td data-bbox="991 1079 1087 1192">21.a</td> <td data-bbox="1087 1079 1793 1192"><i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i></td> <td data-bbox="1793 1079 1887 1192">27</td> </tr> <tr> <td data-bbox="991 1192 1087 1268">21.b</td> <td data-bbox="1087 1192 1793 1268"><i>Of those in 21.a, number of individuals who were assessed in their primary language</i></td> <td data-bbox="1793 1192 1887 1268">12</td> </tr> <tr> <td data-bbox="991 1268 1087 1344">22.a</td> <td data-bbox="1087 1268 1793 1344"><i>Of those in 21.a, number of individuals who could not be assessed</i></td> <td data-bbox="1793 1268 1887 1344">9</td> </tr> <tr> <td data-bbox="991 1344 1087 1416">22.b</td> <td data-bbox="1087 1344 1793 1416"><i>Of those in 22.a, number of individuals who had plans developed to meet their assessment</i></td> <td data-bbox="1793 1344 1887 1416">7</td> </tr> </table>	21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	27	21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	12	22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	9	22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment</i>	7
21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	27												
21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	12												
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		<table border="1"> <tr> <td data-bbox="989 188 1087 228"></td> <td data-bbox="1087 188 1793 228" style="text-align: center;"><i>needs</i></td> <td data-bbox="1793 188 1892 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">23.</td> <td data-bbox="1087 228 1793 342" style="text-align: center;"><i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i></td> <td data-bbox="1793 228 1892 342" style="text-align: center;">7</td> </tr> </table>		<i>needs</i>		23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	7
	<i>needs</i>							
23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	7						
		<p>The overall compliance rate was 93% for the review period.</p> <p>Findings of a review of the charts of eight individuals tested in their primary/ preferred language (AR, FV, JC, LM, MC, MD, RG and YL) were in agreement with the facility's findings. For example, YL is Vietnamese but had lived in the USA since 12 years of age and thus was conversant in the English language and opted to respond in English (the psychological examiner had found the individual competent in the English language during the assessment and had concluded that the assessment was valid).</p> <p>PSH should identify some brief standardized language assessment tools to evaluate the individual's language competency. Speaking some English is inadequate to comprehend the assessment language, and at times individuals might want to respond in English, but might not understand the level of English needed to fully appreciate the assessment language.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						

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3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u> Sandra Doerner, RN, Nurse Administrator</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Nursing Admission Assessment data summary data, May-October 2010 2. PSH Nursing Integrated Assessment Monitoring Audit summary data, May-October 2010 3. PSH's training rosters 4. Admission and integrated assessments and WRPs for the following 40 individuals: AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JTT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 31% mean sample of admissions each month during the review period (May-October 2010), and reported a mean compliance rate of 97%. Comparative data indicated that PSH has</p>

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		<p>maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JTT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that PSH has maintained the quality of the assessments and all 40 were found to be in substantial compliance. These findings comport with PSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 28% mean sample of admissions each month during the review period (May-October 2010):</p> <table border="1" data-bbox="991 711 1890 860"> <tr> <td data-bbox="991 711 1087 860">1.</td> <td data-bbox="1087 711 1795 860"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1795 711 1890 860">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JTT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that PSH had also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings comport with PSH's data.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	95%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	95%			

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D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 266 1887 563"> <tr> <td data-bbox="991 266 1087 563">2.</td> <td data-bbox="1087 266 1793 563"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 266 1887 563">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 786 1887 972"> <tr> <td data-bbox="991 786 1087 972">2.</td> <td data-bbox="1087 786 1793 972"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 786 1887 972">94%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	98%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	94%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	98%						
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	94%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u> 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>						

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D.3.a.iv	allergies;	<p><u>Admission Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.v	pain;	<p><u>Admission Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u> 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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D.3.a.viii	<p>immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and</p>	<p><u>Admission Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH training rosters verified that all 57 RNs who were required to complete competency-based training regarding Nursing Assessments passed the training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Substantial.</p>
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 31% mean sample of admissions each month during the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>A review of Nursing Admission Assessments for 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JJT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that all were timely completed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 28% mean sample of admissions each month during the review period (May-October 2010):</p> <table border="1" data-bbox="991 894 1887 1044"> <tr> <td data-bbox="991 894 1087 1044">10.</td> <td data-bbox="1087 894 1793 1044"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1793 894 1887 1044">96%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JJT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that all were timely completed.</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	96%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	96%			

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that staff members who attend the WRPCs sign the WRP signature page.</p> <p>Findings: PSH implemented random weekly audits by Nurse Coordinators to ensure that the signature page of the WRP was appropriately signed by the participants.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on a mean sample of 21% of WRPCs observed each month during the review period (May-October 2010):</p> <table border="1" data-bbox="991 1117 1915 1269"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>98%</td> <td>97%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>96%</td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	98%	97%	<i>Psychiatric Technician attendance at WRPC</i>	96%	97%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	98%	97%									
<i>Psychiatric Technician attendance at WRPC</i>	96%	97%									

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		<p>A review of the charts of 40 individuals (AA, ANP, AR, CGT, CLW, DB, DC, DDF, DJW, EB, EH, EM, FJS, FR, GEL, GHB, IG, JAC, JBG, JDD, JG, JJT, JMM, JMV, JSM, LEM, LL, LTV, MRM, NMT, OIB, QW, RC, RCB, REB, RJS, SCG, TCN, TOK and TS) found that an RN attended the WRPC in 38 cases and a PT attended the WRPC in 38 cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <ol style="list-style-type: none"> 1. Chris Keierleber, Senior Rehabilitation Therapist 2. Greg Siples, Director of Rehabilitation Therapy Services 3. Rebecca Griffin, Acting Senior Rehabilitation Therapist 4. Renata Geyer, Senior Rehabilitation Therapist 5. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 6. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA:RTS assessments from May to October 2010 2. Records of the following 13 individuals who had IA:RTS assessments from May to October 2010: DH, DSM, GRS, JBB, JMV, LAO, LRT, MH, RDJ, RMO, RRJ, SPM and TJ 3. List of individuals who had Occupational Therapy assessments from May to October 2010 4. Records of the following six individuals who had Occupational Therapy assessments from May to October 2010: CCR, GCD, GH, JH, MG and SMK 5. List of individuals who had Physical Therapy assessments from May to October 2010 6. Records of the following seven individuals who had Physical Therapy assessments from May to October 2010: JM, KCY, LSC, MLB, MM, MMB and RDB 7. List of individuals who had Speech Therapy assessments from May to October 2010 8. Records of the following seven individuals who had Speech Therapy assessments from May to October 2010: DA, GDG, GWS, JP, JU, SM and SNC 9. List of individuals who had Vocational Rehabilitation assessments from May to October 2010

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		<p>10. Records of the following eight individuals who had Vocational Rehabilitation assessments from May to October 2010: AJM, DCG, DLS, EM, PDP, RLG, RTN and SMK</p> <p>11. List of individuals who had CIPRTA assessments from May to October 2010</p> <p>12. Records of the following four individuals who had CIPRTA assessments from May to October 2010: EK, HV, RED and SRD</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Assessment tools should be revised, updated, and streamlined based on review and analysis of audit data, clinician recommendations for improving clinical utility, and changes in systemic needs and evolving standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness (completion</p>

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		<p>within five calendar days of admission) based on an average sample of 25% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2010 (total of 120 out of 488), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTS assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (completion within 14 days of referral) based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period May-October 2010 (total of 33), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (completion within 14 days of referral) based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period May-October 2010 (total of 50), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found five records in compliance (JM, KCY, MLB, MMB and RDB) and two records not in</p>
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		<p>compliance (LSC and MM).</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (completion within 14 days of referral) based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period May-October 2010 (total of 32), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness (completion within 30 days of referral) based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period May-October 2010 (total of 133), and reported a mean compliance rate of 98%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment (CIPRTA) 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 2010 (total of six), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>
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		<p>A review of the records of four individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 25% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2010 (total of 120 out of 488), and reported a mean compliance rate of 99%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>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 2010 (total of 33), and reported a mean compliance rate of 100%. Comparative data</p>

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		<p>indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 50), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 32), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an</p>
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		<p>average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period May-October 2010 (total of 133), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, 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 2010 (total of six), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>

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		<p>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 25% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2010 (total of 120 out of 488):</p> <table border="1" data-bbox="991 451 1908 602"> <tr> <td data-bbox="991 451 1087 526">3.</td> <td data-bbox="1087 451 1793 526"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 451 1908 526">100%</td> </tr> <tr> <td data-bbox="991 526 1087 602">4.</td> <td data-bbox="1087 526 1793 602"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 526 1908 602">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 33):</p> <table border="1" data-bbox="991 1084 1908 1235"> <tr> <td data-bbox="991 1084 1087 1159">3.</td> <td data-bbox="1087 1084 1793 1159"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1084 1908 1159">100%</td> </tr> <tr> <td data-bbox="991 1159 1087 1235">4.</td> <td data-bbox="1087 1159 1793 1235"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1159 1908 1235">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to assess compliance of</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 50):</p> <table border="1" data-bbox="991 487 1908 639"> <tr> <td data-bbox="991 487 1087 561">3.</td> <td data-bbox="1087 487 1793 561"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 487 1908 561">100%</td> </tr> <tr> <td data-bbox="991 561 1087 639">4.</td> <td data-bbox="1087 561 1793 639"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 561 1908 639">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 32):</p> <table border="1" data-bbox="991 1118 1908 1271"> <tr> <td data-bbox="991 1118 1087 1193">3.</td> <td data-bbox="1087 1118 1793 1193"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1118 1908 1193">100%</td> </tr> <tr> <td data-bbox="991 1193 1087 1271">4.</td> <td data-bbox="1087 1193 1793 1271"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1193 1908 1271">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, 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 2010 (total of 133):</p> <table border="1" data-bbox="991 561 1908 712"> <tr> <td data-bbox="991 561 1087 638">3.</td> <td data-bbox="1087 561 1793 638"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 561 1908 638">100%</td> </tr> <tr> <td data-bbox="991 638 1087 712">4.</td> <td data-bbox="1087 638 1793 712"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 638 1908 712">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, 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 2010 (total of six):</p> <table border="1" data-bbox="991 1193 1908 1344"> <tr> <td data-bbox="991 1193 1087 1269">3.</td> <td data-bbox="1087 1193 1793 1269"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1193 1908 1269">100%</td> </tr> <tr> <td data-bbox="991 1269 1087 1344">4.</td> <td data-bbox="1087 1269 1793 1344"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1269 1908 1344">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>least 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 25% of Integrated Rehabilitation Therapy Assessments due each month for the review period May-October 2010 (total of 120 out of 488):</p> <table border="1" data-bbox="991 1079 1906 1195"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of 13 individuals to assess compliance of IA:RTS Assessments with D.4.b.iii criteria found all records in substantial</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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		<p>compliance.</p> <p>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 2010 (total of 33):</p> <table border="1" data-bbox="991 451 1906 565"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of six individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, 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 2010 (total of 50):</p> <table border="1" data-bbox="991 1047 1906 1161"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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7.	<i>Motivation for engaging in wellness activities.</i>	100%																		

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		<p>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 2010 (total of 32):</p> <table border="1" data-bbox="993 414 1904 527"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>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 2010 (total of 133):</p> <table border="1" data-bbox="993 1047 1904 1161"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of eight individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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		<p>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 2010 (total of six):</p> <table border="1" data-bbox="993 414 1906 529"> <tr> <td data-bbox="993 414 1087 451">5.</td> <td data-bbox="1087 414 1793 451"><i>Identifies the individual's life goals,</i></td> <td data-bbox="1793 414 1906 451">100%</td> </tr> <tr> <td data-bbox="993 451 1087 488">6.</td> <td data-bbox="1087 451 1793 488"><i>Strengths, and</i></td> <td data-bbox="1793 451 1906 488">100%</td> </tr> <tr> <td data-bbox="993 488 1087 526">7.</td> <td data-bbox="1087 488 1793 526"><i>Motivation for engaging in wellness activities.</i></td> <td data-bbox="1793 488 1906 526">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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7.	<i>Motivation for engaging in wellness activities.</i>	100%									
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported that during the review period, one out of one physical therapist and four out of four rehabilitation therapists were trained to competency on the screening tools and/or assessments for which they are responsible. Inter-rater agreement was reported to</p>									

Section D: Integrated Assessments

		<p>range from 97-100% for Integrated and Focused Assessments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of the June 2009 tour.</p> <p>Compliance: Substantial.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Delores Otto-Moreno, Assistant Director of Nutrition Services 3. Grace Ferris, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Acting Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for May to October 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from May to October 2010 for each assessment type 3. Records of the following seven individuals with type D.5.d assessments from May to October 2010: CG, FT, HLD, LEL, MC, QW and UVJ 4. Records of the following six individuals with type D.5.e assessments from May to October 2010: AA, ABE, DMC, EM, LDL and VJ 5. Records of the following six individuals with type D.5.f assessments from May to October 2010: FR, JBG, JDD, JMV, MR and WE 6. Records of the following eight individuals with type D.5.g assessments from May to October 2010: AA-2, AGA, CL, DC, HM, IG, MDF and TR 7. Records of the following ten individuals with type D.5.i assessments from May to October 2010: AY, CB, DT, JW, LSC, PJ, PLJ, RA, RR and TLO 8. Records of the following ten individuals with type D.5.j.i assessments from May to October 2010: BD, CGD, EO, HK, JL, ME, MRJ, ST, TYH and WAM 9. Records of the following ten individuals with type D.5.j.ii assessments from May to October 2010: GRO, JEP, JJB, JW, KJJ, LRR, MJ, MSW, RH and RLZ

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D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	<p>Current findings on previous recommendations:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility reported that no individuals met criteria for referral for a type D.5.a assessment.</p> <p>Compliance: Unable to determine.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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</p>

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	<p>be completed within 7 days of admission.</p>	<p>assessments due each month for the review period May-October 2010 (total of 49):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>98%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>98%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	98%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	98%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.d criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																		
D.5.e	<p>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010 (total of 11):</p> <table border="1" data-bbox="991 1079 1906 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated,</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated,</i>	100%
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			<i>prioritized and validated</i>	
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
		9.	<i>Progress is monitored, measured, and evaluated</i>	N/A
		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	93%
		11.	<i>Recommendations are appropriate and complete</i>	93%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		

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<p>D.5.f</p>	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010 (total of 44):</p> <table border="1" data-bbox="991 597 1906 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>98%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>98%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	95%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	98%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	98%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	98%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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		<table border="1" data-bbox="993 188 1908 423"> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>98%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p data-bbox="993 464 1908 570">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p data-bbox="993 610 1908 678">A review of the records of six individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.</p> <p data-bbox="993 719 1140 787">Compliance: Substantial.</p> <p data-bbox="993 828 1457 896">Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	98%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p data-bbox="993 946 1577 976">Current findings on previous recommendation:</p> <p data-bbox="993 1016 1457 1084">Recommendation, June 2010: Continue to monitor this requirement.</p> <p data-bbox="993 1125 1871 1308">Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.g assessments due each month for the review period May-October 2010 (total of 73 out of 314):</p> <table border="1" data-bbox="993 1344 1908 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%									
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		<table border="1"> <tr> <td data-bbox="989 190 1087 266">3.</td> <td data-bbox="1087 190 1793 266"><i>All pertinent objective nutrition information is accurately addressed</i></td> <td data-bbox="1793 190 1904 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">4.</td> <td data-bbox="1087 266 1793 342"><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td data-bbox="1793 266 1904 342">100%</td> </tr> <tr> <td data-bbox="989 342 1087 418">5.</td> <td data-bbox="1087 342 1793 418"><i>Assessment utilizes findings from subjective and objective data</i></td> <td data-bbox="1793 342 1904 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 495">6.</td> <td data-bbox="1087 418 1793 495"><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td data-bbox="1793 418 1904 495">100%</td> </tr> <tr> <td data-bbox="989 495 1087 537">7.</td> <td data-bbox="1087 495 1793 537"><i>Nutrition education is documented</i></td> <td data-bbox="1793 495 1904 537">100%</td> </tr> <tr> <td data-bbox="989 537 1087 643">8.</td> <td data-bbox="1087 537 1793 643"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td data-bbox="1793 537 1904 643">100%</td> </tr> <tr> <td data-bbox="989 643 1087 685">9.</td> <td data-bbox="1087 643 1793 685"><i>Progress is monitored, measured, and evaluated</i></td> <td data-bbox="1793 643 1904 685">N/A</td> </tr> <tr> <td data-bbox="989 685 1087 761">10.</td> <td data-bbox="1087 685 1793 761"><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td data-bbox="1793 685 1904 761">100%</td> </tr> <tr> <td data-bbox="989 761 1087 803">11.</td> <td data-bbox="1087 761 1793 803"><i>Recommendations are appropriate and complete</i></td> <td data-bbox="1793 761 1904 803">99%</td> </tr> <tr> <td data-bbox="989 803 1087 880">12.</td> <td data-bbox="1087 803 1793 880"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1793 803 1904 880">100%</td> </tr> <tr> <td data-bbox="989 880 1087 956">13.</td> <td data-bbox="1087 880 1793 956"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1793 880 1904 956">100%</td> </tr> <tr> <td data-bbox="989 956 1087 1032">14.</td> <td data-bbox="1087 956 1793 1032"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 956 1904 1032">N/A</td> </tr> <tr> <td data-bbox="989 1032 1087 1075">15.</td> <td data-bbox="1087 1032 1793 1075"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 1032 1904 1075">99%</td> </tr> <tr> <td data-bbox="989 1075 1087 1117">16.</td> <td data-bbox="1087 1075 1793 1117"><i>Assessment is concise</i></td> <td data-bbox="1793 1075 1904 1117">100%</td> </tr> <tr> <td data-bbox="989 1117 1087 1159">17.</td> <td data-bbox="1087 1117 1793 1159"><i>Assessment is legible</i></td> <td data-bbox="1793 1117 1904 1159">100%</td> </tr> <tr> <td data-bbox="989 1159 1087 1201">18.</td> <td data-bbox="1087 1159 1793 1201"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 1159 1904 1201">99%</td> </tr> </table>	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	99%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	99%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	99%	<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of eight individuals to assess compliance with</p>
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		<p>Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.5.h	<p>Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010 (592 out of 2349). The facility reports that a weighted mean of 98% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 57 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST.</p>	<p>Current findings on previous recommendation:</p>

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	<p>Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.i assessments due each month for the review period May-October 2010 (total of 251 out of 1222):</p> <table border="1" data-bbox="991 522 1911 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>79%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>99%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>97%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>96%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	79%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	96%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	98%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	98%	7.	<i>Nutrition education is documented</i>	99%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	99%	9.	<i>Progress is monitored, measured, and evaluated</i>	99%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	97%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	96%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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		<table border="1" data-bbox="993 191 1913 423"> <tr> <td data-bbox="993 191 1087 269">14.</td> <td data-bbox="1087 191 1793 269"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 191 1913 269">N/A</td> </tr> <tr> <td data-bbox="993 269 1087 305">15.</td> <td data-bbox="1087 269 1793 305"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 269 1913 305">96%</td> </tr> <tr> <td data-bbox="993 305 1087 341">16.</td> <td data-bbox="1087 305 1793 341"><i>Assessment is concise</i></td> <td data-bbox="1793 305 1913 341">100%</td> </tr> <tr> <td data-bbox="993 341 1087 376">17.</td> <td data-bbox="1087 341 1793 376"><i>Assessment is legible</i></td> <td data-bbox="1793 341 1913 376">100%</td> </tr> <tr> <td data-bbox="993 376 1087 423">18.</td> <td data-bbox="1087 376 1793 423"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 376 1913 423">98%</td> </tr> </table> <p data-bbox="993 467 1913 605">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period, except item 1. Compliance for item 1 improved from 50% in the previous review period.</p> <p data-bbox="993 649 1913 716">A review of the records of 10 individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p> <p data-bbox="993 760 1140 826">Compliance: Substantial.</p> <p data-bbox="993 870 1457 937">Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	96%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	98%
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D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p data-bbox="993 984 1577 1013">Current findings on previous recommendation:</p> <p data-bbox="993 1057 1457 1123">Recommendation, June 2010: Continue to monitor this requirement.</p> <p data-bbox="993 1167 1881 1344">Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 24% of Nutrition Type D.5.j.i assessments due each month for the review period May-October 2010 (total of 42 out of 173):</p> <table border="1" data-bbox="993 1385 1913 1421"> <tr> <td data-bbox="993 1385 1087 1421">1.</td> <td data-bbox="1087 1385 1793 1421"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1385 1913 1421">100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%												
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		2.	<i>All required subjective concerns are addressed</i>	100%
		3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%
		4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%
		5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%
		6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
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		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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		10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%
		11.	<i>Recommendations are appropriate and complete</i>	98%
		12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	98%
		13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		15.	<i>Assessment utilizes approved abbreviations</i>	100%
		16.	<i>Assessment is concise</i>	100%
		17.	<i>Assessment is legible</i>	100%
		18.	<i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p>		

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		<p>A review of the records of 10 individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010 (total of 120 out of 556):</p> <table border="1" data-bbox="991 933 1908 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>78%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	78%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	99%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	99%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	100%
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		<i>identified</i>	
9.	<i>Progress is monitored, measured, and evaluated</i>		100%
10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>		97%
11.	<i>Recommendations are appropriate and complete</i>		100%
12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>		97%
13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>		100%
14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>		N/A
15.	<i>Assessment utilizes approved abbreviations</i>		95%
16.	<i>Assessment is concise</i>		100%
17.	<i>Assessment is legible</i>		100%
18.	<i>Each page of the assessment is signed</i>		99%
<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period, except item 1. Compliance for item 1 improved from 58% in the previous review period.</p> <p>A review of the records of 10 individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			

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6. Social History Assessments					
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christopher Smart, LCSW, Section E Lead 2. Hope Marriott, LCSW, Assistant to the Clinical Administrator 3. Lisa Hilder, LCSW, Supervisor Social Worker 4. Rachel Strydom, LCSW, Supervising Social Worker 5. Samantha Lillo, LCSW, Family Services Clinic 6. Tiffany Rector, JD, LCSW (A), Supervising Social Worker and Section Leader 7. Veronica Kaufman, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 10 individuals: CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT 2. PSH Social History Assessments Monitoring Form summary data, May-October 2010 3. DMH Integrated Assessments: Social Work Section 4. DMH 30-Day Psychosocial Assessments 			
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23% of the Integrated Assessments: Social Work Sections due each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 1377 1892 1416"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate</i></td> <td style="width: 15%; text-align: right;">100%</td> </tr> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%
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		<table border="1"> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td>100%</td> </tr> </table>	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%			
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3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%									
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 10 individuals to evaluate the Integrated Assessments: Social Work Sections found that all 10 assessments were current and comprehensive (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p> <p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 22% of the Integrated Assessments: Social Work Sections due each month during the review period (May-October 2010):</p>											
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2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%									
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 10 individuals to evaluate the 30-Day Psychosocial Assessments found that all 10 assessments were current and comprehensive (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p>											

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		<p>Other findings: According to the Chief of Social Work, all units are fully staffed. Turnover has been low during this review period. Vacancies exist for off-unit allocations. When there are coverage issues, they are due to extended absences and not due to vacancies.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 22% of the 30-Day Psychosocial Assessments due each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 1044 1887 1195"> <tr> <td>4.</td> <td><i>Expressly identifies factual inconsistencies among sources.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Resolves or attempts to resolve inconsistencies.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Explains the rationale for the resolution offered.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 10 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

Section D: Integrated Assessments

		<p>found that all 10 assessments identified and resolved factual inconsistencies (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT). Factual inconsistencies and the rationales and clarifications given for CCS and KA were noteworthy.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23% of Integrated Assessments: Social Work Sections due each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 1008 1892 1045"> <tr> <td data-bbox="993 1008 1087 1045">7.</td> <td data-bbox="1087 1008 1793 1045"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 1008 1892 1045">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals to evaluate timeliness of the Social Work Integrated Assessment found that all 10 assessments were timely (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p> <p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 22% of 30-Day</p>	7.	<i>Is included in the 7-day integrated assessment</i>	100%
7.	<i>Is included in the 7-day integrated assessment</i>	100%			

Section D: Integrated Assessments

		<p>Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 264 1887 342"> <tr> <td data-bbox="993 264 1087 342">8.</td> <td data-bbox="1087 264 1793 342"><i>Fully documented by the 30th day of the individual's admission.</i></td> <td data-bbox="1793 264 1887 342">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that all 10 assessments were timely (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	8.	<i>Fully documented by the 30th day of the individual's admission.</i>	99%			
8.	<i>Fully documented by the 30th day of the individual's admission.</i>	99%						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 23% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 1268 1887 1346"> <tr> <td data-bbox="993 1268 1087 1308">9.</td> <td data-bbox="1087 1268 1793 1308"><i>Social factors</i></td> <td data-bbox="1793 1268 1887 1308">100%</td> </tr> <tr> <td data-bbox="993 1308 1087 1346">10.</td> <td data-bbox="1087 1308 1793 1346"><i>Educational status</i></td> <td data-bbox="1793 1308 1887 1346">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	9.	<i>Social factors</i>	100%	10.	<i>Educational status</i>	100%
9.	<i>Social factors</i>	100%						
10.	<i>Educational status</i>	100%						

Section D: Integrated Assessments

		<p>at least 90% from the previous review period for each item.</p> <p>A review of the records of 10 individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all 10 assessments included this information (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p> <p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 22% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="991 597 1890 675"> <tr> <td>9.</td> <td><i>Social factors</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for each item.</p> <p>A review of the records of 10 individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that all 10 assessments included this information (CCS, CH, DCL, EAH, EH, HAC, KA, LLU, MJC and RIT).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	9.	<i>Social factors</i>	100%	10.	<i>Educational status</i>	100%
9.	<i>Social factors</i>	100%						
10.	<i>Educational status</i>	100%						

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section D: Integrated Assessments

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

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has maintained substantial compliance with the requirements of this section since the last review period 2. PSH has conducted a wide range of activities, meetings, and development of resources and databases during this review period to track and monitor discharge processes and procedures.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Christopher Smart, LCSW, Section E Lead 2. Hope Marriott, LCSW, Assistant to the Clinical Administrator 3. Lisa Hilder, LCSW, Supervisor Social Worker 4. Rachel Strydom, LCSW, Supervising Social Worker 5. Samantha Lillo, LCSW, Family Services Clinic 6. Tiffany Rector, JD, LCSW (A), Supervising Social Worker and Section Leader 7. Veronica Kaufman, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 32 individuals: ABD, AE, CES, CJT, DCL, DDP, DLR, DWD, EEC, FD, HAC, HC, HCA, JS, JV, LET, MA, MLK, PLM, PLN, LET, LGA, LMA, RA, RB, RKR, RMM, SDW, SJP, TB, TG and WM 2. List of individuals referred for discharge but still hospitalized 3. Legal discussion meeting notes on discharge held between the PSH forensic doctors, public defenders, and district attorneys from Los Angeles and Riverside Counties and the judge 4. Discharge protocol 5. Tracking system for all discharges by penal code 6. ICF DMH Patient Discharge Checklist

Section E: Discharge Planning and Community Integration

		<p>7. PSH Discharge Protocol: A Best Practice Approach</p> <p>8. Skills and supports documentation for individuals at discharge status</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program 1, unit E11) for monthly review of LGM 2. WRPC (Program 6, unit 75) for quarterly review for RMM 3. WRPC (Program 6, unit EBO9) for 14-day review for LMA 4. Operation of a Master Discharge Planning database of resources by each County
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings:
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals found that 13 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 (ABD, AE, CES, CJT, DDP, HCA, LET, PLM, RA, RB, RKR, SDW and</p>

Section E: Discharge Planning and Community Integration

		<p>TG). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining two WRPs (EEC and FD).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals found that all 14 WRPs included the individual's psychosocial functioning in the Present Status section (ABD, AE, CES, CJT, DDP, EEC, FD, HCA, LET, RA, RB, RKR, SDW and TG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>

Section E: Discharge Planning and Community Integration

E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 95%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals found that all 14 WRPs contained documentation that discharge barriers were discussed with the individual (ABD, AE, CES, CJT, DDP, EEC, FD, HCA, LET, RA, RB, RKR, SDW and TG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period</p>

Section E: Discharge Planning and Community Integration

		<p>(May-October 2010), and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals found that 14 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (ABD, AE, CES, CJT, DDP, EEC, FD, HCA, LET, RA, RB, RKR, SDW and TG). The remaining one WRP did not (PLM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 18% of the quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals found that 12 WRPs contained documentation indicating that the individual was an active participant in the discharge process (AE, CES, CJT, DDP, EEC, FD, LET, RA, RB, RKR, SDW and TG). The remaining two WRPs contained no documentation that</p>

Section E: Discharge Planning and Community Integration

		<p>the individual participated in the discussion (ABD and HAC).</p> <p>This monitor observed three WRPCs (LGM, LMA and RMM). All three WRPTs reviewed with the individual the discharge criteria, progress made towards the discharge criteria, and what the individual needs to do to meet the discharge criteria.</p> <p>A review of the records of 11 individuals found that 10 WRPs contained measurable objectives and interventions to address the individual's discharge criteria (ABD, AE, DDP, EEC, FD, HCA, LET, PLM, RB and TG) and one did not (CES).</p> <p>A review of the records of 10 individuals found that nine WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (AE, DDP, EEC, LET, RA, RB, RKR, SDW and TG) and one did not (CJT).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations;	Current findings on previous recommendation:

Section E: Discharge Planning and Community Integration

		<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 96%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of 15 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in 13 WRPs (ABD, AE, CJT, DDP, EEC, FD, HCA, LET, PLM, RA, RB, RKR and TG). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining two WRPs (CES and SDW).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period</p>

Section E: Discharge Planning and Community Integration

		<p>(May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals found that all 15 WRPs identified the staff member responsible for the interventions (ABD, AE, CES, CJT, DDP, EEC, FD, HCA, LET, PLM, RA, RB, RKR, SDW and TG).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (May-October 2010), and reported a mean compliance rate of 97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals found that all 10 WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AE, CES, CJT, DDP, LET, RA, RB, RKR, SDW and TG).</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p>Compliance: Substantial.</p>
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: According to facility report, 324 individuals hospitalized under PC 1370 met discharge criteria during the previous six months, and 25 remain hospitalized. Thirty individuals hospitalized under other legal commitments (PC 1026, PC 2962, PC 2972, and LPS) met discharge criteria; 26 remain hospitalized due to external barriers (CONREP placement delays, court date delays, immigration barriers, court hearing date delays, and PC 290 placement barriers) and four remain hospitalized due to internal barriers (sending referral packets, completion of physical examinations).</p> <p>The table below shows the status of 1370 individuals who are still hospitalized and the facility's efforts to resolve the barriers to discharge:</p>

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Indiv- idual	Referral Date	Status	Efforts by PSH to solve issues as of 11/30/2010
MA	2/2/10	CONREP report dated 8/9/10 stated that MA is not ready for less restrictive facility.	San Diego CONREP requested WRPT to rescind referral. WRPT in process of reviewing MA's progress to respond to the court and the CONREP.
JG	3/2/10	COT recommended with Orange County CONREP. CONREP's formal evaluation is pending.	WRPT is currently waiting for the court's decision on subsequent discharge date
SP	4/2/10	CONREP has agreed to accept SP to Golden Gate. Waiting for court ordered release.	SW staff providing clothing and SSI application.
RF	5/7/10	Cleared for COT on 9/15/10. Waiting for an open bed.	SW is in contact with San Bernardino County CONREP.
VR	5/20/10	Accepted to San Bernardino County CONREP. Awaiting placement in Southpoint.	SB CONREP informed SW staff that VR's transfer will be in December 2010.
FD	6/3/10	Recommended for COT under LA CONREP.	SW staff working to provide transitional needs.
MC	6/15/10	Accepted to San Bernardino County	SB CONREP informed SW staff that MC's

Section E: Discharge Planning and Community Integration

			CONREP. Awaiting placement in Southpoint.	transfer will be in December 2010.	
		ER	6/15/10	Approved for COT. Waiting for an opening for SB County CONREP.	Unit SW and WRPT in contact with CONREP to coordinate placement and services upon release from hospital.
		KR	6/16/10	Denied to La Casa/IMD in October 2010. Coast Care staff found KR not appropriate for their services.	SW staff collaborating with relevant departments at PSH. SSI packet sent in 11/2010 to the Trust office.
		AC	6/17/10	CONREP referred to Sylmar. Sylmar determined he was not appropriate for their facility.	WRPT believes he is appropriate for locked community and continues recommendation.
		RH	7/2/10	COT packet sent to Golden Gate CONREP. Follow-up phone call made to CONREP. Awaiting evaluation.	Evaluation to be scheduled when date is fixed.
		DD	7/4/10	Recommended to San Bernardino CONREP, to be placed in a SNF. Difficulty finding placement.	SW staff is in contact with DD's attorney and mother regarding discharge status.
		PC	7/8/10	Recommended for community facility. PC wants to live with his family.	SW staff continues to work with PC's sister. Sister is yet respond.

Section E: Discharge Planning and Community Integration

		JM	7/14/10	Report from CONREP COT evaluation on 11/02/10 not received.	SW staff working with PSH Trust Office to initiate transitional needs.
		JS	7/21/10	Earned a COT. CONREP on 09/30 did not agree, stating he is not ready.	WRPT will not rescind the COT, and is working with JS on meeting CONREP's criteria.
		MD	7/29/10	Accepted by San Bernardino CONREP. Awaiting interview by Southpoint.	SW staff in contact with Public Defender to expedite the process with CONREP.
		JM	8/10/10	Is awaiting CONREP interview for COT recommendation.	PSH contacted CONREP to verify that COT packet was received.
		MS	COT letter done on 9/9/09.	GATEWAYS CONREP in process of contracting facilities for court ordered placement.	SW staff is in communication with GATEWAYS regarding MS's placement progress.
		BM	9/28/10	CONREP is unwilling to accept him at this time. WRPT will pursue conservatorship due to disability	SW is in contact with BM's sister. COT recommendation resources to be addressed.
		MW	10/14/10	CONREP has not approved WRPT recommendation. WRPT will re-refer depending on court outcomes.	SW has begun process for discharge planning, contingent on CONREP acceptance.
The Social Work department at PSH has taken numerous steps to					

Section E: Discharge Planning and Community Integration

		<p>expedite discharge of individuals referred for discharge. Interview and documentation review found that the Social Work Department had conducted the following activities pertaining to discharge matters during this review period:</p> <ul style="list-style-type: none"> • Researched and reviewed the best practice approaches to discharging individuals into the community; • Developed and implemented a Discharge Protocol, and conducted training of staff on the protocol; • Developed a Discharge Planning Database to track and monitor individuals' risk factors and community resources; • Placed discharge documents on the hospital shared drive for availability to all staff involved in discharge planning; • Conducted a legal discussion between PSH forensic doctors, the public defenders and district attorneys from Los Angeles and Riverside Counties, Katrina West (judge), and San Bernardino CONREP to discuss the MDO law and its implications on discharges and CONREP; • Conducted a meeting between the Immigration and Customs Enforcement (ICE) and PSH staff to discuss the laws, ethics, and legal mandates regarding undocumented individuals who are approaching discharge; • Attended the tri-annual meeting with the Southern California CONREP to discuss discharge issues; • Developed and implemented a tracking system for all discharges by Penal Code; • Developed a master database of resources by county. The database currently has over 2000 resources, and the staff continue to update the database; and • Developed and distributed the CONREP lesson plans and DVDs on CONREP discharge issues to all state hospitals in California. <p>The Social Work Department has analyzed the internal and external</p>
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Section E: Discharge Planning and Community Integration

		<p>system factors that are barriers to timely discharge once an individual had been referred for discharge. The following were identified as some of the barriers:</p> <ul style="list-style-type: none"> • Internal: delay in preparing face sheet, copy materials, and sending referral packets; completing physical assessments/examination; delay in risk assessments. • External: sex offenders (290) placement, immigration, CONREP, and the courts. <p>The staff is working with the appropriate individuals and agencies to eliminate or reduce these barriers.</p> <p>Current recommendation: Continue current practice.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010) for individuals who have met their discharge criteria, and reported a mean compliance rate of 99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals found that all 10 WRPs contained documentation of the assistance needed by the individual in the new setting (DCL, DLR, DWD, JS, JV, MA, MLK, SJP, TB and WM). Types</p>

Section E: Discharge Planning and Community Integration

		<p>of assistance given to the individuals included: SSI applications, medication management and group therapies, and transportation.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to PSH as it does not serve children and adolescents.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services: PSH has maintained substantial compliance with all requirements of this section.</p> <p>Summary of Progress on Psychological Services:</p> <ol style="list-style-type: none">1. PSH has maintained substantial compliance with all but one of the requirements of this section.2. PSH has initiated a number of projects to address patient-to-patient and patient-to-staff violence. <p>Summary of Progress on Nursing Services:</p> <ol style="list-style-type: none">1. PSH has invested significant efforts in the area of documentation of PRN and Stat medications, which has proven effective in the facility maintaining substantial compliance with this requirement.2. PSH needs to implement additional strategies addressing problematic issues regarding changes in status to ensure that the nursing assessments and documentation are clinically adequate and appropriate. This critical area continues to show no progress and warrants intense and immediate focus. In addition, the quality of the information provided during shift change has decreased. The facility needs to continue to provide mentoring to unit staff so that clinically relevant information is provided in alignment with the reasons the individuals are at PSH--their Axis diagnoses. <p>Summary of Progress on Rehabilitation Therapy Services: PSH has maintained substantial compliance with all of the requirements of Section F.4 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: PSH has attained substantial compliance with all of the requirements of</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Section F.5, and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Pharmacy Services: PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p>Summary of Progress on General Medical Services: PSH has maintained substantial compliance with all requirement of this section.</p> <p>Summary of Progress on Infection Control: PSH's Infection Control Department continues to critically analyze and update its practices in alignment with the standards of practice in this specialty area. To achieve compliance with the requirements of Section F.8 of the EP, the facility needs to ensure that WRPs are individual-specific regarding infection control issues and that the reasons for refusals are included in the WRPs and addressed in the objectives and interventions. In addition, the facility needs to ensure that its data regarding individuals who have Hepatitis C is accurate.</p> <p>Summary of Progress on Dental Services PSH's Dental Department has maintained substantial compliance with all requirements except those related to refusals. The facility needs to continue to implement the policy/guidelines addressing dental refusals and develop and implement a system for the Dental Department to track the refusal risk levels of individuals. In addition, efforts need to be continued to ensure that WRPs are individualized and include the individuals' reasons for the dental refusals and contain interventions addressing these reasons to achieve compliance in this area.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Crystal Borck, RN, Standard Compliance Department 2. George Proctor, MD, Acting Psychopharmacology Consultant 3. Michael Cummings, MD, Psychopharmacology Advisory Committee Chair 4. Nitin Kulkarni, MD, Assistant Medical Director 5. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 39 individuals: AH, ASDG, BDH, BR, CAM, CDA, CDF, CR, DMJ, DML, DRD, DT, EG, EK, FMD, GA, GJD, GL, HEH, JG, JM, JRM, KED, LEM, MB, MDL, MLB, MRR, PC, PSP, RAE, RDK, SBM, SRB, SRF, TS, VEB, VGC, and WM 2. DMH Psychotropic Medication Policies: <ul style="list-style-type: none"> ➤ Dose Maximum Tables ➤ Olanzapine Protocol ➤ SSRI Antidepressant Protocol ➤ Memorandum from Michael Cummings, MD, Chair, Psychopharmacology Advisory Committee regarding Psychotropic Medication Policy Changes, May 20, 2010 ➤ Memorandum from Michael Cummings, MD, Chair, Psychopharmacology Advisory Committee regarding Psychotropic Medication Policy Changes, October 1, 2010 3. PSH Admission Psychiatric Assessment Auditing summary data (May to October 2010) 4. PSH Integrated Assessment: Psychiatry Section Auditing summary data (May to October 2010) 5. PSH Monthly PPN Audit summary data (May to October 2010) 6. PSH PRN and Stat monitoring summary data (May to October 2010) 7. PSH Tardive Dyskinesia database

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> 8. PSH Polypharmacy database 9. PSH Movement Disorder Monitoring summary data (May to October 2010) 10. PSH aggregated data regarding Adverse Drug Reactions (May to October 2010) 11. Last ten Adverse Drug Reactions (ADRs) for this review period 12. ADR tracking sheet for the review period 13. Intensive Case Analyses (ICAs) for ADRs completed during this review period 14. Department of Medicine/Psychiatry meeting minutes (page 2 only) 10/27/10, sign-in attendance sheets, Pharmacy and Therapeutic Topiramate Protocol #2.08 and Topiramate Policy Review by Dr Michael Cummings 15. Drug Utilization Evaluations (DUEs) completed by PSH during this review period 16. PSH aggregated data regarding medication variances (May to October 2010) 17. Last ten MVRs for this review period 18. MVR tracking sheet for the review period 19. Intensive Case Analyses (ICAs) for MVRs completed during this review period 20. Pharmacy and Therapeutics Committee Minutes (May 2010 to October 2010) 21. Psychiatric outcome data for the previous and current review period on the following: Aggression, Abuse/Neglect/Exploitation, Polypharmacy, Serious Medication Variances, Restraint and Seclusion, Prescribed Medications to High Risk populations, Severe Adverse Drug Reactions, and Substance Abuse Services. 22. Assault Reduction Taskforce (ART) procedure for administrative response to severe assaults. 23. Selected Treatment of Psychomotor Agitation (STOP-A) admission unit psychopharmacology algorithm. 24. Summary of Assault Reduction Task Force activities since last review
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Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.a</p>	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that the individualized medication guidelines are continually updated, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the updates during the review period.</p> <p>Findings: During this review period, several updates were made to the DMH medication guidelines in the following areas:</p> <ol style="list-style-type: none"> 1. Loading dose strategies for haloperidol decanoate; 2. Maximum daily dose of lithium, duloxetine and desvenlafaxine; and 3. Risks of olanzapine and SSRIs during pregnancy. <p>In addition, the facility updated its Pharmacy and Therapeutics Manual as follows:</p> <ol style="list-style-type: none"> 1. The definition of a complete order was modified by adding the requirement that "a titration order must include the date and time of initiation." 2. The method for counting ADRs for the same reaction, same severity, and same medication was modified (to be counted a maximum of once within 90 days). 3. The requirements for monitoring individuals receiving topiramate were modified by adding metabolic profile to baseline labs and quarterly monitoring and increasing monitoring in frequency from quarterly to monthly if certain risk factors are identified (e.g. oliguria and renal function decline to insufficiency/failure). <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>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 25%, 28% and 20%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and provide specific summary outline of these updates. 2. Continue to monitor this requirement. 																					
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 857 1887 935"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td><i>Plan of care</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 1084 1887 1200"> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <table border="1" data-bbox="991 1349 1887 1424"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.b</td> <td><i>Subjective complaints and symptoms are documented</i></td> <td>100%</td> </tr> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care</i>	100%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation</i>	100%	10.	<i>Psychopharmacology treatment plan</i>	99%	Monthly PPN			2.b	<i>Subjective complaints and symptoms are documented</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i></td> <td></td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>		<i>or there is documentation substantiating the reason that subjective complaints/concerns are not available.</i>		3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	97%			
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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>5.b</td> <td><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i>	99%			
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F.1.a.iii	tailored to each individual's symptoms;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>5.b</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.b	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</i>	99%			
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F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.									
F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose</i></td> <td>96%</td> </tr> </table>	Monthly PPN			2.g	<i>Current AIMS</i>	99%	5.d	<i>Justify/explain the use of medications that pose</i>	96%
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		<p><i>elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></p>										
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F.1.a.vi	modified based on clinical rationales;	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>96%</td> </tr> </tbody> </table>		Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	99%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	96%
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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	<table border="1"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose 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</i></td> <td>96%</td> </tr> </tbody> </table>		Monthly PPN			5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and</i>	96%			
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		<table border="1"> <tr> <td></td> <td><i>atypical antipsychotics and other psychiatric medications.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>		<i>atypical antipsychotics and other psychiatric medications.</i>							
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F.1.a.viii	Properly documented.	<table border="1"> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>99%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>100%</td> </tr> <tr> <td>Monthly PPN</td> <td>2.b, 3 and 5.a-5.d</td> <td>99%</td> </tr> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	99%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2.b, 3 and 5.a-5.d	99%
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Monthly PPN	2.b, 3 and 5.a-5.d	99%									
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 20% of individuals who have been hospitalized for 90 or more days during the review period (May-October 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 23% and 27% of PRN and Stat medications given per month, respectively. The following tables summarize the data:</p> <table border="1"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td>6.</td> <td><i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	Monthly PPN			6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	99%			
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		<p>at least 90% from the previous review period.</p> <table border="1" data-bbox="993 264 1887 493"> <thead> <tr> <th colspan="3">Nursing Services PRN</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of PRN medication.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring PRN medication.</i></td> <td>96%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to PRN medication.</i></td> <td>95%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="993 643 1887 872"> <thead> <tr> <th colspan="3">Nursing Services Stat</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Safe administration of Stat medication.</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>Documentation of the circumstances requiring Stat medication.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>Documentation of the individual's response to Stat medication.</i></td> <td>93%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: Same as in D.1.f.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Nursing Services PRN			1.	<i>Safe administration of PRN medication.</i>	93%	2.	<i>Documentation of the circumstances requiring PRN medication.</i>	96%	3.	<i>Documentation of the individual's response to PRN medication.</i>	95%	Nursing Services Stat			1.	<i>Safe administration of Stat medication.</i>	95%	2.	<i>Documentation of the circumstances requiring Stat medication.</i>	98%	3.	<i>Documentation of the individual's response to Stat medication.</i>	93%
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F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and	Current findings on previous recommendations:																								

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	<p>polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH used the standardized DMH Monthly PPN Audit Form to assess compliance (May-October 2010). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 565 1885 863"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines. (%S = 15%)</i></td> <td>95%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 8%)</i></td> <td>92%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 15%)</i></td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Recommendation 2, June 2010: Continue to provide comparative data regarding the following:</p> <ol style="list-style-type: none"> Total number of individuals receiving benzodiazepines for 60 days or more; Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more; Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more; Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning); 	PPN - Revised			5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>		5.d.i.	<i>Benzodiazepines. (%S = 15%)</i>	95%	5.d.ii.	<i>Anticholinergics. (%S = 8%)</i>	92%	5.d.iii.	<i>Polypharmacy. (%S = 15%)</i>	97%
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5.d.iii.	<i>Polypharmacy. (%S = 15%)</i>	97%															

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		<p>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 h) Total number receiving inter-class polypharmacy.</p> <p>Findings: PSH reported the following comparative data:</p> <table border="1" data-bbox="989 560 1896 1421"> <thead> <tr> <th data-bbox="989 560 1045 638"></th> <th data-bbox="1045 560 1610 638">Indicators</th> <th data-bbox="1610 560 1753 638">Previous period</th> <th data-bbox="1753 560 1896 638">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 638 1045 711">1.</td> <td data-bbox="1045 638 1610 711"><i>Total number of individuals receiving benzodiazepines for 60 days or more</i></td> <td data-bbox="1610 638 1753 711">98</td> <td data-bbox="1753 638 1896 711">109</td> </tr> <tr> <td data-bbox="989 711 1045 862">2.</td> <td data-bbox="1045 711 1610 862"><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i></td> <td data-bbox="1610 711 1753 862">70</td> <td data-bbox="1753 711 1896 862">81</td> </tr> <tr> <td data-bbox="989 862 1045 1013">3.</td> <td data-bbox="1045 862 1610 1013"><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more</i></td> <td data-bbox="1610 862 1753 1013">59</td> <td data-bbox="1753 862 1896 1013">68</td> </tr> <tr> <td data-bbox="989 1013 1045 1198">4.</td> <td data-bbox="1045 1013 1610 1198"><i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td data-bbox="1610 1013 1753 1198">12</td> <td data-bbox="1753 1013 1896 1198">18</td> </tr> <tr> <td data-bbox="989 1198 1045 1271">5.</td> <td data-bbox="1045 1198 1610 1271"><i>Total number receiving anticholinergics for 60 days or more</i></td> <td data-bbox="1610 1198 1753 1271">147</td> <td data-bbox="1753 1198 1896 1271">172</td> </tr> <tr> <td data-bbox="989 1271 1045 1421">6.</td> <td data-bbox="1045 1271 1610 1421"><i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td data-bbox="1610 1271 1753 1421">32</td> <td data-bbox="1753 1271 1896 1421">34</td> </tr> </tbody> </table>		Indicators	Previous period	Current period	1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	98	109	2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i>	70	81	3.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more</i>	59	68	4.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	12	18	5.	<i>Total number receiving anticholinergics for 60 days or more</i>	147	172	6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	32	34
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		<p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>This monitor reviewed the charts of 26 individuals receiving the above types of medication regimens. The reviews are outlined as follows (diagnoses are listed if they signify risk for treatment):</p>																										
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		<table border="1"> <thead> <tr> <th data-bbox="989 1011 1142 1049">Individual</th> <th data-bbox="1142 1011 1493 1049">Medication(s)</th> <th data-bbox="1493 1011 1892 1049">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1049 1142 1125">CDF</td> <td data-bbox="1142 1049 1493 1125">Lorazepam</td> <td data-bbox="1493 1049 1892 1125">Borderline Intellectual Functioning</td> </tr> <tr> <td data-bbox="989 1125 1142 1162">GA</td> <td data-bbox="1142 1125 1493 1162">Lorazepam</td> <td data-bbox="1493 1125 1892 1162">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="989 1162 1142 1239">GL</td> <td data-bbox="1142 1162 1493 1239">Clonazepam</td> <td data-bbox="1493 1162 1892 1239">Alcohol Dependence and Cannabis Dependence</td> </tr> <tr> <td data-bbox="989 1239 1142 1276">JG</td> <td data-bbox="1142 1239 1493 1276">Clonazepam</td> <td data-bbox="1493 1239 1892 1276">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="989 1276 1142 1313">JRM</td> <td data-bbox="1142 1276 1493 1313">Lorazepam</td> <td data-bbox="1493 1276 1892 1313">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="989 1313 1142 1390">PC</td> <td data-bbox="1142 1313 1493 1390">Clonazepam and zolpidem (with plan to taper)</td> <td data-bbox="1493 1313 1892 1390">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="989 1390 1142 1424">PSP</td> <td data-bbox="1142 1390 1493 1424">Lorazepam</td> <td data-bbox="1493 1390 1892 1424">Cannabis Dependence</td> </tr> </tbody> </table>			Individual	Medication(s)	Diagnosis	CDF	Lorazepam	Borderline Intellectual Functioning	GA	Lorazepam	Polysubstance Dependence	GL	Clonazepam	Alcohol Dependence and Cannabis Dependence	JG	Clonazepam	Polysubstance Dependence	JRM	Lorazepam	Polysubstance Dependence	PC	Clonazepam and zolpidem (with plan to taper)	Polysubstance Dependence	PSP	Lorazepam	Cannabis Dependence
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		<table border="1"> <tr> <td>SRB</td> <td>Lorazepam</td> <td>Alcohol Dependence</td> </tr> </table> <p>This review found substantial compliance in five charts (CDF, JG, JRM, PC and PSP) and partial compliance in three (GA, GL and SRB).</p> <p><u>Anticholinergic use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BDH</td> <td>Trihexyphenidyl</td> <td></td> </tr> <tr> <td>BR</td> <td>Benztropine</td> <td></td> </tr> <tr> <td>CDA</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>DRD</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>KED</td> <td>Benztropine</td> <td></td> </tr> <tr> <td>PC</td> <td>Benztropine</td> <td></td> </tr> </tbody> </table> <p>This review found substantial compliance in four charts (BDH, BR, CDA, KED and PC) and partial compliance in one (DRD).</p> <p><u>Anticholinergic use for elderly individuals</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>CAM</td> <td>Hydroxyzine</td> <td></td> </tr> <tr> <td>EG</td> <td>Benztropine</td> <td>Rabbit Syndrome and Drug-induced Parkinsonism</td> </tr> <tr> <td>HEH</td> <td>Diphenhydramine</td> <td></td> </tr> <tr> <td>RAE</td> <td>Hydroxyzine</td> <td>Alcohol-induced Dementia</td> </tr> </tbody> </table> <p>This review found substantial compliance in all cases.</p>	SRB	Lorazepam	Alcohol Dependence	Individual	Medication(s)	Diagnosis	BDH	Trihexyphenidyl		BR	Benztropine		CDA	Benztropine	Borderline Intellectual Functioning	DRD	Benztropine	Borderline Intellectual Functioning	KED	Benztropine		PC	Benztropine		Individual	Medication(s)	Diagnosis	CAM	Hydroxyzine		EG	Benztropine	Rabbit Syndrome and Drug-induced Parkinsonism	HEH	Diphenhydramine		RAE	Hydroxyzine	Alcohol-induced Dementia
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		<p><u>Polypharmacy use</u></p> <table border="1"> <thead> <tr> <th data-bbox="991 302 1142 337">Individual</th> <th data-bbox="1142 302 1644 337">Medication(s)</th> <th data-bbox="1644 302 1871 337">Diagnosis</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 337 1142 415">AH</td> <td data-bbox="1142 337 1644 415">Clonazepam, lamotrigine, risperidone and ziprasidone</td> <td data-bbox="1644 337 1871 415"></td> </tr> <tr> <td data-bbox="991 415 1142 493">CR</td> <td data-bbox="1142 415 1644 493">Clozapine, olanzapine, fluoxetine and lamotrigine</td> <td data-bbox="1644 415 1871 493"></td> </tr> <tr> <td data-bbox="991 493 1142 571">EK</td> <td data-bbox="1142 493 1644 571">Aripiprazole, buspirone, trazodone and ziprasidone</td> <td data-bbox="1644 493 1871 571"></td> </tr> <tr> <td data-bbox="991 571 1142 649">GJD</td> <td data-bbox="1142 571 1644 649">Divalproex, haloperidol, quetiapine and benztropine</td> <td data-bbox="1644 571 1871 649"></td> </tr> <tr> <td data-bbox="991 649 1142 727">RDK</td> <td data-bbox="1142 649 1644 727">Aripiprazole, risperidone, buspirone, topiramate and diphenhydramine</td> <td data-bbox="1644 649 1871 727"></td> </tr> <tr> <td data-bbox="991 727 1142 805">SRF</td> <td data-bbox="1142 727 1644 805">Aripiprazole, lithium, quetiapine and sertraline</td> <td data-bbox="1644 727 1871 805"></td> </tr> <tr> <td data-bbox="991 805 1142 883">TS</td> <td data-bbox="1142 805 1644 883">Clozapine, escitalopram, lamotrigine, clonazepam</td> <td data-bbox="1644 805 1871 883">Polysubstance Dependence</td> </tr> <tr> <td data-bbox="991 883 1142 945">VEB</td> <td data-bbox="1142 883 1644 945">Olanzapine, sertraline, divalproex, hydroxyzine and clonazepam</td> <td data-bbox="1644 883 1871 945">Polysubstance Dependence</td> </tr> </tbody> </table> <p data-bbox="991 987 1843 1091">This review found substantial compliance in all cases in terms of justification for treatment. However, the specific potential risks of drug-drug interactions were not addressed in most cases.</p> <p data-bbox="991 1136 1142 1198">Compliance: Substantial.</p> <p data-bbox="991 1247 1327 1273">Current recommendations:</p> <ol data-bbox="991 1286 1827 1390" style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Improve documentation of specific potential risks of drug-drug interactions for individuals receiving polypharmacy. 	Individual	Medication(s)	Diagnosis	AH	Clonazepam, lamotrigine, risperidone and ziprasidone		CR	Clozapine, olanzapine, fluoxetine and lamotrigine		EK	Aripiprazole, buspirone, trazodone and ziprasidone		GJD	Divalproex, haloperidol, quetiapine and benztropine		RDK	Aripiprazole, risperidone, buspirone, topiramate and diphenhydramine		SRF	Aripiprazole, lithium, quetiapine and sertraline		TS	Clozapine, escitalopram, lamotrigine, clonazepam	Polysubstance Dependence	VEB	Olanzapine, sertraline, divalproex, hydroxyzine and clonazepam	Polysubstance Dependence
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F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Monthly PPN Auditing Form, PSH assessed its compliance based on an average sample of 20% of individuals hospitalized for 90 days or more during the review period (May-October 2010):</p> <table border="1" data-bbox="991 561 1906 824"> <tr> <td></td> <td><i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i></td> <td></td> </tr> <tr> <td>5.d.v.i</td> <td><i>Dyslipidemia</i></td> <td>99%</td> </tr> <tr> <td>5.d.v.ii</td> <td><i>Diabetes Mellitus</i></td> <td>99%</td> </tr> <tr> <td>5.d.v.iii</td> <td><i>Obesity</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed the charts of eight individuals who were receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 1195 1871 1385"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>ASDG</td> <td>Risperidone</td> <td>Diabetes Mellitus, Hyperlipidemia and Obesity</td> </tr> <tr> <td>DT</td> <td>Olanzapine</td> <td>Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension</td> </tr> </tbody> </table>		<i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i>		5.d.v.i	<i>Dyslipidemia</i>	99%	5.d.v.ii	<i>Diabetes Mellitus</i>	99%	5.d.v.iii	<i>Obesity</i>	100%	Individual	Medication(s)	Diagnosis	ASDG	Risperidone	Diabetes Mellitus, Hyperlipidemia and Obesity	DT	Olanzapine	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension
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		JM	Olanzapine	Diabetes Mellitus, Hyperlipidemia and Obesity
		LEM	Clozapine	Diabetes Mellitus, Hyperlipidemia, Metabolic Syndrome and Hypertension
		MB	Clozapine	Diabetes Mellitus, Hyperlipidemia and Hypertension
		MDL	Olanzapine and risperidone	Diabetes Mellitus, Dyslipidemia and Obesity
		MLB	Risperidone	Diabetes Mellitus, Metabolic Syndrome and Obesity
		SBM	Quetiapine	Diabetes Mellitus and Hyperlipidemia
		<p>This review found substantial compliance in seven charts and partial compliance in one (DT). In the chart of DT, there was evidence of adequate laboratory monitoring for the metabolic and endocrine risks but the psychiatric reassessments did not adequately document trends in the side effects of treatment</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Ensure consistent documentation of trends (improvement or worsening) in the side effects of treatment. 		
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p>		

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	<p>he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Findings: Using the DMH Movement Disorders Auditing Form, PSH assessed its compliance based on average samples ranging from 11% to 25% of individuals relevant to each indicator during the review period (May-October 2010):</p> <table border="1" data-bbox="991 414 1890 1128"> <tr> <td data-bbox="991 414 1087 490">1.</td> <td data-bbox="1087 414 1795 490"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1795 414 1890 490">99%</td> </tr> <tr> <td data-bbox="991 490 1087 600">2.</td> <td data-bbox="1087 490 1795 600"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1795 490 1890 600">99%</td> </tr> <tr> <td data-bbox="991 600 1087 711">3.</td> <td data-bbox="1087 600 1795 711"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1795 600 1890 711">99%</td> </tr> <tr> <td data-bbox="991 711 1087 787">4.</td> <td data-bbox="1087 711 1795 787"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1795 711 1890 787">100%</td> </tr> <tr> <td data-bbox="991 787 1087 898">5.</td> <td data-bbox="1087 787 1795 898"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1795 787 1890 898">100%</td> </tr> <tr> <td data-bbox="991 898 1087 974">6.</td> <td data-bbox="1087 898 1795 974"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1795 898 1890 974">98%</td> </tr> <tr> <td data-bbox="991 974 1087 1050">7.</td> <td data-bbox="1087 974 1795 1050"><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td data-bbox="1795 974 1890 1050">100%</td> </tr> <tr> <td data-bbox="991 1050 1087 1128">8.</td> <td data-bbox="1087 1050 1795 1128"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1795 1050 1890 1128">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed the charts of six individuals who were currently diagnosed with tardive dyskinesia per the facility's database (DMJ, DML, FMD, MRR, VGC and WM). The database identified 80 individuals as</p>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	99%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	99%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	99%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	100%	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	98%	7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	100%	8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	100%
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		<p>currently having this diagnosis. This review found that PSH has maintained progress in this area as follows:</p> <ol style="list-style-type: none"> 1. Admission AIMS tests were completed on all individuals who were admitted during the past year. 2. Quarterly AIMS monitoring was completed in all charts reviewed. 3. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in all charts reviewed. 4. The psychiatric progress notes provided adequate tracking of the status of TD in all charts reviewed. 5. The objectives related to TD utilized appropriate learning outcomes for all individuals reviewed. 6. Some charts documented attempts to use (or consideration of) safer treatment alternatives for the individuals (DML, FMD and MRR). The chart of FMD included evidence of good outcome as a result of this practice. 7. None of the individuals diagnosed with TD received unnecessary long-term treatment with anticholinergic agents during this review period. <p>In one individual (MRR), the psychiatric progress notes did not address an upward trend in AIMS score over the past year.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Increase reporting of ADRs. • Continue review and analysis of ADRs and present summary of

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		<p>aggregated data to address the following:</p> <ul style="list-style-type: none"> ○ The number of ADRs reported each month during the review period compared with number reported during the previous period; ○ Classification of probability and severity of ADRs; ○ Any negative outcomes for individuals who were involved in serious reactions; ○ Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and ○ Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 820 1887 1279"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>156</td> <td>144</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>34</td> <td>3</td> </tr> <tr> <td>Possible</td> <td>54</td> <td>97</td> </tr> <tr> <td>Probable</td> <td>51</td> <td>42</td> </tr> <tr> <td>Definite</td> <td>17</td> <td>2</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>91</td> <td>77</td> </tr> <tr> <td>Moderate</td> <td>59</td> <td>61</td> </tr> <tr> <td>Severe</td> <td>6</td> <td>6</td> </tr> </tbody> </table> <p>The facility amended the ADR data that were reported in the previous report (added one new ADR that was classified as possible and severe). The decrease in the number of ADRs during this review period reflected</p>		Previous period	Current period	Total ADRs	156	144	Classification of Probability of ADRs			Doubtful	34	3	Possible	54	97	Probable	51	42	Definite	17	2	Classification of Severity of ADRS			Mild	91	77	Moderate	59	61	Severe	6	6
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		<p>the facility's revised method of counting only one ADR per 90-day period for the same drug and same severity.</p> <p>PSH conducted nine intensive case analyses (ICAs), including but not limited to all severe reactions reported during this review period and the ADR that was added to the data of the previous period. The following is an outline of the reactions and the suspected medications:</p> <ol style="list-style-type: none">1. Excessive sedation (chloral hydrate);2. Unresponsiveness (haloperidol and memantine);3. Orthostatic hypotension (amlodipine);4. Delirium (donepezil and olanzapine);5. Movement disorder (tiagabine and gabapentin);6. Hypotension and altered level of consciousness (spironolactone and aspirin/dipyridamole);7. Metabolic acidosis (topiramate);8. Epistaxis (aspirin);9. Hypotension (risperidone, doxazosin and donepezil); and10. Hypoglycemia (insulin). <p>Other findings:</p> <p>The ICAs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. In addition, the facility conducted adequate analysis of patterns and trends of ADRs during this review period. The analysis indicated that the most common ADR type involved extrapyramidal side effects to antipsychotic treatment, as in the previous review period. The second most common ADR involved constipation, usually related to antipsychotic treatment. In response to this analysis, the Department of Medicine and P&T completed clozapine constipation prevention/management guidelines in June/July 2010 to address this issue.</p>
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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase reporting of ADRs. 2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious 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).
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: During this review period PSH conducted the following DUEs:</p> <ol style="list-style-type: none"> 1. Phenytoin levels per facility guidelines; 2. Lithium level, follow-up (limited sample); 3. Rate of metabolic acidosis in individuals receiving topiramate compared to rates in literature; and

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		<p>4. Quetiapine initiation and titration per facility guideline.</p> <p>The DUEs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>
F.1.h	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Continue to present data to address the following:</p> <ul style="list-style-type: none"> • Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; • Total number of actual and potential variances during the review period compared with numbers reported during the previous period; • Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); • Number of critical breakdown points by outcome; • Clinical information regarding each variance (category E or above) and the outcome to the individual involved; • Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and • Outline of ICAs, including description of variance, recommendations and actions taken. <p>Findings: The following summarizes the facility's data for this review period:</p>

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		Number of Medication Variances	Previous Period	Current Period
		Prescribing	29	45
		Transcribing	146	152
		Ordering/Procurement	42	33
		Dispensing	176	257
		Administration	212	342
		Drug Security	2	6
		Documentation	623	336
		Total variances	1230	1171

Total Critical Breakdown Points	Previous Period	Current Period
Total Critical Breakdown Points	1127	1026
Potential MVRs	902	662
Actual MVRs	225	364
# Prescribing	29	39
# Transcribing	133	127
# Order/Procure	41	25
# Dispensing	165	255
# Administration	139	243
# Drug Security	2	6
# Document	618	331
Outcome A	536	374
Outcome B	364	287
Outcome C	220	358
Outcome D	6	7
Outcome E	0	0
Outcome F	1	0

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		<table border="1" data-bbox="1003 190 1717 305"> <tr> <td>Outcome G</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table> <p data-bbox="989 350 1860 565">During this review period, none of the MVRs reached threshold for an ICA. However, the facility conducted one ICA to address breakdown points in the medication pass process in an ADR that involved the administration of an overdose of chloral hydrate. The ICA employed appropriate methodology and the recommendations for systemic corrective were generally adequate.</p> <p data-bbox="989 610 1843 711">Recommendation 2, June 2010: Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p data-bbox="989 756 1902 971">Findings: PSH conducted an adequate analysis of its medication variance data. The analysis included variety of corrective measures to address patterns/ trends of variances in the categories of administration, documentation, dispensing and transcription. In general, the corrective actions were appropriate.</p> <p data-bbox="989 1016 1140 1081">Compliance: Substantial.</p> <p data-bbox="989 1127 1902 1416">Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to present data to address the following: <ol style="list-style-type: none"> a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; 	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0
Outcome G	0	0									
Outcome H	0	0									
Outcome I	0	0									

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		<ul style="list-style-type: none"> c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d. Number of critical breakdown points by outcome; e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and g. Outline of ICAs, including description of variance, recommendations and actions taken. <p>2. Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h. In addition, the facility presented data regarding outcomes of its clinical services. The data addressed the rate per 1000 days of the following indicators:</p> <ul style="list-style-type: none"> 1. Any aggression to self resulting in major injury (increase); 2. Any peer-to-peer aggression resulting in major injury (some increase); 3. Any aggression to staff resulting in major injury (decrease); 4. Individuals having alleged abuse/neglect/exploitation (increase); 5. Individuals having confirmed abuse /neglect exploitation (decrease); 6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons (some increase); 7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons (some increase); 8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder (no change);

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		<p>9. Unique count of individuals in restraint (decrease); 10. Unique count of restraint events (decrease); 11. Unique count of individuals in seclusion (no change); 12. Unique count of seclusion events (decrease); 13. Individuals on benzodiazepines who are diagnosed with substance use (some increase); 14. Individuals on benzodiazepine diagnosed with cognitive disorder (increase); 15. Elderly on anticholinergic medications (age >65) (some increase); 16. Individuals diagnosed with cognitive disorder on anticholinergics (increase); 17. Individuals diagnosed with TD prescribed anticholinergics (increase); 18. Count of severe ADRs (no significant change); and 19. Count of severe medication variances (no change at zero).</p> <p>In addition (see C.2.o), the facility presented data regarding the following indicators:</p> <ol style="list-style-type: none"> 1. Percentage of individuals receiving substance abuse services who advanced at least one stage of change (Stages 1 to 4) (no data for previous period); and 2. Percentage of individuals receiving substance abuse services who maintained Stage 5 (no data for previous period). <p>These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see Section I.2).</p>
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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Continue to present data regarding outcomes of mental health services. 3. Utilize the outcome data regarding mental health care to inform the facility's performance improvement efforts and the oversight function of the facility's Quality Council, as indicated (same as in section I.2).
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in F.1.a through F.1.h.</p>
F.1.k	<p>Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p>

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

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

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

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		<p>Compliance: Substantial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
F.1.o	<p>Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.</p>	<p>This requirement applies exclusively to Metropolitan State Hospital.</p>

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2. Psychological Services		
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Allison Pate, PhD, Senior Supervising Psychologist 2. David Haimson, PhD, Chief of Psychology 3. Gari-Lyn Richardson, Director of Standards Compliance 4. Helga Thordarson, PhD, Senior Supervising Psychologist 5. Hope Marriott, LCSW, Assistant to Clinical Administrator 6. Joseph Melancharuvil, PhD, ABPP, Clinical Administrator 7. Mark Richards, PT, By Choice Assistant Coordinator 8. Mark Williams, PhD, PBS Team member 9. Melanie Byde, PhD, Mall Director 10. Steve Berman, PhD, By Choice Coordinator 11. Susan Velasquez, PhD, PSSC Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Records of the following 42 individuals: AA, AA-9, AER, AG, AR, AWB, BC, BM, CC, DB, DCF, DG, DJ, DLR, DP, GH, GJD, GL, HMN, HS, JA, JD, JG, JK, JL, JMB, JT, KAI, KMS, LAJ, LJ, MH, MK, NM, REH, RJ, RMP, RS, SA, SD, SH, and TY 2. Positive Behavior Support Plans developed and implemented in the last six months 3. Behavioral guidelines developed and implemented in the last six months 4. Structural and functional assessments completed in the last six months 5. List of staff trained to implement Positive Behavior Support Plans. 6. By Choice Training Documents 7. Guidelines for By Choice point ratings during Mall group participation. 8. Proposal to integrate By Choice program into weight management goals 9. Guidelines for Improving the Validity and Fidelity of By Choice

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		<ol style="list-style-type: none"> 10. ETRC/PSSC minutes 11. List of individuals reviewed by the Psychology Specialty Services Committee (PSSC) 12. PSSC database 13. PSSC reports 14. 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 15. List of individual with high psychology triggers 16. List of individuals receiving DCAT services 17. List of individuals identified as needing neuropsychological services 18. Neuropsychological assessments completed in the last six months <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit EB11) for monthly review of LGM 2. WRPC (Program VI, unit 75) for quarterly review of RMM 3. WRPC (Program VI, unit EBO9) for 14-day review of LMD 4. Mall Group: Substance Recovery (Stage of Change 1-3) 5. Mall Group: Cognitive Remediation 6. Mall Group: RISE, Cognitive Remediation 7. Mall Group: SAFE Program 8. Mall Group: Mindfulness Through Laughter 9. Mall Group: Stress Management 10. Mall Group: Karaoke, Spanish Group 11. PSSC Meeting
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that all PBS/DCAT positions are filled.</p> <p>Findings: PSH has the necessary number of PBS teams to meet the required ratio</p>

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	<p>competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>of 1 team per 300 individuals. The facility has five full teams. However, the teams do not have data analysts. Instead, the facility has the services of a student assistant to support the teams with regard to data analysis and related tasks.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																																																
F.2.a.i	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The table below showing the number of direct care staff eligible for training during the month (N), the number of direct care staff trained each month period (n), and the percent staff trained (%C) is a summary of the facility's data:</p> <table border="1" data-bbox="991 1003 1906 1237"> <thead> <tr> <th colspan="8">Staff Training</th> </tr> <tr> <th>2010</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>5</td> <td>6</td> <td>14</td> <td>18</td> <td>25</td> <td>13</td> <td>13.5</td> </tr> <tr> <td>N</td> <td>5</td> <td>6</td> <td>14</td> <td>18</td> <td>25</td> <td>13</td> <td>13.5</td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>	Staff Training								2010	May	Jun	Jul	Aug	Sep	Oct	Mean	N	5	6	14	18	25	13	13.5	N	5	6	14	18	25	13	13.5	%S	100	100	100	100	100	100		%C	100%	100%	100%	100%	100%	100%	100%
Staff Training																																																		
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%C	100%	100%	100%	100%	100%	100%	100%																																											

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
<p>F.2.a.ii</p>	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Monitoring-By Choice Form, PSH assessed its compliance based on an average sample of 11% of WRPs due each month of this review period (May-October 2010):</p> <table border="1" data-bbox="993 673 1887 748"> <tr> <td data-bbox="993 673 1087 748">2.</td> <td data-bbox="1087 673 1793 748"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 673 1887 748">94%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 11 individuals found that nine WRPs had appropriate documentation in the Present Status section of the individual's By Choice points and of the individual's opportunity to reallocate By Choice points (AA, AA-9, DCF, JG, JK, JMB, JT, REH and SH). The documentation was inadequate in the remaining two WRPs (AER and KAI).</p> <p>This monitor observed three WRPCs (LGA, LMM and RMM). All three WRPTs engaged the individuals in the By Choice point allocation process.</p> <p>The following table summarizes staff training on By Choice during the review period (May-October 2010):</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	94%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	94%			

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	Average number of trained staff	Percentage of eligible staff trained
General training	2040	94%
Clinical training	333	87%

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, PSH assessed its compliance based on a sample of 3% of the a.m. and p.m. Level I nursing staff:

1.	<i>Staff understands the goal of the By Choice system</i>	100%
2.	<i>Staff can state the current point cycle</i>	100%
3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	100%
4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%
5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	100%
6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	99%
7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	98%
8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	98%
9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	99%
10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	100%
11.	<i>Staff can correctly state what the By Choice levels</i>	100%

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		<p><i>indicate and how they can achieve higher levels.</i></p>																															
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>																															
		<p>Other findings: Using the Fidelity of Implementation by Individuals Form, PSH also assessed fidelity of By Choice implementation based on a 4% sample of individuals in the facility:</p>																															
		<table border="1"> <tr> <td data-bbox="989 566 1066 639">1.</td> <td data-bbox="1066 566 1776 639"><i>The individual understands the goal of the By Choice system.</i></td> <td data-bbox="1776 566 1871 639">72%</td> </tr> <tr> <td data-bbox="989 639 1066 712">2.</td> <td data-bbox="1066 639 1776 712"><i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i></td> <td data-bbox="1776 639 1871 712">94%</td> </tr> <tr> <td data-bbox="989 712 1066 786">3.</td> <td data-bbox="1066 712 1776 786"><i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i></td> <td data-bbox="1776 712 1871 786">95%</td> </tr> <tr> <td data-bbox="989 786 1066 902">4.</td> <td data-bbox="1066 786 1776 902"><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td data-bbox="1776 786 1871 902">95%</td> </tr> <tr> <td data-bbox="989 902 1066 976">5.</td> <td data-bbox="1066 902 1776 976"><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td data-bbox="1776 902 1871 976">71%</td> </tr> <tr> <td data-bbox="989 976 1066 1049">6.</td> <td data-bbox="1066 976 1776 1049"><i>Individual can indicate how many points he or she may earn each day.</i></td> <td data-bbox="1776 976 1871 1049">71%</td> </tr> <tr> <td data-bbox="989 1049 1066 1122">7.</td> <td data-bbox="1066 1049 1776 1122"><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td data-bbox="1776 1049 1871 1122">54%</td> </tr> <tr> <td data-bbox="989 1122 1066 1195">8.</td> <td data-bbox="1066 1122 1776 1195"><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td data-bbox="1776 1122 1871 1195">61%</td> </tr> <tr> <td data-bbox="989 1195 1066 1268">9.</td> <td data-bbox="1066 1195 1776 1268"><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td data-bbox="1776 1195 1871 1268">90%</td> </tr> <tr> <td data-bbox="989 1268 1066 1354">10.</td> <td data-bbox="1066 1268 1776 1354"><i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i></td> <td data-bbox="1776 1268 1871 1354">18%</td> </tr> </table>	1.	<i>The individual understands the goal of the By Choice system.</i>	72%	2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	94%	3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	95%	4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	95%	5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	71%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	71%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	54%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	61%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	90%	10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	18%	
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		<p>Item 10 pertains to the level system, which is not in place at this time.</p>																															

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		<p>The facility indicated that it will monitor this item once it is in place.</p> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 2-4 and 9, and mixed changes in compliance for the remaining items:</p> <table border="1" data-bbox="991 414 1890 1026"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>79%</td> <td>72%</td> </tr> <tr> <td>5.</td> <td>72%</td> <td>71%</td> </tr> <tr> <td>6.</td> <td>75%</td> <td>71%</td> </tr> <tr> <td>7.</td> <td>53%</td> <td>54%</td> </tr> <tr> <td>8.</td> <td>56%</td> <td>61%</td> </tr> <tr> <td>10.</td> <td>20%</td> <td>18%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>1.</td> <td>92%</td> <td>88%</td> </tr> <tr> <td>5.</td> <td>92%</td> <td>67%</td> </tr> <tr> <td>6.</td> <td>75%</td> <td>65%</td> </tr> <tr> <td>7.</td> <td>53%</td> <td>61%</td> </tr> <tr> <td>8.</td> <td>56%</td> <td>71%</td> </tr> <tr> <td>10.</td> <td>20%</td> <td>35%</td> </tr> </tbody> </table> <p>Using the By Choice Monitoring Form: Satisfaction Check, PSH surveyed a mean sample of 11% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p> <table border="1" data-bbox="991 1209 1879 1396"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>By Choice motivates me to participate in treatment</i></td> <td>70%</td> <td>73%</td> </tr> <tr> <td>2.</td> <td><i>The point system motivates me to</i></td> <td>68%</td> <td>72%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			1.	79%	72%	5.	72%	71%	6.	75%	71%	7.	53%	54%	8.	56%	61%	10.	20%	18%	Compliance rate in last month of period			1.	92%	88%	5.	92%	67%	6.	75%	65%	7.	53%	61%	8.	56%	71%	10.	20%	35%			Previous period	Current period	1.	<i>By Choice motivates me to participate in treatment</i>	70%	73%	2.	<i>The point system motivates me to</i>	68%	72%
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			<i>improve my behavior</i>		
		3.	<i>The point system motivates me to learn new skills</i>	61%	67%
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	60%	60%
		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	63%	66%
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	65%	70%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	65%	69%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	66%	66%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	65%	66%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	64%	63%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	75%	73%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	62%	66%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	58%	61%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	62%	62%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	76%	74%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, PSH further assessed fidelity of implementation based on a 78% sample of Incentive Store staff members:</p>			

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		<table border="1"> <tr> <td data-bbox="989 228 1087 337">1.</td> <td data-bbox="1087 228 1793 337"><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units.</i></td> <td data-bbox="1793 228 1885 337">96%</td> </tr> <tr> <td data-bbox="989 337 1087 446">2.</td> <td data-bbox="1087 337 1793 446"><i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i></td> <td data-bbox="1793 337 1885 446">100%</td> </tr> <tr> <td data-bbox="989 446 1087 526">3.</td> <td data-bbox="1087 446 1793 526"><i>The incentive store is well stocked with appropriate items from the Approved Items list.</i></td> <td data-bbox="1793 446 1885 526">88%</td> </tr> <tr> <td data-bbox="989 526 1087 605">4.</td> <td data-bbox="1087 526 1793 605"><i>The incentive store has an inventory control system to track inventory and individual preferences.</i></td> <td data-bbox="1793 526 1885 605">96%</td> </tr> <tr> <td data-bbox="989 605 1087 685">5.</td> <td data-bbox="1087 605 1793 685"><i>Individuals have substantive input into the items being offered in the Incentive Store.</i></td> <td data-bbox="1793 605 1885 685">100%</td> </tr> <tr> <td data-bbox="989 685 1087 764">6.</td> <td data-bbox="1087 685 1793 764"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1793 685 1885 764">100%</td> </tr> <tr> <td data-bbox="989 764 1087 844">7.</td> <td data-bbox="1087 764 1793 844"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1793 764 1885 844">94%</td> </tr> <tr> <td data-bbox="989 844 1087 924">8.</td> <td data-bbox="1087 844 1793 924"><i>The Incentive Store staff has received appropriate training regarding incentive store policies and procedures.</i></td> <td data-bbox="1793 844 1885 924">96%</td> </tr> <tr> <td data-bbox="989 924 1087 1003">9.</td> <td data-bbox="1087 924 1793 1003"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1793 924 1885 1003">94%</td> </tr> <tr> <td data-bbox="989 1003 1087 1083">10.</td> <td data-bbox="1087 1003 1793 1083"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1793 1003 1885 1083">94%</td> </tr> <tr> <td data-bbox="989 1083 1087 1162">11.</td> <td data-bbox="1087 1083 1793 1162"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1793 1083 1885 1162">91%</td> </tr> </table> <p data-bbox="989 1211 1885 1312">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1, 2, and 4-11. The compliance rate for item 3 was 100% in the previous period.</p> <p data-bbox="989 1360 1885 1424">Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), PSH assessed</p>	1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units.</i>	96%	2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%	3.	<i>The incentive store is well stocked with appropriate items from the Approved Items list.</i>	88%	4.	<i>The incentive store has an inventory control system to track inventory and individual preferences.</i>	96%	5.	<i>Individuals have substantive input into the items being offered in the Incentive Store.</i>	100%	6.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	7.	<i>There is a By Choice Manual located in the incentive store.</i>	94%	8.	<i>The Incentive Store staff has received appropriate training regarding incentive store policies and procedures.</i>	96%	9.	<i>The individuals bring their point cards to the store to make a purchase.</i>	94%	10.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	94%	11.	<i>There is an Alert List in the incentive store for staff reference.</i>	91%
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		<p>fidelity of implementation based on average samples of 3% of the Level of Care Staff, 11% of the Individuals, and 78% of the By Choice program staff. The table below is a summary of the data:</p> <table border="1" data-bbox="993 337 1585 457"> <tr> <td>Level of Care Staff</td> <td>71%</td> </tr> <tr> <td>Individuals</td> <td>74%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>99%</td> </tr> </table> <p>The By Choice Coordinator has undertaken numerous projects to improve the quality of the program. These activities include the following: printing of individuals' Mall schedules on the back of their By Choice cards; timely distribution of reports; medical conditions/alerts automatically generated on a monthly basis; point reduction for healthful foods; validity testing on By Choice point allocation; and ongoing staff training.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Level of Care Staff	71%	Individuals	74%	By Choice Program Staff	99%
Level of Care Staff	71%							
Individuals	74%							
By Choice Program Staff	99%							
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The Chief of Psychology confirmed that he continues to have clinical and administrative authority for the PBS teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p>						

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>																		
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Substantial.</p>																		
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (May-October 2010):</p> <table border="1"> <tr> <td>1.</td> <td><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>A functional assessment interview was completed for</i></td> <td>100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for</i>	100%
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			<i>the structural assessment.</i>	
		7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%
		8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%
		9.	<i>A functional assessment rating scale was completed.</i>	100%
		10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%
		11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>PSH has continued the practice of conducting structural and functional assessments prior to developing behavioral intervention plans. PSH has developed and implemented 38 behavior guidelines and three PBS plans during this review period. A review of 22 behavioral interventions found that all 22 had been developed and implemented based on data derived from structural and functional assessments (AG, AR, BC, BM, CC, DG, DJ, DP, GH, GJD, GL, JA, JD, JG, LJ, MH, MK, RJ, RS, SA, SD, and TY). The quality of the assessments was good in most cases. A few cases were missing some elements and/or were not aligned between sections (e.g. GJD and MH).</p> <p>PSH should consider the following for further improvement:</p> <ol style="list-style-type: none"> 1. Collect and analyze data in settings in which the target behavior(s) does not occur or is least likely to occur. This will provide additional 		

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		<p>critical information to substantiate the hypothesis and the identification of antecedents and consequences for interventions.</p> <ol style="list-style-type: none"> 2. Emphasize data collection of precursors. This will help early intervention before the target behavior is fully exhibited. 3. Incorporate psychiatric and medical factors in the structural and functional assessment process. This is useful to differentiating the different functional properties of the target behaviors. 4. Resolve data triangulation when generating hypothesis. This will assist in prioritizing hypotheses and interventions. 5. Conduct secondary assessment and data analysis. Do not totally depend on the data obtained from the screening instruments. 6. Address mediating and moderating factors. This will assist in homing in on specific intervention strategies. 7. Focus on idiosyncratic variables that could confound the hypothesis and interventions. <p>Current recommendation: Continue current practice.</p>			
F.2.c.ii	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (May-October 2010):</p> <table border="1" data-bbox="991 1300 1892 1377"> <tr> <td data-bbox="991 1300 1087 1377">12.</td> <td data-bbox="1087 1300 1793 1377"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1793 1300 1892 1377">100%</td> </tr> </table>	12.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans developed and implemented during this review period (HS, JD and JL) found that the hypotheses in all three were based on structural and functional assessment data and the hypotheses aligned with the assessment data.</p> <p>Current recommendation: Continue current practice.</p>			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (May-October 2010):</p> <table border="1" data-bbox="991 1008 1892 1118"> <tr> <td data-bbox="991 1008 1087 1118">5</td> <td data-bbox="1087 1008 1793 1118"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 1008 1892 1118">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three PBS plans developed and implemented during this review period (HS, JD and JL) found that all three documented previous behavioral interventions and their effects.</p>	5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			

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		<p>Current recommendation: Continue current practice.</p>			
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (May-October 2010):</p> <table border="1" data-bbox="993 711 1890 824"> <tr> <td data-bbox="993 711 1087 824">17.</td> <td data-bbox="1087 711 1795 824"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1795 711 1890 824">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of all three PBS plans developed and implemented during this review period (HS, JD and JL) found that the interventions in all three plans were based on a positive behavioral supports model without any use of aversive or punishment contingencies. Ten behavior guidelines reviewed (AR, BC, BM, CC, DG, GL, JG, KJ, LJ and TY) also were based on a positive behavioral supports model.</p> <p>A comparison of the pre-/post-intervention data for the Positive Behavioral Support Plans and behavior guidelines was made. The comparison was made between the mean baseline data and a two-month mean intervention data. The outcome data of 19 cases showed strong positive changes in the target behaviors in 18 cases, and a no change in</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

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		<p>one case.</p> <p>Current recommendation: Continue current practice.</p>			
F.2.c.v	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (May-October 2010):</p> <table border="1" data-bbox="993 784 1890 898"> <tr> <td data-bbox="993 784 1087 898">22.</td> <td data-bbox="1087 784 1795 898"><i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></td> <td data-bbox="1795 784 1890 898">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor's review of fidelity/integrity check data for the PBS plans and behavior guidelines of nine individuals (AR, BC, BM, CC, HS, JD, JG, JL and TY) found that PSH had conducted fidelity checks on all nine PBS plans and PBS-driven behavior guidelines. PBS teams found that in many cases treatment integrity was poor (ranging from 52% to 85%). This situation needs attention from unit managerial, senior and administrative staff. Poor treatment implementation adversely affects everyone involved, mainly the individuals. It is impossible to know the effectiveness of interventions unless fully implemented with high integrity over a period of time. This appears to not be the case in a</p>	22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%
22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%			

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		<p>number of behavioral plans implemented at the facility. It is interesting to note that outcome was positive for all but one behavioral intervention plan implemented during this review period. Better treatment integrity can only mean a more positive outcome at a more rapid rate, which will be of great benefit to the individuals and the unit staff handling these individuals.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																																																																								
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</p> <table border="1" data-bbox="991 971 1906 1393"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>0</td> <td>5</td> <td>3</td> <td>5</td> <td>5</td> <td>8</td> <td>4</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Seclusion</td> <td>0</td> <td>0</td> <td>1</td> <td>3</td> <td>0</td> <td>0</td> <td>.6</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>1:1</td> <td>95</td> <td>80</td> <td>80</td> <td>101</td> <td>86</td> <td>79</td> <td>87</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to others</td> <td>50</td> <td>50</td> <td>50</td> <td>45</td> <td>20</td> <td>45</td> <td>43</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to self</td> <td>12</td> <td>13</td> <td>9</td> <td>12</td> <td>6</td> <td>4</td> <td>56</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>		May	Jun	Jul	Aug	Sep	Oct	Mean	Restraint	0	5	3	5	5	8	4	%C	100	100	100	100	100	100	100	Seclusion	0	0	1	3	0	0	.6	%C	100	100	100	100	100	100	100	1:1	95	80	80	101	86	79	87	%C	100	100	100	100	100	100	100	Aggression to others	50	50	50	45	20	45	43	%C	100	100	100	100	100	100	100	Aggression to self	12	13	9	12	6	4	56	%C	100	100	100	100	100	100	100
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		<p>Review of PSSC documentation and the facility's trigger data found that the PSSC had reviewed all individuals who had triggered on the key indicators. Staff education and training and supportive intervention strategies had been implemented for individuals whose triggers had been determined to be due to medical/psychiatric reasons. Behavioral assessments and where appropriate behavioral interventions had been developed and implemented in cases in which the triggers were determined to be due to learned functions.</p> <p>Staff interview and documentation review found that PSH is considering or has undertaken a number of strategies to reduce patient violence at the facility. These strategies include:</p> <ul style="list-style-type: none"> • The proposal to use psychological services on "positive psychology" from the community resources; • Data collection and analysis to better understand the nature, type, and occurrence of violence in terms of time, day, and location; • Literature review to understand the categories and causation of violence at residential facilities; and • Proactive intervention with individuals with a known history of violence. <p>In addition to the above strategies, it is recommended that the facility also place efforts on the following:</p> <ul style="list-style-type: none"> • Ensure a therapeutic milieu in the units; • Provide training and education to unit staff on how their behavior matters and how their behaviors could elicit positive or challenging behaviors in the individuals ; • Teach staff about therapeutic alliance; • Emphasis to unit staff on non-verbal behaviors and their effects; • Conduct proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, and internal physical
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		<p>systems on the safety and health of patients and staff that could contribute to poor mental health; and</p> <ul style="list-style-type: none"> • Display kind, caring, compassionate behavior (not attitude, individuals cannot see the attitude). Emphasize simple features such as smiling, requesting instead of demanding, soft spoken/tone of voice, etc). <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (May-October 2010):</p> <table border="1" data-bbox="993 894 1887 1008"> <tr> <td data-bbox="993 894 1087 1008">11.</td> <td data-bbox="1087 894 1793 1008"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 894 1887 1008">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the three plans (HS, JD and JL) founds that all three contained documentation indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern. Psychologists should consider integration of therapeutic modalities on an ongoing basis, daily, with consultation from nursing staff (constipation, sleep, medication changes, seizure disorder, diabetes, psychotic disorders, etc). Data for individuals</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%			

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		<p>with these variables should be documented daily and reviewed daily for timely action.</p> <p>Current recommendation: Continue current practice.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (May-October 2010):</p> <table border="1" data-bbox="991 821 1887 935"> <tr> <td data-bbox="991 821 1087 935">19.</td> <td data-bbox="1087 821 1793 935"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1793 821 1887 935">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals with PBS plans or PBS assessments (AWB, DB, DLR, GH, HMN, JMP, KMS, LAJ, MK and NM) found that all 10 WRPs in the charts properly discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p> <p>Psychologists should consider the implementation of natural consequences (when consequence manipulation as opposed to setting event and antecedent manipulation is not feasible) where possible (and it is possible</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%			

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		<p>for a majority of the behaviors and situations) to address target behaviors. For example, the common intervention is to have staff talk to individuals in the morning and at other times for target behaviors deemed to function as attention-seeking. Naturally occurring consequences can be paired for such behaviors (e.g. arranging for the individual to lead an activity, assist staff, participate in organized groups, etc). This will reduce staff involvement, increase opportunities for attention, allow skill-building, and most of all generalize to the community (it is almost impossible to arrange for contrived consequences in the community, for example having someone give attention or reinforce the individual).</p> <p>Current recommendation: Continue current practice.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (May-October 2010):</p> <table border="1" data-bbox="993 1117 1890 1193"> <tr> <td data-bbox="993 1117 1087 1193">24.</td> <td data-bbox="1087 1117 1795 1193"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1795 1117 1890 1193">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals with behavioral intervention plans (AWB, DB, DLR, GH, HMN, JMP, KMS, LAJ, MK and NM) found that</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			

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		<p>the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP. For example, the plan for JA's PBS plan had been updated numerous times (7/2/09, 9/8/10, and 9/14/10); and so was SA's behavior guideline (1/22/10, 6/18/10, 7/10 and 8/10).</p> <p>Current recommendation: Continue current practice.</p>						
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Behavior Guidelines and Positive Behavior Support Plan Monitoring Form, PSH assessed its compliance based on a 100% sample of behavior guidelines developed or revised during the review period (May-October 2010):</p> <table border="1" data-bbox="993 933 1890 1008"> <tr> <td data-bbox="993 933 1087 1008">20.</td> <td data-bbox="1087 933 1793 1008"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i></td> <td data-bbox="1793 933 1890 1008">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the same auditing tool, PSH also assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (May-October 2010):</p> <table border="1" data-bbox="993 1307 1890 1382"> <tr> <td data-bbox="993 1307 1087 1382">21.</td> <td data-bbox="1087 1307 1793 1382"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1793 1307 1890 1382">100%</td> </tr> </table>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						

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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 10 PBS plans and Behavior Guidelines (AWB, DB, DLR, GH, HMN, JMP, KMS, LAJ, MK and NM) found that competency-based staff training had been conducted with all staff responsible for implementing the intervention plans. However, treatment integrity data also showed that in a number of cases, the intervention plans had not been implemented as designed. It is essential that this situation is corrected to ensure that the plans are implemented as designed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.</p> <table border="1" data-bbox="1003 1190 1896 1414"> <tr> <td data-bbox="1003 1190 1102 1263">15.a.i</td> <td data-bbox="1102 1190 1787 1263"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1787 1190 1896 1263">100%</td> </tr> <tr> <td data-bbox="1003 1263 1102 1377">15.a.i</td> <td data-bbox="1102 1263 1787 1377"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1787 1263 1896 1377">100%</td> </tr> <tr> <td data-bbox="1003 1377 1102 1414">15.b</td> <td data-bbox="1102 1377 1787 1414"><i>If PBS team members are required to do mandatory</i></td> <td data-bbox="1787 1377 1896 1414">100%</td> </tr> </table>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a.i	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory</i>	100%
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15.b	<i>If PBS team members are required to do mandatory</i>	100%									

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		<table border="1" data-bbox="1003 188 1785 266"> <tr> <td data-bbox="1003 188 1096 266"></td> <td data-bbox="1096 188 1785 266"><i>overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1785 188 1894 266"></td> </tr> </table> <p>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.</p> <p>Current recommendation: Continue current practice.</p>		<i>overtime on state holidays, they are assigned to their usual PBS duties</i>	
	<i>overtime on state holidays, they are assigned to their usual PBS duties</i>				
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: See F.2.a.ii.</p> <p>Current recommendations: See F.2.a.ii.</p>			
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-2, June 2010:</p> <ul style="list-style-type: none"> • Ensure full staffing of the DCAT. • Provide data confirming that the DCAT is providing services to all individuals in need of its services. <p>Findings: PSH has one full DCAT, except for the lack of a data analyst. However, the facility has set up the use of a student trainee to provide the support.</p>			

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	<p>rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Information gathered from documentation review and staff interview indicated that the DCAT has been fully involved in providing support through direct assessments, consultations, and Mall facilitation during this review period. The following are examples of such involvement:</p> <ul style="list-style-type: none"> • Eleven behavior assessments; • Sixteen behavior guidelines and/or prevention strategies; • Twelve consultation with WRPTs and PBS teams for cognitively impaired individuals to learn their court materials; • Twelve Regional Center contacts and assistance is securing placement; and • Expansion of the RISE program to Mall Slot "C" on Mondays and Fridays. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH has maintained the Psychology Specialty Services Committee (PSSC). The PSSC continues to conduct joint meetings with the ETRC. Documentation review found that the PSSC meetings were held regularly and attendance of its core members were high.</p> <p>Staff interviews and documentation review confirmed that the PSSC</p>

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	<p>membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>reviews all trigger referrals for appropriateness of behavioral assessments or consultations. A review of records of individuals who triggered on key indicators found that all were reviewed at the PSSC and decisions were made jointly between the PSSC and ETRC as to the nature of the problem and course of action. Where deemed appropriate, the PSSC has arranged for behavioral assessments and behavioral intervention plans.</p> <p>PSH should continue to address behavioral problems proactively and not use trigger data as the main pathway to services.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.2.f</p>	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement and implementation of the plan to reduce the turnaround time for completion of neuropsychological assessments.</p> <p>Findings: PSH has five neuropsychologists; however only four staff have been actively engaged during this review period. The remaining staff member has yet to be released from her current position to join the NCS team.</p> <p>Documentation review found that Neuropsychology Consultation Service (NCS) received a total of 99 referrals during this review period. However, 23 of these referrals were removed due to attrition or refusal by the individual to participate in the assessments. Data also show that</p>

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the waiting list has been reduced significantly (nine individuals are on the waiting list for this review period, as opposed to 65 individuals during the previous review period).

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 2010):

		Ma y	Jun	Jul	Aug	Sep	Oct	Mean
18.a. i	<i>Number of neuro-psychological assessments due for completion in the review month</i>	7	9	23	21	8	7	12.5
18.a. ii	<i>Of those in 18.a.i, number completed</i>	1	5	13	14	2	4	6.5
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							61 days

PSH has made significant improvement in the number of days taken to complete neuropsychological assessments. The mean turnaround time for this review period was 121 days during the previous review period. PSH should continue to decrease the number of days taken to complete the assessments until the mean required rate of 31 days is achieved.

Corrective action: According to PSH, the facility plans on taking a number of steps to increase awareness of and referral for neuropsychological assessments. The proposed steps include working with WRPTs and senior psychologists, continuing with the training of psychologists and

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		<p>psychiatrists on making appropriate referrals, and improving the efficiency of examiners.</p> <p>This monitor proposes that in addition to the table above, future data presentation include a table with the following information: ID, Referral date, Assignment date, Completion date, and reason(s) for not completing the assessment within 31 days.</p> <p>Compliance: Partial; improved compared to last review.</p> <p>Current recommendation: Continue to monitor this requirement and implementation of the plan to reduce the turnaround time for completion of neuropsychological assessments.</p>
F.2.g	<p>All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>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.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u> Sandra Doerner, RN, Nurse Administrator</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Nursing Services Monitoring PRN Audit summary data, May-October 2010 2. PSH Nursing Services Monitoring Stat Audit summary data, May-October 2010 3. PSH Nursing Staff Familiarity Monitoring Audit summary data, May-October 2010 4. Nursing Policy 538, PRN and Stat Medication 5. PSH Medical Transfer Audit summary data, May-October 2010 6. PSH Nursing Services Audit summary data, May-October 2010 7. PSH Medication Administration Monitoring Audit summary data, May-October 2010 8. PSH's revised Principles of Medication Administration curriculum 9. Medication Variance forms for the review period 10. Medical records for the following 57 individuals : AAD, AB, AGM, AM, BZ, CAK, CAL, CDF, CL, CMR, DABW, DCW, DDR, DJT, DLG, DW, EB, EL, FW, GB, GDG, GG, GPB, HE, JAJ, JAR, JG, JGR, JIM, JJ, JL, JM, JS, JW, LH, LM, LOM, LW, LZ, MA, MC, MG, NB, PB, PN, PS, REP, RO, RT, SAN, SH, SL, SP, SWK, TT, TW and VQ <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit EB04) for quarterly review of BA 2. WRPC (Program III, unit 31) for annual review of PC 3. WRPC (Program VIII, unit 25) for monthly review of RS 4. Shift report on Program III, unit 31 5. Medication administration on Program VI, unit 75,

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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: Substantial.
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>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 2010), and reported a mean compliance rate of 93%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (May-October 2010), and reported a mean compliance rate of 95%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 260 PRN and Stat orders (190 PRN and 70 Stat) for 44 individuals (AAD, AB, AM, BZ, CAK, CAL, CL, CMR, DCW, DJT, DLG, DW, EB, EL, FW, GDG, GG, GPB, HE, JAJ, JAR, JG, JIM, JJ, JM, JS, LH, LM, LOM, LW, LZ, MA, MC, MG, NB, PB, RO, RT, SAN, SH, SL, SP, TT and VQ) found that 255 included specific individual behaviors. In addition, all</p>

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		<p>notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all notes.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>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 2010):</p> <table border="1" data-bbox="991 784 1890 933"> <tr> <td data-bbox="991 784 1087 933">3.</td> <td data-bbox="1087 784 1795 933"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i></td> <td data-bbox="1795 784 1890 933">96%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 190 incidents of PRN medications for 44 individuals (AAD, AB, AM, BZ, CAK, CAL, CL, CMR, DCW, DJT, DLG, DW, EB, EL, FW, GDG, GG, GPB, HE, JAJ, JAR, JG, JIM, JJ, JM, JS, LH, LM, LOM, LW, LZ, MA, MC, MG, NB, PB, RO, RT, SAN, SH, SL, SP, TT and VQ) found adequate documentation in the IDNs of the circumstances requiring the PRN in 183 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 27% mean sample of Stat medications</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i>	96%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/ behavior requiring the medication.</i>	96%			

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		<p>administered each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 266 1892 415"> <tr> <td data-bbox="993 266 1087 415">4.</td> <td data-bbox="1087 266 1793 415"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i></td> <td data-bbox="1793 266 1892 415">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 70 incidents of Stat medications for 23 individuals (AAD, AB, CAK, CL, DCW, DJT, DLG, GDG, GPB, HE, JAR, JIM, JJ, JM, JS, LM, LW, MC, NB, RO, SH, SL and SP) found adequate documentation in the IDNs of the circumstances requiring the PRN in 68 incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i>	98%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/ behavior requiring the medication.</i>	98%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>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 2010):</p> <table border="1" data-bbox="993 1230 1892 1347"> <tr> <td data-bbox="993 1230 1087 1347">5.</td> <td data-bbox="1087 1230 1793 1347"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 1230 1892 1347">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	95%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	95%			

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		<p>at least 90% from the previous review period.</p> <p>A review of 190 incidents of PRN medications for 44 individuals (AAD, AB, AM, BZ, CAK, CAL, CL, CMR, DCW, DJT, DLG, DW, EB, EL, FW, GDG, GG, GPB, HE, JAJ, JAR, JG, JIM, JJ, JM, JS, LH, LM, LOM, LW, LZ, MA, MC, MG, NB, PB, RO, RT, SAN, SH, SL, SP, TT and VQ) found a timely, comprehensive assessment in the IDNs of the individual's response in 186 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 27% mean sample of Stat medications administered each month during the review period (May-October 2010):</p> <table border="1" data-bbox="993 673 1890 787"> <tr> <td data-bbox="993 673 1087 787">6.</td> <td data-bbox="1087 673 1795 787"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1795 673 1890 787">93%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 70 incidents of Stat medications for 23 individuals (AAD, AB, CAK, CL, DCW, DJT, DLG, GDG, GPB, HE, JAR, JIM, JJ, JM, JS, LM, LW, MC, NB, RO, SH, SL and SP) found a timely, comprehensive assessment in the IDNs of the individual's response in all incidents.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	93%
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	93%			
F.3.b	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	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that clinical reviews for MVRs are timely completed.</p>			

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	<p>variances.</p>	<p>Findings: The Clinical Review Committee (CRT) is reviewing MVRs which lead to an ADR (Categories E through I) within three business days of the completion of the MVR as required by the Pharmacy & Therapeutics Manual, Section II.C.5.</p> <p>Crystal Borck, RN from the Standards Compliance Department works with the Clinical Review Team and as of June 2010, those MVRs which lead to an ADR (Categories E through I) are prioritized and reviewed by the CRT within three business days.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>Findings: A review of 50 MVRs found that PSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.3.c</p>	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.I for findings addressing WRP interventions.</p>

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	<p>therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, PSH assessed its compliance based on an average sample of 40% of the nursing staff:</p> <table border="1" data-bbox="991 784 1887 933"> <tr> <td data-bbox="991 784 1087 933">8.</td> <td data-bbox="1087 784 1793 933"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 784 1887 933">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In three WRPCs observed, all team members were very familiar with the individual and the individual's goals and interventions in the WRPs. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	100%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	100%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>						
<p>F.3.e</p>	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that audits regarding nursing documentation for change in status address the quality and clinical appropriateness of the documentation.</p> <p>Findings: As of September 2010, PSH required an HSS to review the nursing documentation when an individual is sent to a community medical facility to ensure appropriate documentation. Bill Holmes, RN from the Standards Compliance Department was assigned specifically to audit the nursing documentation for quality and clinical appropriateness regarding changes in status.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>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 2010):</p> <table border="1" data-bbox="991 1117 1890 1344"> <tr> <td data-bbox="991 1117 1087 1227">1.</td> <td data-bbox="1087 1117 1793 1227"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1117 1890 1227">96%</td> </tr> <tr> <td data-bbox="991 1227 1087 1344">7.</td> <td data-bbox="1087 1227 1793 1344"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 1227 1890 1344">82%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	82%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	82%						

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		<p>at least 90% from the previous review period for item 1. The compliance rate for item 7 decreased from 90% in the previous review period.</p> <p>PSH indicated that previously, physicians were auditing the nursing components of this requirement and were not identifying issues regarding the quality and clinical appropriateness of the nursing documentation. Higher compliance scores were being given for nursing documentation not meeting expectations. To increase compliance in this area, the CNS Department now sends an email to the Unit Supervisor, Conference Coordinator, and Nursing Coordinator when an individual returns from an emergency off-site transfer that includes the date of hospitalization or emergency room transfer and a statement of the need to update the WRP. This is being done to ensure that the Present Status of the Case Formulation includes information about the medical transfer and, as appropriate, that objectives and interventions are developed or revised to reflect the individual's current needs.</p> <p>Although PSH's plan noted above should facilitate improvements in WRP documentation, the consistent problematic issues found at each review reflect issues related to nursing competency in appropriately identifying symptoms indicating change in status and in conducting timely and appropriate assessment of symptoms. A review of the records of 13 individuals who were transferred to a community hospital/emergency room (AGM, CDF, DABW, DDR, GB, JGR, JL, JW, PN, PS, REP, SWK and TW) found that there continued to be a number of critical problematic issues with the nursing documentation for all the reviewed individuals. Examples of problematic issues included:</p> <ul style="list-style-type: none"> • No nursing assessment following an injury to an individual's eye from an assault; • Inadequate documentation in WRP regarding summaries of hospitalizations and outcome of injuries; • No WRP initiated for an individual who lost vision following an injury;
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		<ul style="list-style-type: none"> • No assessment for individual showing cognitive changes who was hospitalized the same day for seizures; • Incomplete assessments of an individual found on bathroom floor having seizure activity; • Lack of follow up assessments for symptoms of constipation; • No documentation in nursing progress notes or WRP regarding possible water intoxication; • No assessments for frequent complaints of pain; • Lack of documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline; • Significant gaps in documentation after individuals were identified as experiencing a change in status; • Lack of adequate documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; • Difficulty in determining from progress notes and change of status forms the actual time individuals are sent to the community hospital/ER; • No consistent summary documented of treatments provided at the community hospital or ER; • No documentation that physicians were timely notified when individuals were experiencing changes in their health status; • Lack of a complete nursing assessment upon return to the facility addressing the symptoms that precipitated the hospitalization or ER visit; • Lack of neurological checks and mental status documented for individuals with a significant change in mental/health status; • Some Change of Status Forms report information regarding the individual's status from previous days that was not found in the progress notes; • Illegible progress notes. signatures and titles; • Lack of regular assessment of bowel sounds, abdomen, and regularity
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		<p>of bowel movements for individuals with constipation;</p> <ul style="list-style-type: none"> • Duplication of documentation in progress notes and the Change of Status form; • Discrepancies in documentation between information contained in the progress notes and Change of Status forms; • Inconsistent use of the Change of Status forms when documenting changes in status; and • A number of progress notes out of sequential order or missing. <p>These findings do not comport with PSH's data. From a discussion with the Nursing staff, much of the auditing is only focused on the day the individual is transferred to the hospital, and not on reviewing the documentation indicating when a change in status occurred. For most of the cases reviewed, symptoms were noted in the documentation days or sometimes weeks prior to a hospitalization or ER visit but were not adequately assessed or followed. The overall deficits listed above indicate that significant work in this area needs to be done to ensure that individuals are provided timely and appropriate assessments and interventions, and to ultimately attain substantial compliance with this requirement.</p> <p>When auditing this requirement, the auditor(s) for this area needs to first read the clinical story at least days prior to the change of status in order to accurately assess the strengths and deficits in the nursing documentation. Reading only the progress notes from the day the individual was transferred to a community hospital or ER and the note upon return to the facility will not provide an accurate assessment of compliance for changes in status.</p> <p>Using the DMH Nursing Services Audit, PSH assessed its compliance based on a 82% sample of Change of Shift Reports observed during in the review months (May-October 2010):</p>
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		<p>10. <i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></p>	<p>100%</p>
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on Program III, unit 31 found that the report was largely generic and significantly lacked report to the oncoming shift of clinically relevant information regarding the individuals' status. There was basically no association made between the individuals' symptoms in relation to their Axis diagnoses and clinical information indicating if the individuals were doing better or worse regarding their symptoms. There was a significant decrease in the quality of the information provided during the shift report, which does not comport with PSH's data. The facility needs to continue its efforts in mentoring appropriate shift reports.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that audits regarding nursing documentation for change in status address the quality of the documentation. 2. Audit change of status requirement by first reading the "clinical story" regarding the change of status, which may begin days or weeks prior to the hospitalization or ER visit, to assess the strengths and deficits in the nursing documentation and then score the monitoring tool. 3. Continue training focused on building and improving nursing competency regarding assessments and documentation addressing changes in status. 4. Ensure that audits addressing change of shift report accurately 	

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		<p>reflect the shift report observed.</p> <p>5. Continue efforts in mentoring appropriate shift reports to include clinically relevant information related to the Axis diagnoses.</p> <p>6. Continue to monitor this requirement.</p>
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Substantial.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 71% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period. Compliance rates for other items in this audit are reported in the following cells.</p> <p>From observations of medication administration on Program VI, unit 75, the medication nurse demonstrated good interaction with the individuals receiving medications and provided some medication education. Also, the facility nurse observing the medication administration provided appropriate feedback and correction when appropriate.</p> <p>Current recommendation: Continue to monitor this requirement.</p>

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F.3.f.ii	education is provided to individuals during medication administration;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, June 2010:</p> <ul style="list-style-type: none"> • Provide retraining to staff addressing the need to document the medication, dosage, route and time administered for PRNs and Stat medications on the medication administration record. • Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice. <p>Findings: PSH's Nursing Policy NPPM 538, PRN and Stat Medication, was appropriately revised in August 2010 to reflect the Medication Treatment Record (MTR) documentation requirements. In addition, the Unit Supervisors provided in-services to the unit staff regarding the revisions. The Shift Leads are now monitoring the MTRs to ensure compliance with the documentation requirements. At the time of the review, 225 out of 1010 licensed nurses have received training regarding the revised policy as part of the Annual Mandated Training and as part of new employee training.</p> <p>Recommendation 3, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 71% of level of care nursing staff who are licensed and medication-certified:</p>

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		<table border="1"> <tr> <td>14.</td> <td><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>PSH was able to produce MVRs for the blanks found on the MTRs and Narcotic Logs during the review period. In addition, the facility revised its policy regarding the documentation of PRN and Stat medications and is providing training regarding the revisions.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	100%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	100%			
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	There were no previous recommendations, as PSH did not care for any bed-bound individuals during the previous review period.			
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH's training rosters verified that the 26 newly hired nursing staff received and passed competency-based training addressing Employee</p>			

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		<p>Medication Certification, Mental Health Nursing, Therapeutic Strategy Interventions (TSI), and Positive Behavior Support Principles.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	<p>the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.iii	<p>positive behavior support principles.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: See F.3.h.i.</p> <p>Current recommendation: Continue current practice.</p>
F.3.i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p>

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	<p>completion of the MTR and the controlled medication log.</p>	<p>Findings: PSH's training rosters indicated that 100% of the existing unit staff are currently in compliance with this requirement. See F.3.h.i. for New Employee medication certification training data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chris Keierleber, Senior Rehabilitation Therapist 2. Greg Siples, Director of Rehabilitation Therapy Services 3. Rebecca Griffin, Acting Senior Rehabilitation Therapist 4. Renata Geyer, Senior Rehabilitation Therapist 5. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 6. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for May-October 2010 2. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 23 individuals participating in observed PSR Mall groups: AAA, AKA, CC, CEH, CF, CTH, DCF, DG, EB, EJ, GB, GDG, GDG-2, JEL, JRB, JTH, LS, MAE, MEH, MF, MPA, OVR and WS 4. List of individuals who received direct physical therapy services from May-October 2010 5. List of individuals who received direct speech therapy services from May-October 2010 6. List of individuals who received direct occupational therapy services from May-October 2010 7. Records of the following 13 individuals who received direct physical, speech, and/or occupational therapy services from May-October 2010: AKA, EJW, EK, KRE, MJM, MLR, PH, PT, RH, RRA, RS, THE and YRR 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following five individuals with 24-Hour Rehabilitation Support Plans: JAS, JD, JU, RM and SRD 10. List of individuals with an INPOP plan 11. Records of the following four individuals with an INPOP plan: DM,

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		<p>HV, TS and VT</p> <p>12. Records for the following three individuals at high risk for falls: DVL, RD and RSW</p> <p>13. Records for the following two individuals who had three or more falls in 30 days or a fall with a major injury during the review period: JH and KDM</p> <p>14. List of individuals at high risk for impaired skin integrity</p> <p>15. Records for the following three individuals with impaired skin integrity: GS, HMD and MC</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Creative Arts Therapy for Stress Management PSR Mall Group 2. Impulse Control Rhythm Band PSR Mall Group 3. Music Making PSR Mall Group 4. Peaceful Living PSR Mall Group 5. Social Skills Training PSR Mall Group 6. Tone Chime Cognitive Skill Building PSR Mall Group 7. Video Productions PSR Mall Group 8. Writing and Studies PSR Mall Group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	<p>Compliance: Substantial.</p>
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The table below presents the number of scheduled and actual hours of</p>

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		<p>direct services provided by OT, PT, and SLP during one week of the review period:</p> <table border="1" data-bbox="989 302 1587 456"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>OT</td> <td>20</td> <td>17</td> </tr> <tr> <td>PT</td> <td>20</td> <td>13</td> </tr> <tr> <td>SLP</td> <td>9</td> <td>8</td> </tr> </tbody> </table> <p>The facility determined that two appointments were missed due to conflicting appointments, five were missed due to individual refusal, two were missed because the individual was ill, and two were missed due to unit staff error.</p> <p>Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 16% of individuals receiving occupational, speech and/or physical therapy direct treatment during the May-October 2010 review period, and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>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 11 records in substantial compliance (AKA, EJW, EK, KRE, MJM, MLR, PH, PT, RH, THE and YRR) and two records in partial compliance (RRA and RS).</p> <p>In terms of individualized outcomes, record review found that 12 out of 13 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Scheduled	Provided	OT	20	17	PT	20	13	SLP	9	8
	Scheduled	Provided												
OT	20	17												
PT	20	13												
SLP	9	8												

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<p>F.4.a.ii</p>	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 33% of plans completed during the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of four individuals with INPOP plans to assess compliance with F.4.a.ii criteria found all records in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>F.4.b</p>	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to enhance current practice.</p> <p>Findings: The facility reported that 165 out of 165 nurses identified as requiring training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
F.4.c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010), and reported a mean compliance rate of 96%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 23 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 22 records in substantial compliance (AAA, CC, CEH, CF, CTH, DCF, DG, EB, EJ, GB, GDG, GDG-2, JEL, JRB, JTH, LS, MAE, MEH, MF, MPA, OVR and WS) and one record in partial compliance (AKA).</p> <p>In terms of individualized outcomes, record review found that 12 out of 21 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes; three out of 23 individuals were just added to groups and so progress could not be assessed.</p> <p>Observation of eight PSR Mall groups found that in all groups, a lesson plan was in use and the groups provided activities that were in line with the individuals' assessed needs. During the maintenance period, the</p>

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		<p>facility should focus on making lesson plans more specific, detailed and instructive to group providers.</p> <p>The table below presents the number of hours scheduled versus number of hours provided of PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 9/13/10:</p> <table border="1" data-bbox="989 451 1654 565"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>741</td> <td>695</td> </tr> <tr> <td>Voc Rehab</td> <td>138</td> <td>127</td> </tr> </tbody> </table> <p>The facility reported that discrepancies between hours scheduled and hours provided was due to staff time off including furloughs, vacation, illness; staff shortages; lockdowns; and mandatory training.</p> <p>Using the DMH F.4 Monitoring Tool, PSH also assessed its compliance based on an average sample of 50% of individuals with 24-hour support plans during the review period (May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of five individuals with 24-hour support plans to assess compliance with F.4.c criteria found all records in substantial compliance.</p> <p>Other findings: The Vocational Rehabilitation program continues to provide excellent services to individuals who have vocational life and recovery goals. The programs for vocational skills groups, interviewing skills groups, distance learning, and IT assignments were developed following extensive literature review, and reflect evidence-based practice. Vocational groups have been piloted and modified using individual feedback and guidance.</p>		Scheduled	Provided	RT	741	695	Voc Rehab	138	127
	Scheduled	Provided									
RT	741	695									
Voc Rehab	138	127									

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		<p>A review of individuals who were at high risk for falls found evidence that Physical Therapy focused assessment was ordered and completed for one individual (RD) for whom it was clinically indicated, and one individual (DVL) was attending a risk prevention group for mobility-related fall risk. A review of the record of one individual (JH) who had three or more falls in 30 days found that the individual had a timely CIPRTA assessment incorporating occupational and physical therapy recommendations, is enrolled in direct physical therapy to address mobility-related fall risk factors, and has a 24-hour support plan to promote safe and functional mobility. Review of the record of an individual (KDM) who had a fall resulting in major injury found that physical therapy assessment and services were provided to treat arm fracture but not the underlying mobility-related fall risk factors. Records for three individuals at high risk for impaired skin integrity were reviewed, but no documentation of reason for risk was found in the WRP, and it was not possible to determine whether a PT or OT assessment was clinically indicated to address potential decubitus risk.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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</p>

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		<p>equipment database each month during the review period May-October 2010:</p> <table border="1" data-bbox="989 302 1904 678"> <tr> <td data-bbox="989 302 1087 378">e.</td> <td data-bbox="1087 302 1793 378"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 302 1904 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 454">f.</td> <td data-bbox="1087 378 1793 454"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 378 1904 454">100%</td> </tr> <tr> <td data-bbox="989 454 1087 531">g.</td> <td data-bbox="1087 454 1793 531"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 454 1904 531">100%</td> </tr> <tr> <td data-bbox="989 531 1087 607">h.</td> <td data-bbox="1087 531 1793 607"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 531 1904 607">100%</td> </tr> <tr> <td data-bbox="989 607 1087 678">i.</td> <td data-bbox="1087 607 1793 678"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 607 1904 678">100%</td> </tr> </table> <p data-bbox="989 721 1904 789">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 831 1140 899">Compliance: Substantial.</p> <p data-bbox="989 941 1457 1010">Current recommendation: Continue to monitor this requirement.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
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i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Delores Otto-Moreno, Assistant Director of Nutrition Services 3. Grace Ferris, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Acting Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from May-October 2010 for each assessment type 10. Records of the following 57 individuals with types a-j.ii assessments from May-October 2010: AA, AA-2, ABE, AGA, AY, BD, CB, CG, CGD, CL, DC, DMC, DT, EM, EO, FR, FT, GRO, HK, HLD, HM, IG, JBG, JDD, JEP, JJB, JL, JMV, JW, JW, KJJ, LDL, LEL, LRR, LSC, MC, MDF, ME, MJ, MR, MRJ, MSW, PJ, PLJ, QW, RA, RH, RLZ, RR, ST, TLO, TR, TYH, UVJ, VJ, WAM and WE 2. Meal Accuracy Report audit data from May-October 2010 3. Nutrition Care Monitoring Tool audit data from May-October 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 4. List of individuals at risk for choking and aspiration 5. Record of one individual at risk for choking 6. Records of the following three individuals with an incident of choking during the review period: DA, JP and JU 7. List of individuals with a new diabetes diagnosis during the review period 8. Records for the following three individuals with a new diabetes diagnosis of diabetes during the review period: JHB, RWW and TLO 9. List of individuals at risk for metabolic syndrome

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		10. Records for the following three individuals at high risk for metabolic syndrome: ER, LMM and TLH						
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 and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010 (total of 592 out of 2349):</p> <table border="1" data-bbox="989 711 1906 862"> <tr> <td data-bbox="989 711 1087 748">7.</td> <td data-bbox="1087 711 1793 748"><i>Nutrition education is documented.</i></td> <td data-bbox="1793 711 1906 748">99%</td> </tr> <tr> <td data-bbox="989 748 1087 862">8</td> <td data-bbox="1087 748 1793 862"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1793 748 1906 862">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 57 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>Other findings: PSH assessed its compliance with tray accuracy based on an average sample of 23% of the average daily census from May-October 2010 (total of 2037 out of 9024) and found that 98% of trays audited were in 100% compliance.</p>	7.	<i>Nutrition education is documented.</i>	99%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%
7.	<i>Nutrition education is documented.</i>	99%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%						

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		<p>Other findings: A review of records for three individuals at high risk for metabolic syndrome and three individuals with a new diagnosis of diabetes found that five records (ER, JHB, LMM, RWW and TLO) had evidence of a nutrition assessment that addressed risk factors, appropriate contributing factors, and clinical recommendations, with reassessment administered in accordance with assigned acuity level; one record (TLH) did not show a timely nutrition update (last assessment was dated 3/23/10, and the individual should have been reviewed quarterly according to acuity level).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current efforts to improve compliance.</p> <p>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 2010 (592 out of 2349):</p> <table border="1" data-bbox="989 1227 1887 1414"> <tr> <td data-bbox="989 1227 1087 1304">19.</td> <td data-bbox="1087 1227 1793 1304"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1793 1227 1887 1304">88%</td> </tr> <tr> <td data-bbox="989 1304 1087 1414">20.</td> <td data-bbox="1087 1304 1793 1414"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1793 1304 1887 1414">80%</td> </tr> </table>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	88%	20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	80%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	88%						
20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	80%						

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		<p>Comparative data indicated mixed changes in compliance since the previous review period:</p> <table border="1" data-bbox="989 339 1887 531"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>19.</td> <td>95%</td> <td>88%</td> </tr> <tr> <td>20.</td> <td>63%</td> <td>80%</td> </tr> </tbody> </table> <p>A review of the records of 44 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found 43 records in substantial compliance (AA, AA-2, ABE, AY, BD, CB, CG, CGD, DC, DT, EM, EO, FR, FT, HK, HLD, HM, JBG, JDD, JEP, JMV, JW, KJJ, LEL, LSC, MC, MDF, ME, MJ, MR, PJ, PLJ, QW, RA, RH, RLZ, RR, ST, TLO, TR, VJ, WAM and WE) and one record in partial compliance (LDL).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			19.	95%	88%	20.	63%	80%
	Previous period	Current period												
Mean compliance rate														
19.	95%	88%												
20.	63%	80%												
F.5.c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: No incidences of aspiration pneumonia were reported during the review period.</p>												

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		<p>Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>Other findings: A review of the records of three individuals with an incident of choking found that all three individuals had an assessment by a speech therapist with subsequent recommendations incorporated into the treatment plan; a 24-hour support plan was developed for JU as clinically indicated due to dysphagia diagnosis-related physiological causes. While an open Focus 6 to address risk of choking was noted in all three records, two individuals (DA and JP) appeared to be in need of behavioral interventions to manage choking risk, and yet a Focus 3 treatment objective to address fast and impulsive eating behaviors was not noted in either record. A review of the record of one individual at high risk for choking and/or aspiration found that the record contained documentation of an open focus, objective and intervention to remediate risk and/or future occurrence.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: No training was provided to dietitians during this review period. The facility reported that two recently hired dietitians will be trained on procedures related to dysphagia in December 2010.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding should be updated and revised as needed to align with accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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6. Pharmacy Services																																											
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> Laura Yao, Business Manager II Washington Ubillus, Jr., Pharmacist I <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> PSH self-assessment monitoring data Executive Summary - Pharmacists' recommendations regarding new psychotropic medication orders and physicians' response to these recommendations during this review 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	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following data regarding the recommendations made during the current review period:</p> <table border="1"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>64</td> <td>66</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>100</td> <td>119</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>222</td> <td>202</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>72</td> <td>69</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>9</td> <td>57</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>9</td> <td>11</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>0</td> <td>3</td> </tr> <tr> <td>8.</td> <td>Others</td> <td>21</td> <td>36</td> </tr> <tr> <td colspan="2">Total number of recommendations*</td> <td>497</td> <td>563</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	64	66	2.	Side effects	100	119	3.	Need for laboratory testing	222	202	4.	Dose adjustment	72	69	5.	Indications	9	57	6.	Contraindications	9	11	7.	Need for continued treatment	0	3	8.	Others	21	36	Total number of recommendations*		497	563
		Previous period	Current period																																								
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 748 1795 1013"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>450</td> <td>531</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>39</td> <td>29</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>8</td> <td>3</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the facility's records regarding three pharmacy recommendations that were not followed by the physicians or no response was documented. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.</p> <p>Compliance: Substantial.</p>		Previous period	Current period	Recommendations followed	450	531	Recommendations not followed, but rationale documented	39	29	Recommendations not followed and rationale/response not documented	8	3
	Previous period	Current period												
Recommendations followed	450	531												
Recommendations not followed, but rationale documented	39	29												
Recommendations not followed and rationale/response not documented	8	3												

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		Current recommendation: Continue to monitor this requirement.
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Arporn Sungkakitkorane, MD, Physician and Surgeon 2. Aung Zin, MD, Physician and Surgeon 3. Beth Chung, MD, Physician and Surgeon 4. Chinh Pham, MD, Physician and Surgeon 5. Dien Mach, MD, Chief Physician and Surgeon 6. Dominique Tran, MD, Physician and Surgeon 7. Duc Nguyen, MD, Physician and Surgeon 8. Faye Owen, MD, Staff Psychiatrist 9. Hai Le, MD, Physician and Surgeon 10. Kenny Win, MD, Physician and Surgeon 11. Khanh Ngo, MD, Physician and Surgeon 12. Khue Nguyen, MD, Physician and Surgeon 13. Lidia Lau, RN, Assistant Coordinator, Nursing Services 14. Luminita Andronescu, MD, Physician and Surgeon 15. Luzmin Inderias, MD, Physician and Surgeon 16. Michael Ilas, MD, Staff Psychiatrist 17. Mohamed Hafez, MD, Physician and Surgeon 18. My Tran, MD, Physician and Surgeon 19. Nibonth Viravathana, MD, Physician and Surgeon 20. Richard Morrissey, MD, Physician and Surgeon 21. Sandra Doerner, RN, Nurse Administrator 22. Stephanie Nguyen, MD, Physician and Surgeon 23. Susan Protacio, MD, Physician and Surgeon 24. Talat Khan, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 16 individuals who were transferred to an outside medical facility during this review period: AM, CF, CH, DR, DV, DW, GB, JL, JR, JW, KS, PN, PS, RP, TW, and WA

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		<ol style="list-style-type: none"> 2. Quarterly Progress note for the following 19 individuals: AR, CG, DR, EE, EM, ET, JA, JAP, JB, JEF, JG, JL, JR, LF, OD, RSW, SH, SWM, and TN 3. Analysis of Hepatitis C Key Indicator data for the current review period 4. List of all individuals admitted to external hospitals during the review period 5. Summary - Infection Control Activities as Related to Enhancement Plan 2010 6. Joint Medical Nursing Policy and Procedures for the following: <ul style="list-style-type: none"> ➤ Asthma ➤ Constipation ➤ Chronic Obstructive Pulmonary Disease ➤ Dehydration ➤ Diabetes ➤ Hypertension ➤ Pressure Ulcers and Wounds (Impaired Skin Integrity) ➤ Seizures ➤ Weight Management 7. Outline of PSH's Re-Privileging Process 8. Mortality Review of individual CR, including the following documents: <ul style="list-style-type: none"> ➤ Minutes of MIRC, 11/18/10 - Cinde Brown, Risk Manager ➤ Special Investigator Report, 11/18/10 ➤ Medical Death Summary, 11/30/10 - Dr. Cor and Dr. Chung ➤ Nursing Death Summary 11/17/10 - Sandra Doerner, Nurse Administrator ➤ Initial MIRC Report, 11/25/10 - Dr. Kulkarni, Assistant Medical Director ➤ Psychopharmacology Report, 11/22/10 - Dr. Proctor ➤ Internal Medicine: Internal Interdisciplinary Review, 11/29/10 - Dr. Tran, Internal Medicine Consultant 9. Mortality Review of individual GHF, including the following documents: <ul style="list-style-type: none"> ➤ Minutes of MIRC, 9/10/10 - Nitin Kulkarni, MD, Assistant Medical
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		<p>Director</p> <ul style="list-style-type: none"> ➤ Office of Special Investigation, Special Investigative Death Report, 9/22/10 ➤ Medical Death Summary, 8/31/10 - Dr. Lo and Dr. Nguyen ➤ Nursing Death Summary 9/9/10 - Sandra Doerner, Nurse Administrator ➤ Internal Review Death Summary Report, 9/13/10 - Dr. Zin, Surgical Mortality Review Committee ➤ Initial Summary Report of MIRC, 9/20/10 - Dr. Christison, Acting Medical Director ➤ Independent Medical Report, 10/11/10 - Dr. Zwerin <ol style="list-style-type: none"> 10. PSH Medical-Surgical Progress Note Auditing summary data (May to October 2010) 11. PSH Medical Transfer Auditing summary data (May to October 2010) 12. PSH Medical Emergency Response Evaluation, Mock Codes, summary data (May to October 2010) 13. PSH Medical Emergency Response Evaluation, Emergency Medical Transport, summary data (May to September 2010) 14. PSH Integration of Medical Conditions into the WRP Auditing summary data (May to October 2010) 15. Hospitalization and ER Visit Medical Records summary data (May to October 2010) 16. PSH Diabetes Mellitus Auditing summary data (May to October 2010) 17. PSH Hypertension Auditing summary data (May to October 2010) 18. PSH Dyslipidemia Auditing summary data (May to October 2010) 19. PSH Asthma/COPD Auditing summary data (May to October 2010) 20. PSH Medicine Peer Review data (May to October 2010) 21. PSH Process and Clinical Outcome summary data (previous and current review period) for the following indicators: <ul style="list-style-type: none"> ➤ Diabetes Mellitus ➤ Dyslipidemia ➤ Obesity ➤ Hypertension
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		<ul style="list-style-type: none"> ➤ Bowel Dysfunction ➤ Falls ➤ Aspiration Pneumonia ➤ Seizure Disorder ➤ Metabolic Syndrome ➤ Specialty Consultations ➤ Unexpected Mortalities
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure consistency of nursing assessments of changes in the status of individuals, including abdominal pain and tracking of seizure activity.</p> <p>Findings: The facility reported that mentoring on nursing assessments of changes in the status of individuals was provided on an ongoing basis during the review period.</p> <p>Recommendation 2, June 2010: Provide a summary outline of any changes in the current medical and joint medical nursing ADs, policies and procedures.</p> <p>Findings: In June 2010, joint medical and nursing ADs were issued to address care of individuals suffering from the following conditions:</p> <ol style="list-style-type: none"> 1. Asthma 2. Constipation 3. Chronic Obstructive Pulmonary Disease 4. Dehydration 5. Diabetes 6. Hypertension

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		<p>7. Pressure Ulcers and Wounds (Impaired Skin Integrity) 8. Seizures 9. Weight Management</p> <p>If properly implemented, the joint procedures can correct the previously mentioned deficiencies in nursing assessments of changes in the physical status of the individuals.</p> <p>Other findings: This monitor reviewed the charts of 16 individuals who were transferred to an outside medical facility during this review period (on 17 occasions) and interviewed the Physicians and Surgeons who were involved in their care. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 781 1896 1390"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>5/4/10</td> <td>Head Trauma</td> </tr> <tr> <td>2</td> <td>6/4/10</td> <td>Loss of Consciousness, COPD</td> </tr> <tr> <td>3</td> <td>6/13/10</td> <td>Confusion R/O Intracranial Hemorrhage</td> </tr> <tr> <td>4</td> <td>6/23/10</td> <td>Slurred Speech</td> </tr> <tr> <td>5</td> <td>6/29/10</td> <td>Hyponatremia</td> </tr> <tr> <td>6</td> <td>7/7/10</td> <td>Abdominal Pain</td> </tr> <tr> <td>7</td> <td>7/7/10</td> <td>Questionable Seizure</td> </tr> <tr> <td>8</td> <td>7/28/10</td> <td>Vertigo</td> </tr> <tr> <td>9</td> <td>8/5/10</td> <td>Lethargy</td> </tr> <tr> <td>10</td> <td>9/9/10</td> <td>Pain Right Breast, Breast CA</td> </tr> <tr> <td>11</td> <td>9/10/10</td> <td>S/P Fall, Head Injury</td> </tr> <tr> <td>12</td> <td>10/4/10</td> <td>Rupture Left Eye Globe</td> </tr> <tr> <td>10</td> <td>10/5/10</td> <td>Pain Right Breast, Breast CA</td> </tr> <tr> <td>13</td> <td>10/10/10</td> <td>Abdominal Pain</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1	5/4/10	Head Trauma	2	6/4/10	Loss of Consciousness, COPD	3	6/13/10	Confusion R/O Intracranial Hemorrhage	4	6/23/10	Slurred Speech	5	6/29/10	Hyponatremia	6	7/7/10	Abdominal Pain	7	7/7/10	Questionable Seizure	8	7/28/10	Vertigo	9	8/5/10	Lethargy	10	9/9/10	Pain Right Breast, Breast CA	11	9/10/10	S/P Fall, Head Injury	12	10/4/10	Rupture Left Eye Globe	10	10/5/10	Pain Right Breast, Breast CA	13	10/10/10	Abdominal Pain
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		14	10/15/10	New Onset Seizure
		15	10/18/10	Small Bowel Obstruction
		16	10/21/10	Recurrent Seizure
		<p>The review found general evidence that PSH has maintained progress in the provision of timely and appropriate care of the individuals. The following process deficiencies were identified:</p> <ol style="list-style-type: none"> 1. There was evidence of inadequate communication between PSH and the outside medical facility regarding the medication regimen that was prescribed for an individual upon the return transfer to PSH. 2. An individual was diagnosed with new onset seizure and transferred to an outside facility for workup and management. The transfer assessment did not provide adequate information to the outside hospital regarding the medication history of the individual. 3. There was evidence of inadequate nursing assessment of an individual who was transferred to an outside hospital due to questionable bowel obstruction. 4. The facility's current procedure that allows the use of quetiapine at doses that exceed generally accepted standards does not include precautions to ensure adequate monitoring for the risk of postural hypotension. 5. The medical assessment of an individual who developed significant changes in his neurological condition did not include a neurological examination. <p>This monitor reviewed the facility's Mortality Review documents regarding all unexpected deaths that occurred from May to November 2010 (#2). This review found that the facility conducted thorough reviews and analysis of contributing factors, including development and implementation of adequate and timely corrective actions to address these factors and to minimize the risks for the individuals at the facility.</p>		

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		<p>Compliance: Substantial. In order to maintain compliance, the facility must implement Recommendations 1 to 3 below.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure consistent and clear documentation of the communication between PSH and the outside medical facility regarding the medication regimen that was prescribed for individuals upon the return transfer to PSH. 2. Develop and implement a mechanism to provide adequate medication history to outside facilities upon the transfer of individuals who suffer from seizure activity. 3. Revise the current procedure regarding the use of quetiapine at doses that exceed generally accepted standards to include adequate monitoring for the risk of postural hypotension. 4. 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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010):</p>

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		<table border="1"> <tr> <td data-bbox="987 196 1087 266">1.</td> <td data-bbox="1087 196 1793 266"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 196 1906 266">99%</td> </tr> <tr> <td data-bbox="987 266 1087 380">2.</td> <td data-bbox="1087 266 1793 380"><i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 266 1906 380">98%</td> </tr> <tr> <td data-bbox="987 380 1087 565">3.</td> <td data-bbox="1087 380 1793 565"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 380 1906 565">96%</td> </tr> </table> <p data-bbox="987 607 1906 678">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="987 721 1142 786">Compliance: Substantial.</p> <p data-bbox="987 834 1457 899">Current recommendation: Continue to monitor this requirement.</p>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%	2.	<i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	98%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	96%
1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	99%									
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F.7.b.ii	<p data-bbox="373 945 957 1230">require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p data-bbox="987 945 1591 977">Current findings on previous recommendations:</p> <p data-bbox="987 1019 1457 1084">Recommendation 1, June 2010: Continue to monitor this requirement.</p> <p data-bbox="987 1127 1843 1273">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 2010):</p> <table border="1"> <tr> <td data-bbox="987 1312 1087 1416">1.</td> <td data-bbox="1087 1312 1793 1416"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1312 1906 1416">96%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%						
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		2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	97%
		3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	90%
		4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	96%
		5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	93%
		6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	96%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	82%
	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 1 through 6. The compliance rate for item 7 was 90% in the previous review period.</p>			
	<p>PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 22% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (May-October 2010). The following is a summary of the data:</p>			
		1.	<i>All medical conditions listed in Axis III are included</i>	97%

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			<i>on the Medical Conditions form</i>	
		2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	97%
		3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	95%
		4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	99%
		5.	<i>There are appropriate intervention(s) for each objective</i>	98%
		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the same tool, the facility reviewed a 2% sample of individuals who have refused medical treatment or laboratory tests. The facility reported a rate of 83% regarding the indicator that the interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures. Comparative data indicated a decline in compliance from 98% in the previous review period. The facility found that the reasons for this decline were that none of the WRPT members took responsibility to ensure implementation and that current appointment tracking forms were not conducive to tracking refused appointments. Adequate corrective actions were developed and implemented.</p> <p>Using the DMH Medical Emergency Response Evaluation, PSH assessed its compliance based on a sample of 100% of mock codes (total of 188) performed during the review period (May-October 2010):</p>		
		1.	<i>Did the first responder appropriately assess and call for help?</i>	99%
		2.	<i>Did the first responder provide appropriate CPR procedures?</i>	69%

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		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	93%
		4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A
		5.	<i>Did the first responder provide appropriate BFA procedures?</i>	98%
		6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%
		7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	98%
		8.	<i>Did the MD respond within 15 minutes?</i>	89%
		9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	90%
		10.	<i>Was the unit milieu appropriately managed?</i>	100%
		11.	<i>Was all required equipment available?</i>	83%
		12.	<i>Was all required equipment in working order?</i>	97%
		13.	<i>Were all medical supplies available?</i>	89%
		14.	<i>Were all medications available?</i>	85%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	88%
		16.	<i>Did all the staff perform according to assigned roles?</i>	96%
		17.	<i>Was staff competent in operating equipment?</i>	90%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%
		19.	<i>Was all required documentation completed?</i>	100%
		20.	<i>Was EMS able to access the site in a timely manner?</i>	100%
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	98%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1, 3, 5-7, 9, 10, 12, 16, 17, 19 and 21 (items 18 and 20 were N/A in the previous review period). Changes in compliance were mixed for the remaining items:</p>		

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	Previous period	Current period
Mean compliance rate		
2.	98%	69%
4.	63%	N/A
8.	83%	89%
11.	79%	83%
13	96%	89%
14.	98%	85%
15.	97%	88%

Using the same form, PSH assessed its compliance based on a sample of 100% of actual medical emergencies (total of 15) during the review period (May-October 2010):

1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%
3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A
5.	<i>Did the first responder provide appropriate BFA procedures?</i>	100%
6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%
7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
8.	<i>Did the MD respond within 15 minutes?</i>	100%
9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained</i>	100%

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			<i>staff were available to run the code efficiently?</i>	
		10.	<i>Was the unit milieu appropriately managed?</i>	93%
		11.	<i>Was all required equipment available?</i>	100%
		12.	<i>Was all required equipment in working order?</i>	93%
		13.	<i>Were all medical supplies available?</i>	93%
		14.	<i>Were all medications available?</i>	100%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%
		16.	<i>Did all the staff perform according to assigned roles?</i>	100%
		17.	<i>Was staff competent in operating equipment?</i>	100%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%
		19.	<i>Was all required documentation completed?</i>	100%
		20.	<i>Was EMS able to access the site in a timely manner?</i>	100%
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1-3, 7-11, 13-17, 19 and 20 (item 4 was N/A in both periods and item 5 was N/A in the previous period). Compliance improved for the remaining items:</p>		
			Previous period	Current period
		Mean compliance rate		
		6.	0%	100%
		12.	88%	93%
		18.	88%	100%
		21.	88%	100%
		<p>Recommendation 2, June 2010: In order to maintain substantial compliance, provide a summary outline of the issues identified during the performance of medical emergency drills</p>		

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		<p>and corresponding corrective actions.</p> <p>Findings: PSH provided a brief report of the issues that were identified during the review of drills and that required corrective actions. The report was adequate.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide an outline of the issues identified during the performance of medical emergency drills and corresponding corrective actions.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH has continued its practice. The duties and responsibilities are adequately defined in the current policies, procedures and administrative directives regarding medical (and nursing) assessments and care.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric	<p>Current findings on previous recommendation:</p>

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	<p>training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH has continued its practice.</p> <p>Other findings: Review of the schedule of on-call coverage found that both a Primary Care Physician and a Psychiatrist provided after-hours coverage.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.7.b.v</p>	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: The facility presented data based on a 94% sample of individuals returning from outside medical treatment during the review period (May-October 2010) tracking whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 94%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor's chart reviews (see F.7.a) found that records from outside hospitalization were available in all cases reviewed.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																					
F.7.c	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 18% (diabetes mellitus), 18% (hypertension), 19% (dyslipidemia) and 17% (COPD/asthma) of individuals diagnosed with these disorders during the review months (May-October 2010). The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 1003 1887 1421"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>97%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>97%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	97%	2.	<i>HgbA1C was ordered quarterly.</i>	98%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%	4.	<i>Blood sugar is monitored regularly.</i>	99%	5.	<i>Urinary micro albumin is monitored annually.</i>	97%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	97%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%
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Section F: Specific Therapeutic and Rehabilitation Services

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<p><u>Asthma/COPD</u></p>								
1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	98%						
2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	99%						
3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	98%						
4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	94%						
5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	98%						
6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	99%						
7.	<i>The individual has been assessed for a flu vaccination.</i>	97%						
8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	96%						
<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>								
<p>Compliance: Substantial.</p>								

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. The facility may reduce the sample sizes for the above-mentioned data to no less than 10% in order to free some resources for self-assessment of other areas (e.g. preventive and cardiac care). 																					
<p>F.7.d</p>	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following peer review aggregated data, based on a 100% sample of primary care physicians:</p> <table border="1" data-bbox="991 784 1887 1052"> <tr> <td>1.</td> <td><i>Quality of care</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Timeliness of care</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>WRP planning and documentation</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Appropriate consultations ordered</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate consultations reviewed</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate labs/diagnostics ordered</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate labs/diagnostics reviewed</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Recommendation 2, June 2010: Ensure that the process and clinical outcome data are reported in alignment with the framework agreed to by the facility medical directors in December 2009.</p>	1.	<i>Quality of care</i>	96%	2.	<i>Timeliness of care</i>	99%	3.	<i>WRP planning and documentation</i>	99%	4.	<i>Appropriate consultations ordered</i>	100%	5.	<i>Appropriate consultations reviewed</i>	99%	6.	<i>Appropriate labs/diagnostics ordered</i>	99%	7.	<i>Appropriate labs/diagnostics reviewed</i>	99%
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7.	<i>Appropriate labs/diagnostics reviewed</i>	99%																					

		<p>Findings:</p> <p>During this review period, PSH continued to gather and expanded both process and clinical outcome data for the current review period, including comparisons with the previous review period. The following is a summary outline of the indicators used:</p> <ol style="list-style-type: none"> 1. Process outcomes: <ol style="list-style-type: none"> a. Number of individuals newly diagnosed with Diabetes Mellitus; b. Number of new diagnoses of Diabetes Mellitus in individuals receiving new generation antipsychotics; c. Number of individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics; d. Percentage of individuals whose BMI is tracked monthly; e. Percentage of individuals receiving clozapine and prescribed high fiber diet (or documentation of diet is refused); f. Percentage of individuals receiving clozapine and enrolled in exercise program; g. Number of individuals with 3+ falls in 30 days; h. Total number of falls; i. Number of individuals with cognitive disorders and receiving older anticonvulsant agents; j. Adequate documentation of seizure activity; k. Documentation of medical, neurological and neuropsychological referrals/assessments/consultations for individuals with seizure disorders; l. Documentation of appropriate anticonvulsant medication selection for individuals with seizure disorders; m. Number of individuals with metabolic syndrome; n. Number of individuals with metabolic syndrome who had cardiac disease and o. Number of individuals with metabolic syndrome who had cardiac disease and were hospitalized (or had ER visits) p. Timeliness and appropriateness of external consultations;
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		<ul style="list-style-type: none"> q. Number of unexpected mortalities and r. Review process for unexpected deaths. <p>2. Clinical outcomes:</p> <ul style="list-style-type: none"> a. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus; b. Hemoglobin A1C levels in individuals diagnosed with Diabetes Mellitus and receiving new generation antipsychotics; c. Percentage of individuals with dyslipidemia with LDL <130; d. Percentage of individuals with diabetes mellitus with LDL <100; e. Number/percentage of individuals with BMI >25; f. Percentage of individuals with hypertension with blood pressure < 140/90; g. Percentage of individuals with diabetes mellitus and blood pressure <130/80; h. Number of individuals hospitalized for bowel dysfunction; i. Individuals with falls resulting in major injury; j. Number of individuals diagnosed with aspiration pneumonia; k. Number of individuals with refractory seizures and l. Number of individuals with status epilepticus <p>Review of the outcome data found that the facility has, in general, maintained positive outcomes of its medical services.</p> <p>The above outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, the compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see Section I.2).</p>
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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to provide data on process and clinical outcomes of medical care.2. Utilize the outcome data regarding medical care to inform the facility's performance improvement efforts and the oversight function of the facility's Quality Council, as indicated (same as in Section I.2).
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Section F: Specific Therapeutic and Rehabilitation Services

8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cindy Blaire, RN 2. Donna Rowe, PHN II 3. Mary Lou Remetir, RN, PHN I 4. Richard Morrissey, MD 5. Sandra Doerner, RN, Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH IC Admission PPD summary data, May-October 2010 2. PSH IC Annual PPD Audit summary data, May-October 2010 3. PSH IC Hepatitis C Audit summary data, May-October 2010 4. PSH IC HIV Positive Audit summary data, May-October 2010 5. PSH IC Immunization Audit summary data, May-October 2010 6. PSH IC Immunization Refusal Audit summary data, May-October 2010 7. PSH IC MRSA Audit summary data, May-October 2010 8. PSH IC Positive PPD Audit summary data, May-October 2010 9. PSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, May-October 2010 10. PSH IC Sexually Transmitted Disease (STD) Audit summary data, May-October 2010 11. Department of Medicine meeting minutes for 5/5/10, 6/2/10, 7/7/10, 8/4/10 and 9/1/10 12. Joint Department of Medicine/Psychiatry meeting minutes dated 5/26/10, 8/25/10 and 10/27/10 13. PSH Enhancement Plan of Action Team Leader meeting minutes dated 7/23/10, 8/20/10, 9/17/10 and 10/15/10, 14. Infection Control Committee meeting minutes dated 5/13/10, 6/17/10, 7/22/10, 8/12/10, 9/9/10 and 10/14/09 15. Quality Council meeting minutes dated 5/4/10, 7/6/10, 8/3/10,

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		<p>9/7/10 and 10/12/10</p> <p>16. PSH Key Indicator data for Infection Control</p> <p>17. Infection Control Activities as Related to Enhancement Plan 2010 document provided by Dr. Morrissey</p> <p>18. Medical records for the following 103 individuals: AA, AH, AKR, ALW, ANA, AND, BM, BT, CCK, CGT, CLM, CLW, CMS, CPC, CW, CYH, DAL, DAR, DCW, DDF, DGA, DHH, DLR, DMC, DMK, DRC, DRP, DUS, DVDA, DVT, DW, EA, EB, EDA, EEE, EIO, EM, FR, GGS, GLG, GOC, GRG, HRG, HRT, JAC, JBW, JCM, JDD, JFL, JG, JIK, JJC, JJS, JMK, JMM, JOD, JRM, JTM, JTS, JU, JUS, JYR, KDM, LEM, LKR, LLM, LTV, MAH, MJB, MLB, MM, NMT, NTC, PC, PEB, PFB, PIP, QDB, QEW, QW, RC, RCB, RDT, REB, RHT, RJS, RPT, SBM, SCG, SFA, SHEL, SIM, SMG, SML, SVH, TCN, TOK, VC, VEL, WGD, WSD, WTD and YH</p>
F.8.a	Each State hospital shall establish an effective infection control program that:	<p>Compliance:</p> <p>Partial related to problematic issues found in WRPs.</p>
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that there is continued collaboration between the Infection Control Department and nursing regarding WRPs addressing infection control issues.</p> <p>Findings: Minutes of the monthly Enhancement Plan Meeting indicated that there was collaboration with the Department of Nursing and the Clinical Administrator's office regarding Infection Control data and barriers to compliance.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p>

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		<p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, PSH assessed its compliance based on an average sample of 63% of individuals admitted to the hospital with a negative PPD in the review months (May-October 2010):</p> <table border="1"> <tr> <td data-bbox="989 488 1087 561">1.</td> <td data-bbox="1087 488 1793 561"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 488 1892 561">100%</td> </tr> <tr> <td data-bbox="989 561 1087 634">2.</td> <td data-bbox="1087 561 1793 634"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 561 1892 634">99%</td> </tr> <tr> <td data-bbox="989 634 1087 708">3.</td> <td data-bbox="1087 634 1793 708"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1793 634 1892 708">99%</td> </tr> <tr> <td data-bbox="989 708 1087 781">4.</td> <td data-bbox="1087 708 1793 781"><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1793 708 1892 781">96%</td> </tr> <tr> <td data-bbox="989 781 1087 854">5.</td> <td data-bbox="1087 781 1793 854"><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 781 1892 854">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	99%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	99%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	96%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	99%
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5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	99%															

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		<p>A review of the records of 20 individuals admitted during the review period (CGT, CLW, DDF, EB, FR, JAC, JDD, JG, JMM, LEM, LTV, NMT, QW, RC, RCB, REB, RJS, SCG, TCN and TOK) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, PSH assessed its compliance based on an average sample of 29% of individuals needing an annual PPD during the review months (May-October 2010):</p> <table border="1" data-bbox="991 636 1887 937"> <tr> <td data-bbox="991 636 1087 711">1.</td> <td data-bbox="1087 636 1793 711"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 786">2.</td> <td data-bbox="1087 711 1793 786"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 711 1887 786">96%</td> </tr> <tr> <td data-bbox="991 786 1087 859">3.</td> <td data-bbox="1087 786 1793 859"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 786 1887 859">100%</td> </tr> <tr> <td data-bbox="991 859 1087 937">4.</td> <td data-bbox="1087 859 1793 937"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 859 1887 937">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. There were no documented cases of PPD conversion following admission to the facility during the review period.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	96%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	99%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 15 individuals requiring an annual PPD during the review period (ANA, AND, DAR, DGA, DMK, DRP, GGS, LEM, MJB, MM, PEB, PIP, QEW, VEL and WSD) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, PSH assessed its compliance based on an average sample of 93% of individuals admitted to the hospital in the review months (May-October 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 782 1890 1421"> <tr> <td data-bbox="991 782 1081 896">1.</td> <td data-bbox="1081 782 1795 896"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1795 782 1890 896">100%</td> </tr> <tr> <td data-bbox="991 896 1081 1010">2.</td> <td data-bbox="1081 896 1795 1010"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1795 896 1890 1010">100%</td> </tr> <tr> <td data-bbox="991 1010 1081 1123">3.</td> <td data-bbox="1081 1010 1795 1123"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1795 1010 1890 1123">100%</td> </tr> <tr> <td data-bbox="991 1123 1081 1205">4.</td> <td data-bbox="1081 1123 1795 1205"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1795 1123 1890 1205">96%</td> </tr> <tr> <td data-bbox="991 1205 1081 1237">5.</td> <td data-bbox="1081 1205 1795 1237"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1795 1205 1890 1237">100%</td> </tr> <tr> <td data-bbox="991 1237 1081 1310">6.</td> <td data-bbox="1081 1237 1795 1310"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1795 1237 1890 1310">100%</td> </tr> <tr> <td data-bbox="991 1310 1081 1421">7.</td> <td data-bbox="1081 1310 1795 1421"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1795 1310 1890 1421">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	96%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%
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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 16 individuals who were admitted Hepatitis C positive during the review period (ALW, BM, DRC, DUS, DVT, EA, GRG, JIK, JU, JUS, JYR, LLM, PFB, SVH, WTD and YH) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and eight had adequate and appropriate objectives and interventions. Problematic issues were found with seven WRPs that included generic interventions that were not appropriate for the individual. For example, interventions included statements that "if" the individual is being treated, "then" side effects of the treatment would be monitored. The WRPTs should know if the individual is receiving treatment or not and modify the WRP accordingly.</p> <p>In addition, discussions with Dr. Morrissey indicated that the list of individuals with Hepatitis C was not accurate and that some individuals on the list did not have Hepatitis C. PSH will review and appropriately modify this list by the next review.</p>
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		<p><u>HIV Positive</u> 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 2010):</p> <table border="1"> <tr> <td data-bbox="991 378 1087 492">1.</td> <td data-bbox="1087 378 1793 492"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 378 1887 492">100%</td> </tr> <tr> <td data-bbox="991 492 1087 605">2.</td> <td data-bbox="1087 492 1793 605"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 492 1887 605">100%</td> </tr> <tr> <td data-bbox="991 605 1087 719">3.</td> <td data-bbox="1087 605 1793 719"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 605 1887 719">100%</td> </tr> <tr> <td data-bbox="991 719 1087 833">4.</td> <td data-bbox="1087 719 1793 833"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 719 1887 833">N/A</td> </tr> <tr> <td data-bbox="991 833 1087 979">5.</td> <td data-bbox="1087 833 1793 979"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 833 1887 979">100%</td> </tr> <tr> <td data-bbox="991 979 1087 1027">6.</td> <td data-bbox="1087 979 1793 1027"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 979 1887 1027">100%</td> </tr> <tr> <td data-bbox="991 1027 1087 1092">7.</td> <td data-bbox="1087 1027 1793 1092"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 1027 1887 1092">100%</td> </tr> <tr> <td data-bbox="991 1092 1087 1133">8.</td> <td data-bbox="1087 1092 1793 1133"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 1092 1887 1133">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%	6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%	7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%	8.	<i>Appropriate interventions are written.</i>	100%
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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of two individuals who were admitted during the review period with HIV (EB and JRM) found that both were in compliance regarding clinic referrals and follow-up, and both WRPs contained appropriate objectives and/or interventions.</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, PSH assessed its compliance based on an average sample of 29% of individuals admitted to the hospital during the review months (May-October 2010):</p> <table border="1" data-bbox="991 894 1887 1232"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1793 971"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 894 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">2.</td> <td data-bbox="1087 971 1793 1047"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 971 1887 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1123">3.</td> <td data-bbox="1087 1047 1793 1123"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 1047 1887 1123">100%</td> </tr> <tr> <td data-bbox="991 1123 1087 1232">4.</td> <td data-bbox="1087 1123 1793 1232"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 1123 1887 1232">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%												
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals (CGT, CLW, DDF, EB, FR, JAC, JDD, JG, JMM, LEM, LTV, NMT, QW, RC, RCB, REB, RJS, SCG, TCN and TOK) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, PSH assessed its compliance based on a 100% sample (108 individuals) of individuals in the hospital who refused to take their immunizations during the review months (May-October 2010):</p> <table border="1" data-bbox="991 1079 1890 1416"> <tr> <td data-bbox="991 1079 1081 1193">1.</td> <td data-bbox="1081 1079 1795 1193"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1795 1079 1890 1193">100%</td> </tr> <tr> <td data-bbox="991 1193 1081 1266">2.</td> <td data-bbox="1081 1193 1795 1266"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1795 1193 1890 1266">91%</td> </tr> <tr> <td data-bbox="991 1266 1081 1339">3.</td> <td data-bbox="1081 1266 1795 1339"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 1266 1890 1339">91%</td> </tr> <tr> <td data-bbox="991 1339 1081 1416">4.</td> <td data-bbox="1081 1339 1795 1416"><i>There are appropriate interventions written for the objective(s) developed for the refusal of</i></td> <td data-bbox="1795 1339 1890 1416">90%</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	91%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	91%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	90%
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		<table border="1"> <tr> <td data-bbox="978 186 1087 228"></td> <td data-bbox="1087 186 1793 228"><i>immunization(s).</i></td> <td data-bbox="1793 186 1923 228"></td> </tr> <tr> <td data-bbox="978 228 1087 342">5.</td> <td data-bbox="1087 228 1793 342"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 228 1923 342">90%</td> </tr> </table>		<i>immunization(s).</i>		5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	90%
	<i>immunization(s).</i>							
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	90%						
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 20 individuals who refused immunizations during the review period (AH, BT, CLM, CW, DAL, DLR, DMC, DW, EEE, EM, JBW, JCM, JJC, JJS, JOD, MAH, QDB, SBM, SHEL and VC) found that all WRPs contained an open Focus 6 and nine contained appropriate objectives and interventions (AH, CW, DLR, DW, JBW, JJC, JOD, SBM and VC). Ten WRPs were not individualized and only contained the template for refusals with no reason for the refusal stated to guide the goals and interventions.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 75% sample (22 individuals) of individuals in the hospital who tested positive for MRSA during the review months (May-October 2010):</p>								

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		<table border="1"> <tr> <td data-bbox="989 228 1087 337">1.</td> <td data-bbox="1087 228 1793 337"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 228 1885 337">100%</td> </tr> <tr> <td data-bbox="989 337 1087 446">2.</td> <td data-bbox="1087 337 1793 446"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 337 1885 446">100%</td> </tr> <tr> <td data-bbox="989 446 1087 527">3.</td> <td data-bbox="1087 446 1793 527"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 446 1885 527">100%</td> </tr> <tr> <td data-bbox="989 527 1087 609">4.</td> <td data-bbox="1087 527 1793 609"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 527 1885 609">100%</td> </tr> <tr> <td data-bbox="989 609 1087 717">5.</td> <td data-bbox="1087 609 1793 717"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1793 609 1885 717">100%</td> </tr> <tr> <td data-bbox="989 717 1087 750">6.</td> <td data-bbox="1087 717 1793 750"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 717 1885 750">100%</td> </tr> <tr> <td data-bbox="989 750 1087 831">7.</td> <td data-bbox="1087 750 1793 831"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 750 1885 831">100%</td> </tr> <tr> <td data-bbox="989 831 1087 906">8.</td> <td data-bbox="1087 831 1793 906"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 831 1885 906">100%</td> </tr> </table> <p data-bbox="989 948 1898 1015">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="989 1057 1480 1123"><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p data-bbox="989 1170 1688 1237"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p data-bbox="989 1284 1570 1351"><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%																								
2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%																								
3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%																								
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5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%																								
6.	<i>A Focus 6 is opened for MRSA.</i>	100%																								
7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%																								
8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%																								

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F.8.a.v: Monitors to ensure that appropriate remedies are achieved
PSH will continue to monitor this requirement.

A review of the records of 19 individuals with MRSA (AKR, CCK, CMS, CYH, DCW, EIO, GLG, HRG, HRT, JFL, JTM, KDM, MLB, NTC, PC, RHT, RPT, SFA and WGD) found that all individuals were placed on contact precautions; all individuals were placed on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.

Positive PPD

Using the DMH IC Positive PPD Audit, PSH assessed its compliance based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (May-October 2010):

1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%
2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	92%
3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%
4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	100%
5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%
6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%
7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%

Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).

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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. There were no documented cases of PPD conversion following admission during the review period. There was one active TB case identified during the review period (item 4) who was admitted from the jail. The individual was isolated and the case reported to the local Health Department as required. The individual was no longer at PSH at the time of the review.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals who had a positive PPD (AJC, CD, CJM, CPR, IG, MBA and SWL) found that all individuals had the required chest x-rays; all records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions. The individual found to have active TB upon admission to the facility was transferred and the medical record was not available for review. However, Dr. Morrissey provided a summary of the case and appropriate actions taken by the facility.</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> Using the 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 2010):</p>
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		<table border="1"> <tr> <td data-bbox="978 181 1087 337">1.</td> <td data-bbox="1087 181 1793 337"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 181 1921 337">100%</td> </tr> <tr> <td data-bbox="978 337 1087 412">2.</td> <td data-bbox="1087 337 1793 412"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 337 1921 412">93%</td> </tr> <tr> <td data-bbox="978 412 1087 487">3.</td> <td data-bbox="1087 412 1793 487"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 412 1921 487">92%</td> </tr> <tr> <td data-bbox="978 487 1087 565">4.</td> <td data-bbox="1087 487 1793 565"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 487 1921 565">92%</td> </tr> </table>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	93%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	92%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	92%	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of nine individuals who refused admitting or annual labs/diagnostics (DHH, DVDA, GOC, JMK, JTS, LKR, LTV, RDT and SML) found that seven refusals were adequately addressed in the WRPs.</p> <p><u>Sexually Transmitted Diseases</u> Using the DMH IC Sexually Transmitted Disease (STD) Audit, PSH assessed its compliance based on an average sample of 100% of</p>
1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%													
2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	93%													
3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	92%													
4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	92%													

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		<p>individuals in the hospital who tested positive for an STD during the review months (May-October 2010):</p> <table border="1"> <tr> <td data-bbox="989 302 1087 378">1.</td> <td data-bbox="1087 302 1793 378"><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td data-bbox="1793 302 1892 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 454">2.</td> <td data-bbox="1087 378 1793 454"><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td data-bbox="1793 378 1892 454">100%</td> </tr> <tr> <td data-bbox="989 454 1087 531">3.</td> <td data-bbox="1087 454 1793 531"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1793 454 1892 531">100%</td> </tr> <tr> <td data-bbox="989 531 1087 607">4.</td> <td data-bbox="1087 531 1793 607"><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td data-bbox="1793 531 1892 607">100%</td> </tr> <tr> <td data-bbox="989 607 1087 683">5.</td> <td data-bbox="1087 607 1793 683"><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td data-bbox="1793 607 1892 683">100%</td> </tr> <tr> <td data-bbox="989 683 1087 760">6.</td> <td data-bbox="1087 683 1793 760"><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td data-bbox="1793 683 1892 760">N/A</td> </tr> <tr> <td data-bbox="989 760 1087 836">7.</td> <td data-bbox="1087 760 1793 836"><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td data-bbox="1793 760 1892 836">100%</td> </tr> <tr> <td data-bbox="989 836 1087 878">8.</td> <td data-bbox="1087 836 1793 878"><i>Appropriate objective(s) are written.</i></td> <td data-bbox="1793 836 1892 878">100%</td> </tr> <tr> <td data-bbox="989 878 1087 920">9.</td> <td data-bbox="1087 878 1793 920"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 878 1892 920">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 6 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. All individuals with a positive STD had the diagnosis upon admission to the facility, thus item 6 was not applicable.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%																											
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%																											
3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%																											
4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%																											
5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%																											
6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A																											
7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																											
8.	<i>Appropriate objective(s) are written.</i>	100%																											
9.	<i>Appropriate interventions are written.</i>	100%																											

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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of six individuals with diagnosed STDs (AA, CPC, EDA, JG, SIM and SMG) found that the appropriate lab work indicating a positive STD was obtained in all cases and the STD was adequately addressed in the WRP in four cases.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRPs are individual-specific and that the reasons for the refusals are included in the WRPs and addressed in the objectives and interventions. 2. Ensure that the facility's data regarding individuals who have Hepatitis C is accurate. 3. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Ensure that Key Indicator data for Infection Control is reviewed by the Infection Control Department and changes in data collection methodology are shared between departments.</p> <p>Findings: PSH's Infection Control Department provides the Standards Compliance Department with the data for the Key Indicator Report, then Standards Compliance provides the data back to Infection Control for review by the</p>

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		<p>Infection Control Committee.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>Findings: PSH's key indicator data accurately reflected the infection control trends from the review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p>

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		<p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>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</p>

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		<p>Medicine and the Enhancement Plan Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, RN, Nurse Auditor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Dental Services Audit summary data, May-October 2010 2. PSH's dental appointment logs 3. Nursing Policy and Clinical Protocol Guidelines 500-A, Refusal of Medical/Dental Appointments and/or Procedures (October 2010) 4. Medical records for the following 155 individuals: AA, AAM, ABR, ABS, ANA, AND, ANP, AOA, AS, ATS, AW, BC, BHY, BJB, BK, BPH, CAM, CG, CGT, CLG, CLW, CMC, CMR, CNO, COR, CRR, DAA, DAH, DAR, DB, DC, DCF, DDF, DDR, DGA, DIM, DLR, DMK, DOH, DRP, DS, EAG, EB, EFM, EGR, EH, EIM, EM, ETM, FEW, FR, GGA, GGS, GHB, GP, GRA, GVA, HAA, IAL, IB, IL, JAC, JAL, JAP, JB, JBG, JD, JDD, JEC, JFE, JG, JGR, JHG, JJ, JJT, JM, JMC, JMM, JMV, JNG, JPD, JRM, JSO, JU, KW, KY, LEB, LEL, LEM, LJH, LOM, LTV, LW, MA, MCR, MH, MHB, MHM, MJA, MJB, MLC, MLM, MM, MMB, MPA, MR, MRA, MRM, MTC, MUR, NCG, NMT, NTB, PEB, PIP, PLD, QEW, QW, RC, RCB, RDT, REB, RH, RJS, RLJ, RLZ, RO, RR, RUR, RUT, RYR, SAL, SCG, SHH, SNK, SP, STW, TCB, TCN, TFH, TMY, TN, TNH, TO, TOK, TTG, TTM, TWW, VEL, VW, VY, WSD, YOR, YR and YZB
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: No new staff have been added to the PSH Dental Department since the</p>

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		<p>last review. However, one Dental Assistant was on medical leave and may be out of the department for one year. The reviewer's findings for this section indicated that the facility has an adequate number of dentists to provide timely and adequate dental care and treatment.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 40% mean sample of individuals scheduled for comprehensive dental exams during the review months (May-October 2010):</p> <table border="1" data-bbox="991 1081 1887 1122"> <tr> <td data-bbox="991 1081 1087 1122">1.a</td> <td data-bbox="1087 1081 1793 1122"><i>Comprehensive dental exam was completed</i></td> <td data-bbox="1793 1081 1887 1122">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 30 individuals (AA, ANP, CGT, CLW, DB, DC, DDF, EB, EH, FR, GHB, JAC, JBG, JDD, JG, JJT, JMM, JMV, LEM, LTV, MRM, NMT, QW, RC, RCB, REB, RJS, SCG, TCN and TOK) found that all individuals received a comprehensive dental exam.</p>	1.a	<i>Comprehensive dental exam was completed</i>	100%
1.a	<i>Comprehensive dental exam was completed</i>	100%			

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		<p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 50% mean sample of individuals who have been in the hospital for 90 days or less during the review period (May-October 2010):</p> <table border="1" data-bbox="991 375 1890 415"> <tr> <td data-bbox="991 375 1087 415">1.b</td> <td data-bbox="1087 375 1793 415"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 375 1890 415">97%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 30 individuals (AA, ANP, CGT, CLW, DB, DC, DDF, EB, EH, FR, GHB, JAC, JBG, JDD, JG, JJT, JMM, JMV, LEM, LTV, MRM, NMT, QW, RC, RCB, REB, RJS, SCG, TCN and TOK) found that all individuals were timely seen for their admission exams.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 20% mean sample of individuals due for annual routine dental examinations during the review months (May-October 2010):</p> <table border="1" data-bbox="991 898 1890 972"> <tr> <td data-bbox="991 898 1087 972">1.c</td> <td data-bbox="1087 898 1793 972"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 898 1890 972">92%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals (ANA, AND, DAR, DGA, DMK, DRP, GGS, LEM, MJB, MM, PEB, PIP, QEW, VEL and WSD) found that all annual exams were timely completed.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (May-October 2010):</p>	1.b	<i>If admission examination date was 90 days or less</i>	97%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	92%
1.b	<i>If admission examination date was 90 days or less</i>	97%						
1.c	<i>Annual date of examination was within anniversary month of admission</i>	92%						

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		<table border="1" data-bbox="991 228 1885 342"> <tr> <td data-bbox="991 228 1087 342">1.d</td> <td data-bbox="1087 228 1793 342"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 228 1885 342">100%</td> </tr> </table> <p data-bbox="991 386 1885 451">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 495 1885 673">A review of the records of 44 individuals (AA, ANA, AND, ANP, CGT, CLW, DAR, DB, DC, DDF, DGA, DMK, DRP, EB, EH, FR, GGS, GHB, JAC, JBG, JDD, JG, JTT, JMM, JMV, LEM, LTV, MJB, MM, MRM, NMT, PEB, PIP, QEW, QW, RC, RCB, REB, RJS, SCG, TCN, TOK, VEL and WSD) found that all individuals were timely seen for follow-up care.</p> <p data-bbox="991 717 1885 863">Using the DMH Dental Services Audit, PSH assessed its compliance based on a 54% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (May-October 2010):</p> <table border="1" data-bbox="991 898 1885 1044"> <tr> <td data-bbox="991 898 1087 1044">1.e</td> <td data-bbox="1087 898 1793 1044"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 898 1885 1044">100%</td> </tr> </table> <p data-bbox="991 1088 1885 1153">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1196 1885 1310">A review of the records of 20 individuals (ABR, BC, CAM, ETM, GP, JD, JHG, JJ, JNG, JPD, KW, LEL, MHB, MLM, MRA, NTB, RDT, RLJ, SNK and TTG) found that all individuals received timely follow-up care.</p> <p data-bbox="991 1354 1885 1414">Current recommendation: Continue to monitor this requirement.</p>	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%						
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%						

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<p>F.9.b.ii</p>	<p>documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 44 individuals (AA, ANA, AND, ANP, CGT, CLW, DAR, DB, DC, DDF, DGA, DMK, DRP, EB, EH, FR, GGS, GHB, JAC, JBG, JDD, JG, JJT, JMM, JMV, LEM, LTV, MJB, MM, MRM, NMT, PEB, PIP, QEW, QW, RC, RCB, REB, RJS, SCG, TCN, TOK, VEL and WSD) found compliance with the documentation requirements in all cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
<p>F.9.b.iii</p>	<p>use of preventive and restorative care whenever possible; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 45% mean sample of individuals due for annual routine dental examinations during the review months (May-October 2010):</p> <table border="1" data-bbox="989 1377 1892 1414"> <tr> <td data-bbox="989 1377 1087 1414">3.a</td> <td data-bbox="1087 1377 1793 1414"><i>Preventive care was provided, including but not limited</i></td> <td data-bbox="1793 1377 1892 1414">100%</td> </tr> </table>	3.a	<i>Preventive care was provided, including but not limited</i>	100%
3.a	<i>Preventive care was provided, including but not limited</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 188 1887 267"> <tr> <td data-bbox="991 188 1087 267"></td> <td data-bbox="1087 188 1793 267"><i>to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 188 1887 267"></td> </tr> </table> <p data-bbox="991 310 1887 378">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 420 1887 565">A review of the records of 30 individuals (AA, AAM, AOA, AW, BHY, COR, CRR, DDR, DIM, EAG, EFM, EGR, FEW, GGA, JEC, JRM, KY, MA, MHM, MJA, MTC, MUR, PLD, RC, RYR, TMY, TWW, VW, VY and YR) found that all individuals were provided preventive care.</p> <p data-bbox="991 607 1887 711">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 2010):</p> <table border="1" data-bbox="991 748 1887 824"> <tr> <td data-bbox="991 748 1087 824">3.c</td> <td data-bbox="1087 748 1793 824"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 748 1887 824">100%</td> </tr> </table> <p data-bbox="991 867 1887 935">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 977 1887 1081">A review of the records of 20 individuals (ATS, BK, CLG, CMC, DS, EIM, GVA, HAA, IL, JAC, JFE, JM, JMC, LOM, MLC, NCG, RUT, STW, TO and TTM) found that all individuals received restorative care.</p> <p data-bbox="991 1123 1887 1192">Current recommendation: Continue to monitor this requirement.</p>		<i>to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>		3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%
	<i>to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>							
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%						
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p data-bbox="991 1240 1887 1269">Current findings on previous recommendation:</p> <p data-bbox="991 1312 1887 1380">Recommendation, June 2010: Continue to monitor this requirement.</p>						

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		<p>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 2010):</p> <table border="1" data-bbox="991 375 1887 636"> <tr> <td data-bbox="991 375 1087 636">4.</td> <td data-bbox="1087 375 1793 636"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></td> <td data-bbox="1793 375 1887 636">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 23 individuals (BJB, CNO, DAH, DOH, IAL, JAL, JAP, JB, JSO, LEB, MCR, MMB, RH, RO, RUR, SAL, SHH, SP, TCB, TN, TNH, YOR and YZB) found that all records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%			
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 66% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months</p>			

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		<p>(May-October 2010), and reported a mean compliance rate of 100%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 44 individuals (AA, ANA, AND, ANP, CGT, CLW, DAR, DB, DC, DDF, DGA, DMK, DRP, EB, EH, FR, GGS, GHB, JAC, JBG, JDD, JG, JJT, JMM, JMV, LEM, LTV, MJB, MM, MRM, NMT, PEB, PIP, QEW, QW, RC, RCB, REB, RJS, SCG, TCN, TOK, VEL and WSD) found that all records were in compliance with the documentation requirements.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010), and reported a mean compliance rate of 96%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility provided the following data on missed appointments:</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="997 228 1885 534"> <thead> <tr> <th>Month</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>May</td> <td>93</td> <td>8</td> <td>2</td> </tr> <tr> <td>June</td> <td>101</td> <td>15</td> <td>0</td> </tr> <tr> <td>July</td> <td>85</td> <td>10</td> <td>1</td> </tr> <tr> <td>August</td> <td>124</td> <td>9</td> <td>1</td> </tr> <tr> <td>Sept.</td> <td>89</td> <td>23</td> <td>1</td> </tr> <tr> <td>Oct.</td> <td>103</td> <td>22</td> <td>0</td> </tr> </tbody> </table> <p data-bbox="989 574 1908 646">A review of PSH's dental logs found that refusals continue to be the major reason for missed appointments; not staff or transportation issues.</p> <p data-bbox="989 686 1591 719">See F.9.e for findings regarding dental refusals.</p> <p data-bbox="989 760 1140 824">Compliance: Substantial.</p> <p data-bbox="989 873 1457 938">Current recommendation: Continue to monitor this requirement.</p>	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	May	93	8	2	June	101	15	0	July	85	10	1	August	124	9	1	Sept.	89	23	1	Oct.	103	22	0
Month	Refused to come to appt	Unit staff procedural problem	Transportation problem																											
May	93	8	2																											
June	101	15	0																											
July	85	10	1																											
August	124	9	1																											
Sept.	89	23	1																											
Oct.	103	22	0																											
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p data-bbox="989 987 1591 1019">Current findings on previous recommendations:</p> <p data-bbox="989 1060 1892 1166">Recommendation 1, June 2010: Continue to develop and implement a system addressing this requirement that includes a system to track this specific population.</p> <p data-bbox="989 1206 1885 1421">Findings: PSH provided Nursing Policy and Clinical Protocol Guidelines 500-A, Refusal of Medical/Dental Appointments and/or Procedures, which describes the procedure the facility implemented in October 2010 addressing refusals. The policy outlined staff's responsibility in the event that an individual refuses a procedure or appointment and the use</p>																												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>of the Daily Appointment Refusal Tracking Log. In addition, the individual's PCP will determine the risk level of the refusal and depending on the risk level assigned, the WRTs will have 14 days to conduct a treatment refusal review for low or moderate risks levels and for refusals deemed high risk, a psychologist will have one week to complete an evaluation with a plan to address the refusal. The required documentation will be included in the IDNs, the WRPs, the Daily Appointment Refusal Tracking Log, Interdisciplinary Patient/Family Health Education Record, and the nurses' weekly progress notes.</p> <p>Recommendation 2, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 53% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (May-October 2010):</p> <table border="1" data-bbox="991 894 1887 1044"> <tr> <td data-bbox="991 894 1087 1044">7.</td> <td data-bbox="1087 894 1793 1044"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 894 1887 1044">83%</td> </tr> </table> <p>The compliance rate was 100% in the previous review period. The facility reported that the drop in compliance was due to auditing only the high risk dental refusals for May through September 2010 (10 individuals), for which compliance was 100%. In October 2010, the documentation for all dental refusals (52 individuals out of 103) was audited as required by the WRP Manual Addendum for Individual Refusal of Appointments and/or Procedures and compliance was found to be 0%. In September 2010, all nursing staff, Unit Supervisors and Primary Care Physicians was trained on the WRP Manual Addendum in attempts to increase future compliance</p>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	83%
7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	83%			

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		<p>rates.</p> <p>A review of the records of 10 individuals whose dental appointment refusals were reported by the facility to be high risk (ABS, AS, CG, DCF, EM, IB, LW, MLM, MR and RLZ) found that five WRPs contained an open focus addressing refusals (AS, CG, DCF, EM and MR). However, the reason for the refusals was included in only one of the WRPs, but the interventions did not address the reason for the refusal. In addition, there was no indication that the refusals were designated as high risk or that Psychology had completed an evaluation regarding the refusals from a review of the documentation contained in the WRPs. These findings do not comport with PSH's data.</p> <p>Also, a review of the records of 12 individuals whose refusals were reported by the facility to be low or moderate risk (BPH, CMR, DAA, DLR, GRA, JGR, JU, LJH, MH, MPA, RR and TFH) found that the dental refusals was noted in only two of the WRPs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to implement the policy/guidelines addressing dental refusals. 2. Develop and implement a system for the Dental Department to track individuals' refusal risk levels. 3. Ensure that WRPs are individualized and include the reasons for the refusals and interventions addressing these reasons. 4. Continue to monitor this requirement.
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Section G: Documentation

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

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress: PSH continues to be committed to decreasing the use of restraint and seclusion and has maintained substantial compliance with all requirements of Section H.</p>
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u> Harry Oreol, Program Director</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Seclusion/Restraint Audit summary data, May-October 2010 2. PSH training rosters 3. DMH Physician Order for Behavioral Seclusion or Restraint form 4. ACNS Emergency Seclusion or Restraint Checklist (10/2010) 5. Medical records of the following 22 individuals: AB, AM, AR, AWB, CLB, DT, GHP, HS, JD, JDG, JGC, J JL, JL, JRA, JSA, KAM, LC, NB, SA, SAM, SC and YNL
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: No incidents of prone restraint, containment or transportation were found during this review.</p> <p>Other findings: A review of Restraint/Seclusion data from the initial review period of November 2006 to April 2007 to the current review period indicated</p>

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

		<p>PSH's overall positive efforts regarding the use of these restrictive measures as follows:</p> <ul style="list-style-type: none"> • The average daily census increased from 1500 to 1505. • Mean duration hours of restraint decreased from 6.51 to 3.66 (44% reduction). • Mean duration hours of seclusion increased from 3.71 to 11.97 (this increase was due to two individuals during the review period). • Mean hours of restraint decreased from 485.22 to 136.45 (72% reduction). • Mean hours of seclusion increased from 4.33 to 15.95 (this increase was due to two individuals during the review period). • Mean number of restraint events decreased from 74.50 to 37.33 (50% reduction). • Mean number of seclusion events increased from 1.17 to 1.33 (this increase was due to two individuals during the review period). • Mean number of individuals in restraint decreased from 33.2 to 24.2 (27% reduction). • Mean number of individuals in seclusion decreased from 1.2 to 0.83 (31% reduction). <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Substantial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive	<p>Current findings on previous recommendation:</p>

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

	<p>measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (a total of seven episodes) of initial seclusion orders each month during the review period (May-October 2010):</p> <table border="1" data-bbox="991 488 1887 712"> <tr> <td data-bbox="991 488 1087 529">1.</td> <td data-bbox="1087 488 1793 529"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1793 488 1887 529">64%</td> </tr> <tr> <td data-bbox="991 529 1087 602">2.</td> <td data-bbox="1087 529 1793 602"><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 529 1887 602">93%</td> </tr> <tr> <td data-bbox="991 602 1087 712">3.</td> <td data-bbox="1087 602 1793 712"><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 602 1887 712">71%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for item 2, while the compliance rates for items 1 and 3 both decreased from 100%.</p> <p>The significant decrease in compliance for some seclusion/restraint indicators was reflective of two individuals (HS and JDG) who demonstrated extremely challenging behaviors and safety concerns. PSH's data for July 2010 were reflective of two episodes of seclusion for the same individual. PSH reported that this individual had demonstrated aggressive behaviors resulting in a serious assault to staff and were beyond the facility's ability to maintain a safe environment for other individuals and staff members. After these incidents, the individual was returned to the Department of Corrections. A review of this case indicated that the facility consistently documented efforts to work with the individual to provide a safe environment for the individual as well as for others. Several detailed progress notes from Nursing, Psychiatry and the Medical Director supported the facility's clinical efforts. PSH's data for August 2010 was reflective of a second individual who also</p>	1.	<i>Seclusion is used in a documented manner.</i>	64%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	93%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	71%
1.	<i>Seclusion is used in a documented manner.</i>	64%									
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	93%									
3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	71%									

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

		<p>demonstrated extremely challenging behaviors that resulted in a planned and very serious assault of a staff member. Similarly, a review of the documentation for this case found detailed and consistent progress notes clinically justifying the actions of the facility in its efforts to maintain a safe environment for the individual, peers, and staff members. The Hospital Administration, including the Medical Director, met with the unit staff and WRPT and provided additional support and training to the unit that resulted in assisting the individual to to regain control. The individual has not assaulted anyone since this administrative intervention, and has not utilized any additional seclusion or restraints, and was able to remain on the unit.</p> <p>Due to the serious safety threats, these two individuals remained in seclusion and/or restraint for extended periods of time and given intensive clinical attention. Although these situations were clearly outliers for PSH, the facility included these episodes in their data for the review period and critically scored the audits for this area, which resulted in a significant decrease in compliance rates. As noted above, these cases were reviewed, and the documentation was found to support the clinical decisions made by the facility. Thus, this reviewer has not included these episodes in the sample reviewed for the subsequent cells in this section when making the findings in each area.</p> <p>A review of five episodes of seclusion for four individuals (AR, AM, DT and SAM) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (a total of 219 episodes) of initial restraint orders each month during the review period (May-October 2010):</p>
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" data-bbox="991 191 1887 418"> <tr> <td data-bbox="991 191 1087 228">1.</td> <td data-bbox="1087 191 1793 228"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 191 1887 228">96%</td> </tr> <tr> <td data-bbox="991 228 1087 305">2.</td> <td data-bbox="1087 228 1793 305"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 228 1887 305">99%</td> </tr> <tr> <td data-bbox="991 305 1087 418">3.</td> <td data-bbox="1087 305 1793 418"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 305 1887 418">99%</td> </tr> </table> <p data-bbox="991 461 1887 529">Comparative data indicated that PSH maintained compliance rates of at least 90% from the previous review period for all items.</p> <p data-bbox="991 571 1894 786">A review of 20 episodes of restraint for 16 individuals (AB, AWB, CLB, GHP, JD, JGC, JJL, JL, JRA, JSA, KAM, LC, NB, SA, SC and YNL) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in 19 episodes and orders that included specific behaviors were found in all episodes.</p> <p data-bbox="991 831 1457 899">Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Restraint is used in a documented manner.</i>	96%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	99%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%
1.	<i>Restraint is used in a documented manner.</i>	96%									
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	99%									
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%									
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;	<p data-bbox="991 945 1579 974">Current findings on previous recommendation:</p> <p data-bbox="991 1016 1457 1084">Recommendation, June 2010: Continue to monitor this requirement.</p> <p data-bbox="991 1127 1894 1269">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 2010):</p> <table border="1" data-bbox="991 1308 1887 1421"> <tr> <td data-bbox="991 1308 1087 1385">4.</td> <td data-bbox="1087 1308 1793 1385"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 1308 1887 1385">100%</td> </tr> <tr> <td data-bbox="991 1385 1087 1421">5.</td> <td data-bbox="1087 1385 1793 1421"><i>The individual has been in seclusion and the staff did</i></td> <td data-bbox="1793 1385 1887 1421">86%</td> </tr> </table>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%	5.	<i>The individual has been in seclusion and the staff did</i>	86%			
4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%									
5.	<i>The individual has been in seclusion and the staff did</i>	86%									

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		<p><i>NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></p>	
		<p>6. <i>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.</i></p>	80%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for item 4; compliance rates for items 5 and 6 decreased from 100% due to outlier episodes.</p> <p>A review of five episodes of seclusion for four individuals (AR, AM, DT and SAM) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (May-October 2010):</p>	
		<p>4. <i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></p>	97%
		<p>5. <i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></p>	95%

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		<p>6. <i>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.</i></p>	<p>99%</p>
<p>H.2.c</p>	<p>are not used as part of a behavioral intervention; and</p>	<p>Comparative data indicated that PSH maintained compliance greater than 90% from the previous review period for all items.</p> <p>A review of 20 episodes of restraint for 16 individuals (AB, AWB, CLB, GHP, JD, JGC, JJL, JL, JRA, JSA, KAM, LC, NB, SA, SC and YNL) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 19 episodes indicated that the individual was released when calm</p> <p>Current recommendation: Continue to monitor this requirement.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: See F.2.c.iv.</p> <p>Findings: See F.2.c.iv.</p> <p>Current recommendations: See F.2.c.iv.</p>	
<p>H.2.d</p>	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p>	

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

		<p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>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 2010), and reported a mean compliance rate of 43%. The compliance rate declined from 100% in the previous review period due to outlier episodes. See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of restraint each month during the review period (May-October 2010), and reported a mean compliance rate of 84%. Comparative data indicated that PSH decreased from 95% in the previous review period due to an outlier episode. See H.2.b for review findings.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.3	<p>Each State hospital shall comply with 42 C.F.R. S 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% mean sample of initial seclusion orders each month during the review period (May-October 2010), and reported a mean compliance rate of 81%. The compliance rate declined from 95% in the previous review period due to an outlier episode.</p> <p>A review of five episodes of seclusion for four individuals (AR, AM, DT</p>

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		<p>and SAM) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in four episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (May-October 2010), and reported a mean compliance rate of 90%. Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 20 episodes of restraint for 16 individuals (AB, AWB, CLB, GHP, JD, JGC, J JL, JL, JRA, JSA, KAM, LC, NB, SA, SC and YNL) found that the RN conducted a timely assessment in 19 episodes and that the individual was timely seen by a psychiatrist in 18 episodes.</p> <p>In general, PSH found that although physicians were completing the face-to-face assessment on the order sheet within one hour of restraint, they were not documenting the assessment in the PPN section of the chart. PSH has implemented a new DMH Physician Order for Seclusion and Restraint, which includes a new requirement that a separate face-to-face note needs to be documented in the PPNs. In alignment with this change, the ACNS Checklist was modified in October 2010 to include an audit item addressing this issue. The checklist is completed in "real time" so that prompts can be offered to the physician as needed.</p> <p>PSH's training rosters indicated that 95% of staff required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p>Compliance: Substantial.</p>
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		<p>Current recommendation: Continue to monitor this requirement.</p>
H.4	<p>Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: PSH continues to use the same procedures to ensure the accuracy of the data for the use of restraints, seclusion, psychiatric PRN medication, or Stat medications. A review of the PRN/Stat medications and seclusion and restraints lists provided found no incidents that were not included in the PSH databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to monitor this requirement.</p> <p>Findings: There have been no incidents of seclusion four or more times in a four-week period during this review period.</p> <p>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 2010), and</p>

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		<p>reported a mean compliance rate of 71%. Compliance declined from 93% in the previous review period due to outlier episodes.</p> <p>A review of the records of five individuals who were in restraint more than three times in 30 days during the review period (JL, JL, KAM, SA and YNL) found that all WRPs included documentation within three business days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendation: See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized	<p>Current findings on previous recommendation:</p>

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

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

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		<p>period.</p> <p>Compliance: Not applicable.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8.b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: See H.8.a.</p> <p>Findings: See H.8.a.</p> <p>Current recommendation: See H.8.a.</p>

Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. SO 263 requires that a staff member be removed when he/she is alleged to have engaged in the physical abuse of an individual. The order also provides a procedure for returning that staff member prior to the conclusion of the investigation. The hospital plans to implement the Special Order. Written directions were sent to supervisory staff explaining procedures for implementing the SO. 2. PSH has undertaken a new procedure for auditing the response to sexual incidents. Standards Compliance staff monitor sexual incidents through SIR review, identifying information in the SIR that states that the individual was counseled, supported, provided teaching, or was otherwise appropriately attended to. Monitors then check the clinical record to ensure there is documentation of the actions reported. 3. The facility plans to hire several retired annuitants as investigators and make some other changes that are expected to improve the timeliness of investigations. 4. PSH has an effective system for identifying individuals in high risk situations, advising WRPTs of this status and providing WRPTs with access to data that they use in reviewing these situations, and has set expectations that risk management committees will respond with recommendations. 5. The facility continues to successfully address incontinence in the WRPs of individuals with the problem. 6. With the resources available, the facility continues to make improvements to the environment. These include replacing vent screens and installing new wardrobes that eliminate the danger posed by chains and padlocks affixed to the old wardrobes.

Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Sherer, Hospital Administrator 2. C. Luna, Executive Director 3. G. Richardson, Standards Compliance Director 4. J. Chencharick, Supervising Special Investigator, Acting 5. J. D'Braunstein, Standards Compliance 6. J. Malancharuvil, Clinical Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 13 investigation reports 2. IRC minutes and task tracking form 3. Selected personnel information related to 14 staff members 4. Signed notification of rights forms for 15 individuals 5. Aggression and A/N/E data provided by the facility 6. All materials related to the deaths of one individual 7. Quality Council minutes 8. Cases reviewed by the Case Review Group 9. Sentinel Event report for 10/4/10 incident
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to apply progressive discipline to staff members who fail to report</p>

Section I: Protection from Harm

		<p>allegations of A/N/E according to DMH policy.</p> <p>Findings: Please see I.1.a.ix.</p> <p>Current recommendation: Continue to be alert in identifying staff members who fail to report allegations of A/N/E.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that verbal abuse investigations are carefully reviewed and any that do not meet standards are redone.</p> <p>Findings: The facility had previously planned to have verbal abuse investigations completed by facility policy rather than by OSI. In compliance with SO 263, the facility has abandoned this plan and OSI will be investigating these allegations.</p> <p>Other findings: The facility has convened a Case Review Group, composed of the Hospital Administrator, Supervising Special Investigator, Director of Standards Compliance and the Nurse Administrator, that meets each Thursday. The group reviews incident reports with Program-level reviews and HPD preliminary investigation reports to determine if the allegation meets the definition of A/N/E. If the allegation meets the definition, it is assigned to OSI for investigation. If it does not meet the definition, it is returned to the Program for follow-up and the incident report is changed so that it is no longer classified as abuse, neglect or exploitation. This group was convened as a method to assist in managing the OSI caseload. The decisions of the Case Review Group are reviewed in the Incident Review Committee meetings.</p>

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		<p>Review of five incidents reviewed by the Case Review Group and determined not to meet the definition of abuse found no issue with the process in four incidents. Specifically:</p> <ul style="list-style-type: none">• One case involved an individual's complaint that he was abused when a janitor asked him to move so that she could clean the floor and passed the dust mop too close to his shoes. Several witnesses attested that the janitor made a reasonable request and no abuse occurred.• An individual complained that she is humiliated when she is required to stand against the wall outside the medication room after receiving medication to ensure that she ingests it. The individual has an order for involuntary medication and a history of cheeking medication. This case was referred back to the Program to identify a better way to ensure the individual takes her medication. The case was determined not to constitute abuse.• In a third case, an individual's ex-spouse alleged he was being raped by female nurses at the facility. The individual denied to several staff and to the HPD that this allegation was true and said that he had no concerns, and that his relationship with unit staff was fine. He said he had not had contact with his ex-spouse and she was no longer a part of his life.• An individual complained that he did not like being touched by staff members searching for contraband. He acknowledged to several staff and to HPD that there was nothing inappropriate in the pat-down, but he just does not like anyone touching him. Since the pat-down was legitimate, this case was determined not to meet the definition of physical abuse. <p>In the fifth case, an individual alleged that he was verbally abused on another unit where he resided for a short period of time. He was not willing or able to characterize the abuse other than to say the named staff member was rude and disrespectful when she spoke with individuals, but he</p>
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Section I: Protection from Harm

		<p>also said the staff member's conduct was not abusive. The preliminary investigation determined that the individual was sexually attracted to the named staff member, acted out inappropriately in her presence, and continued to try to contact her after he was transferred to another unit. There was sufficient evidence to determine that the named staff member did not verbally abuse this individual. Since the allegation was made that the named staff was rude and disrespectful to other individuals on the unit as well, the investigation should have proceeded to ascertain whether other individuals and staff found her conduct unacceptable. This additional investigative work was not done.</p> <p>Current recommendation: Ensure that all aspects of an allegation are covered in the preliminary investigation for cases brought for review by the Case Review Group. Continue the IRC review of all determinations made by the Case Review Group.</p>
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice or apply DMH guidelines for removing named staff, should they prescribe a different procedure.</p> <p>Findings: SO 263 requires that a staff member be removed when he/she is alleged to have engaged in the physical abuse of an individual. The order also provides a procedure for returning that staff member prior to the conclusion of the investigation. Written directions provided to supervisory staff by facility leadership broadened this exception and applied it to the decision of whether to remove the staff member in the first place. When this was pointed out to facility leadership, the directions were rewritten to conform to the Special Order.</p>

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		<p>Other findings: Several of the investigations reports reviewed state that the named staff member was or was not removed and upon whose authority:</p> <ul style="list-style-type: none"> • The named staff member in the physical abuse allegation made by BH on 7/25/10 was removed from contact with individuals, with the approval of the Clinical Administrator. • The named staff member in the physical abuse allegation made by MV on 6/1/10 was reassigned to another unit. • Similarly, the named staff member was reassigned to another unit when CM alleged physical abuse on 7/6/10. • The 5/6/10 allegation of neglect resulted in the reassignment of the named staff member. • In response to the allegation of verbal abuse, the named staff member was reassigned for one day. When the individual acknowledged she was not telling the truth in making the allegation, the staff member was returned to the unit with the approval of the Clinical Administrator. • The staff member was not reassigned following the allegation of physical abuse of SV on 5/20/10, with the approval of the Clinical Administrator. <p>The IRC minutes reflect that as investigations are reviewed, the issue of whether the staff member was reassigned or not reassigned in the manner required by facility policy is discussed.</p> <p>Current recommendation: Continue review of reassignment decisions by the IRC.</p>
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p>

Section I: Protection from Harm

		<p>Findings: As shown below, three of the 14 staff members sampled were not current in attendance at annual A/N/E training.</p> <table border="1" data-bbox="953 337 1822 1062"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter abuse form</th> <th>Most recent A/N training TSI</th> </tr> </thead> <tbody> <tr><td>_D</td><td>10/1/99</td><td>9/20/99</td><td>10/4/07</td><td>12/8/10</td></tr> <tr><td>_H</td><td>9/26/05</td><td>9/8/05</td><td>9/26/05</td><td>11/24/10</td></tr> <tr><td>_T</td><td>5/2/06</td><td>4/5/06</td><td>5/2/06</td><td>11/15/10</td></tr> <tr><td>_O</td><td>4/30/06</td><td>3/23/06</td><td>4/3/06</td><td>9/23/10</td></tr> <tr><td>_H</td><td>10/2/00</td><td>9/5/00</td><td>10/2/00</td><td>9/9/10</td></tr> <tr><td>_H</td><td>8/31/07</td><td>7/30/07</td><td>8/31/07</td><td>8/31/10</td></tr> <tr><td>_A</td><td>10/1/93</td><td>10/9/93</td><td>10/1/93</td><td>8/24/10</td></tr> <tr><td>_G</td><td>3/1/07</td><td>2/5/07</td><td>3/1/07</td><td>5/26/10</td></tr> <tr><td>_M</td><td>2/1/94</td><td>3/1/94</td><td>2/1/94</td><td>5/14/10</td></tr> <tr><td>_S</td><td>7/1/06</td><td>3/10/06</td><td>7/3/06</td><td>3/11/10</td></tr> <tr><td>_B</td><td>6/5/06</td><td>5/11/06</td><td>6/5/06</td><td>2/18/10</td></tr> <tr><td>_S</td><td>3/16/04</td><td>2/19/04</td><td>3/16/04</td><td>4/3/09</td></tr> <tr><td>_D</td><td>3/2/00</td><td>2/8/00</td><td>3/2/00</td><td>12/17/07</td></tr> <tr><td>_R</td><td>7/2/01</td><td>6/22/01</td><td>7/2/01</td><td>7/20/02</td></tr> </tbody> </table> <p>*Only last initials are provided to protect confidentiality.</p> <p>Current recommendation: Address attendance at mandatory training through the current practice of including attendance in performance evaluations.</p>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter abuse form	Most recent A/N training TSI	_D	10/1/99	9/20/99	10/4/07	12/8/10	_H	9/26/05	9/8/05	9/26/05	11/24/10	_T	5/2/06	4/5/06	5/2/06	11/15/10	_O	4/30/06	3/23/06	4/3/06	9/23/10	_H	10/2/00	9/5/00	10/2/00	9/9/10	_H	8/31/07	7/30/07	8/31/07	8/31/10	_A	10/1/93	10/9/93	10/1/93	8/24/10	_G	3/1/07	2/5/07	3/1/07	5/26/10	_M	2/1/94	3/1/94	2/1/94	5/14/10	_S	7/1/06	3/10/06	7/3/06	3/11/10	_B	6/5/06	5/11/06	6/5/06	2/18/10	_S	3/16/04	2/19/04	3/16/04	4/3/09	_D	3/2/00	2/8/00	3/2/00	12/17/07	_R	7/2/01	6/22/01	7/2/01	7/20/02
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_R	7/2/01	6/22/01	7/2/01	7/20/02																																																																													
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect	Current findings on previous recommendation:																																																																															

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	<p>to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Recommendation, June 2010: Continue current practice including monitoring for training attendance at the time of annual evaluation to ensure compliance with the facility's expectation for annual training.</p> <p>Findings: See cell above. A review of the training records of nine staff members whose training records were included as part of an investigation revealed that seven had complete TSI training within the last year. The remaining two staff members, TS and LT, had completed TSI training in September 2009 and August 2009, respectively.</p> <p>Other findings: As shown in the table above, one staff member did not sign the mandatory reporter form on the day of or prior to the date of hire. This staff member was hired in 1999, but did not sign until 2007.</p> <p>Current recommendation: Continue current practice.</p>				
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice, including internal monitoring.</p> <p>Findings: As shown below, three individuals were due to sign the statement of rights form during the month of December. Two other individuals had not signed within the last year and the form for one additional individual could not be located.</p> <table border="1" data-bbox="961 1338 1549 1414"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>DG</td> <td>12/8/10</td> </tr> </tbody> </table>	Individual	Date of most recent signing	DG	12/8/10
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DG	12/8/10					

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		<table border="1"> <tr><td>AG</td><td>12/2/10</td></tr> <tr><td>JM</td><td>11/16/10</td></tr> <tr><td>TJ</td><td>10/18/10</td></tr> <tr><td>JS</td><td>10/7/10</td></tr> <tr><td>BZ</td><td>9/23/10</td></tr> <tr><td>KG</td><td>9/20/10</td></tr> <tr><td>PM</td><td>8/12/10</td></tr> <tr><td>PL</td><td>6/8/10</td></tr> <tr><td>BC</td><td>12/3/09</td></tr> <tr><td>JC</td><td>12/3/09</td></tr> <tr><td>DH</td><td>12/2/09</td></tr> <tr><td>KF</td><td>3/30/09</td></tr> <tr><td>GL</td><td>8/27/08</td></tr> <tr><td>MF</td><td>Cannot locate</td></tr> </table> <p>Current recommendation: Continue to monitor the provision of an opportunity to discuss rights on an annual basis.</p>	AG	12/2/10	JM	11/16/10	TJ	10/18/10	JS	10/7/10	BZ	9/23/10	KG	9/20/10	PM	8/12/10	PL	6/8/10	BC	12/3/09	JC	12/3/09	DH	12/2/09	KF	3/30/09	GL	8/27/08	MF	Cannot locate	
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Rights posters were affixed to the wall in a common area of each unit toured. Several investigations reviewed originated as complaints to the Patients Rights Advocate, suggesting communication with her is effective.</p> <p>Current recommendation: Continue current practice.</p>																													

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<p>I.1.a. viii</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The investigations reviewed did not indicate a need for referral to law enforcement. However, the October 12, 2010 IRC minutes note that an individual was arrested and is now at the California Men's Facility related to an incident of aggression not reviewed during this tour.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.a.ix</p>	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Maintain vigilance in questioning individuals about retaliation for reporting incidents, particularly when an individual withdraws an allegation.</p> <p>Findings: The IRC minutes of July 13, 2010 document the review of an incident (12/30/09) in which an individual alleged that the named staff member tried to convince the individual to retract his statement because it could cost the named staff member his job. Further, the individual alleged that the named staff member threatened to ensure that the individual lost his IT job, if he did not retract the statement. The minutes reflect that psychological abuse was sustained and the named staff member was referred to HR.</p> <p>Other findings: During the investigation of the allegation of verbal and psychological abuse of LJ (7/12/10), a staff member told the investigator that she had heard the named staff member "cuss at patients" in the past but did not report it</p>

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		<p>because the named staff member is intimidating and she feared retaliation for reporting. The investigation report noted "the decision was made [with the Program Director] that they would handle [the named staff member's] intimidation of peers as an internal matter."</p> <p>In the investigation of the allegation of verbal and psychological abuse of SJ (6/29/10) two weeks earlier than the incident described above, a staff member reported, in the context of questioning about abuse reporting, that staff were afraid that they "would not be covered when they need help" if they reported the misdeeds of the same named staff member. Adverse action is pending against this staff member.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue to track all MIRC recommendations through to completion.</p> <p>Findings: An individual in care at PSH, CER, died on 11/6/10 at St. Bernadine's Medical Center after she was found unresponsive at PSH. CER was resting in the side room, and when checked was found to have very faint pulse. CPR was initiated and taken over by EMS. The physician who performed the autopsy said he suspected death was caused by a small bowel infarction and myocardial infarction, but would need the final histology and toxicology</p>

		<p>reports before making a final determination.</p> <p>The Initial MIRC completed on 11/18/10 was a forthright and comprehensive review and identified further reviews, investigations and corrective actions that were warranted. PSH has requested the full autopsy report and asked that a level of the antipsychotic medication (haloperidol) be included in the toxicology report.</p> <p>Other findings: A serious incident determined to be a Sentinel Event occurred on 10/4/10 in which one individual assaulted another individual resulting in major injury to the victim. The aggressor was in jail before he returned to PSH on 9/23/10 with a court order for involuntary administration of medication. He reportedly was assaultive in jail and not taking his medications. He had a deferred Axis I diagnosis and an Axis II diagnosis of Antisocial Personality Disorder.</p> <p>The SE review identified several root causes and contributing factors as well as appropriate risk reduction strategies. The Sentinel Event review did not discuss the central question of whether the aggressor was properly placed at PSH. It noted that the individual was reviewed by the ETRC on 11/19/09, 7/27/10, 8/17/10 and after the incident on 10/12 and 11/22. The timing of several of the ETRC meetings was such that the individual was no longer at PSH and hence no recommendations were made. At the 10/12 ETRC meeting, it was agreed that the aggression was not driven by psychosis and a court report would be expedited. Staff reported that the individual is now in jail.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice in reviewing mortalities. 2. Consider adopting the practice of immediately referring individuals to ETRC who had previously been referred but were not reviewed because they were no longer in the facility as soon as they return to the facility.
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I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Presently OSI is investigating all felonies, as well as allegations of A/N/E. HPD officers complete initial investigations.</p> <p>Current recommendation: Continue the practice of HPD officers completing initial investigations, as they generally are able to go to the scene and obtain statements very soon after the incident is reported.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Several investigations reviewed documented the safeguarding of evidence. For example, the investigator took photos of the small bruise on the arm of the alleged victim in the allegation of physical abuse reported on 6/1/10. The investigation report of the allegation of physical abuse of BH reported on 7/25/10 included photos of the bruise on the alleged victim's hip. Similarly, the investigator took photos of the cosmetics and the register receipt involved in the investigation of the 6/16/10 allegation of exploitation.</p> <p>Current recommendation: Continue current practice.</p>

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I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Maintain a critical review of the accuracy and completeness of investigations as a protection to both individuals and staff members.</p> <p>Findings: As described in several cells below, some of the investigations reviewed did not meet practice standards. The Supervising Special Investigator attributed these problems to the volume of cases, many of which were described as felony assault cases (peer-to-peer). Review of the minutes of the IRC reveal that investigators commonly cite a heavy caseload for lack of timeliness. The minutes also document instances in which the committee has referred investigations back to OSI for additional work:</p> <ul style="list-style-type: none"> • The September 28 IRC minutes state that two cases were referred back to OSI. A verbal abuse case was referred back "for revision of a statement regarding failure to produce other witnesses to corroborate the victim's allegation." Another investigation of verbal abuse was referred back "to clarify findings based on the preponderance of evidence." • The August 10 minutes of the IRC state that an investigation of psychological abuse was returned with the request that the investigator interview other individuals who were in the dining room at the time of the incident. <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide supervision and assistance to investigators to support their ability to complete comprehensive investigations in a timely manner. 2. Consider other options to assist in the investigation of felonies.
I.1.b. iv.1	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being</p>	<p>Current findings on previous recommendation:</p>

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	reported	<p>Recommendation, June 2010: Continue current practice and monitoring of timeliness.</p> <p>Findings: All of the investigations reviewed were begun by HPD within 24 hours of the report of the incident.</p> <p>Current recommendation: Continue current practice.</p>																								
I.1.b. iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Take steps to complete investigations in a timely manner.</p> <p>Findings: The facility reported that during five of the six months in the review period, half or fewer than half of the investigations audited were closed within the 30 business day timeframe set by the EP. In October 2010, only one of the 11 investigations audited by the facility met the timeframe. The findings presented below, showing 10 of the 13 investigations reviewed were not completed within 30 business days, are consistent with the facility's findings.</p> <table border="1" data-bbox="955 1079 1879 1421"> <thead> <tr> <th>Incident type</th> <th>Date incident reported</th> <th>To OSI</th> <th>Date closed</th> </tr> </thead> <tbody> <tr> <td>Neglect allegation</td> <td>5/6/10</td> <td>5/7/10</td> <td>7/22/10</td> </tr> <tr> <td>Allegation of Physical Abuse</td> <td>5/20/10</td> <td>7/14/10</td> <td>8/25/10</td> </tr> <tr> <td>Allegation of physical abuse</td> <td>6/1/10 (reported)</td> <td>6/1/10</td> <td>9/29/10</td> </tr> <tr> <td>Verbal abuse allegation</td> <td>6/7/10</td> <td>6/9/10</td> <td>8/3/10</td> </tr> <tr> <td>Allegation of physical &</td> <td>6/8/10</td> <td>6/24/10</td> <td>9/14/10</td> </tr> </tbody> </table>	Incident type	Date incident reported	To OSI	Date closed	Neglect allegation	5/6/10	5/7/10	7/22/10	Allegation of Physical Abuse	5/20/10	7/14/10	8/25/10	Allegation of physical abuse	6/1/10 (reported)	6/1/10	9/29/10	Verbal abuse allegation	6/7/10	6/9/10	8/3/10	Allegation of physical &	6/8/10	6/24/10	9/14/10
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		verbal abuse			
		Exploitation	6/16/10	6/16/10	10/27/10
		Allegation of verbal & psychological abuse	6/29/10	6/30/10	9/30/10
		Allegation of sexual abuse	7/1/10	7/2/10	7/13/10
		Allegation of physical abuse	7/6/10	7/12/10	8/18/10
		Allegation of verbal & psychological abuse	7/12/10	7/14/10	10/5/10
		Allegation of psychological abuse	7/14/10	7/14/10	11/16/10
		Allegation of physical abuse	7/25/10	7/28/10	9/9/10
		Neglect allegation	7/29/10	7/30/10	8/5/10
		<p>Other findings:</p> <p>The listing of cases closed during the review period and the listing of cases that remained open indicated that three of every four A/N/E cases opened remained open at the time of the tour. Specifically, of the 130 A/N/E cases opened during the review period, approximately 96 remained open at the time of the CM review.</p> <p>The investigation report of the allegation of psychological abuse of HG (7/14/10) states that the investigation was completed within 30 days but was not typed until 11/16/10 "due to the investigator's case backlog."</p> <p>The IRC minutes of August 10, 2010 state that during internal audits, two old investigations were found that had not been completed: an investigation of a 7/7/09 exploitation allegation was found on 5/20/10 and an investigation of verbal abuse reported in April 09 was found in June 2010.</p> <p>See also I.1.b.iv.3(iv).</p>			

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide investigators with the supervision and other resources necessary to enable the timely completion of investigation reports. 2. Conduct internal audits of investigation files on a regular basis to avoid cases being overlooked and not completed.
<p>I.1.b. iv.3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Match the findings of fact to the relevant portion of the SIR incident definition.</p> <p>Findings: The investigation reports reviewed did not evidence implementation of this recommendation. See also I.1.b.iv.4 for the description of an investigation in which there is insufficient findings of fact to support the determination.</p> <p>Recommendation 2, June 2010: As planned, provide training to the OSI investigators on the use of the SIR definitions in making determinations.</p> <p>Findings: The facility reported that in August, all investigators attended a video conference training which did include using the SIR definitions in making determinations.</p> <p>Current recommendation: In making determinations, link findings of fact with the relevant sections of the SIR definition of the incident type under review.</p>
<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The OSI practices in the investigation of CM's allegations of abuse and rights violation failed to meet practice standards and failed to protect the right of individuals to report allegations. CM alleged to the Patients Rights Advocate that she was physically abused by the named staff member and that when she attempted to report the allegation, unit staff told her to "contact the Patients Rights Office because they were not going to report it." The physical abuse allegation was investigated, but not the rights violation. The investigator noted that no incident report was completed when CM made the allegation, but did not identify who should have reported it. Instead, the investigator sent the investigation "to HR for further review re: why an SIR was not written."</p> <p>Current recommendation: Fully investigate all allegations of staff misconduct that constitute violations of individuals' rights.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Document efforts to identify all possible witnesses among both individuals and staff members.</p> <p>Findings: Delays in conducting interviews negatively impacted investigations. The interview of the alleged victim in the 6/8/10 allegation of physical and verbal abuse did not occur until 7/28/10. By that time, the alleged victim was unable to remember the incident and could not recall if there may have been witnesses. The interview of the named staff member occurred on 9/14/10. He was able to describe the incident in detail, but was not asked</p>

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		<p>about the presence of witnesses.</p> <p>The interview of the named staff member in the 6/7/10 allegation of verbal abuse was conducted on 7/28/10. When asked if there were any witnesses, the staff member said he was not sure because it was "too long ago."</p> <p>Similarly, during her interview on 9/28/10, one of the named staff members said she could not recall if there were any witnesses to the 7/12/10 incident in which she was alleged to have laughed at the verbal abuse perpetrated by another staff member.</p> <p>Current recommendation: Conduct interviews as near to the date of the incident as possible to avoid individuals and staff member having lost an accurate memory of the circumstances of the incident.</p>
<p>I.1.b. iv.3(iii)</p>	<p>the name(s) of all alleged victims and perpetrators;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: With the exception of the investigation cited in I.1.b.iv.3(i), all of the investigations reviewed identified the alleged victim and perpetrator.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3(iv)</p>	<p>the names of all persons interviewed during the investigation;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Provide a rationale when an investigator makes a decision to depart from standard investigation practice.</p>

		<p>Findings: As per standard procedure, the initial investigation of neglect of MK on 7/29/10 was conducted by HPD. The officer interviewed the staff member who observed and reported the neglect. The officer was not able to interview the victim because she was sleeping nor was he able to interview the named staff member because she had left the facility at the end of the shift. The case was forwarded to OSI. The OSI did no additional work on the investigation, but only made the determination--sustained. The lack of interviews of the named staff member and the victim, in the absence of extenuating circumstances, is a significant departure from standard practice.</p> <p>Recommendation 2, June 2010: Conduct interviews as proximate to the event as possible.</p> <p>Findings: In the investigations reviewed, a pattern of delayed interviews emerged. This impacted not only the timeliness of the investigations, but also their quality. The table below provides examples of delayed interviews.</p> <table border="1" data-bbox="955 933 1864 1351"> <thead> <tr> <th colspan="4">Date of</th> </tr> <tr> <th>Incident</th> <th>First interviews</th> <th>Subsequent interviews</th> <th>Investigation closure</th> </tr> </thead> <tbody> <tr> <td>5/26/10</td> <td>9/26/10</td> <td>None completed</td> <td>9/29/10</td> </tr> <tr> <td>6/7/10</td> <td>7/28/10</td> <td>8/3/10</td> <td>8/3/10</td> </tr> <tr> <td>6/8/10</td> <td>7/28/10</td> <td>9/14/10</td> <td>9/14/10</td> </tr> <tr> <td>6/16/10</td> <td>6/16, 17/10</td> <td>6/22, 10/21/10</td> <td>10/27/10</td> </tr> <tr> <td>6/29/10</td> <td>7/20/10</td> <td>7/27, 8/12, 9/21, 9/28/10</td> <td>9/30/10</td> </tr> <tr> <td>7/12/10</td> <td>7/27/10</td> <td>8/12, 9/21, 9/28/10</td> <td>10/5/10</td> </tr> </tbody> </table>	Date of				Incident	First interviews	Subsequent interviews	Investigation closure	5/26/10	9/26/10	None completed	9/29/10	6/7/10	7/28/10	8/3/10	8/3/10	6/8/10	7/28/10	9/14/10	9/14/10	6/16/10	6/16, 17/10	6/22, 10/21/10	10/27/10	6/29/10	7/20/10	7/27, 8/12, 9/21, 9/28/10	9/30/10	7/12/10	7/27/10	8/12, 9/21, 9/28/10	10/5/10
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		<p>Current recommendation: Supervise investigations in such a manner that the credibility of the investigation is not jeopardized by interviews conducted remote from the incident.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: When open-ended questions do not provide sufficient information, the investigator should ask specific questions that will solicit the required information or will clarify that the interviewee cannot/will not provide the information.</p> <p>Findings: In the investigation of the verbal abuse of LJ, the investigator used follow-up questions to focus the testimony of a staff member witness by asking if the witness actually heard the named staff member use a specific phrase when addressing LJ. This practice illustrated use of appropriate interviewing techniques.</p> <p>Other findings: The investigation reports reviewed contained a summary of the interviews conducted that included the date of the interview and the names of all present.</p> <p>Current recommendation: Continue current practice of providing a summary of each interview conducted along with the date of the interview and any other relevant information regarding the circumstances of the interview.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<p>Current findings on previous recommendation:</p>

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		<p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: All of the investigation reports reviewed included a listing of documents reviewed.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that the IRC is able to review staff members' incident histories on a frequent periodic basis, since investigations do not include this information.</p> <p>Findings: Some investigation reports reviewed included documentation that the incident history of the named staff member and the alleged victim were reviewed. For example:</p> <ul style="list-style-type: none"> • The investigation report of the 6/8/10 allegation of verbal and physical abuse documents that the alleged victim had one prior abuse complaint and the named staff member had "no sustained or not sustained complaints." • The investigation of the 6/16/10 allegation of exploitation notes that the named staff member had "no prior sustained complaints", but does not provide any information about the incident history of the two alleged victims. • The investigation of the 5/6/10 allegation of neglect provides no information regarding the incident history of either the staff member or the individual in care. • The investigation report for the alleged physical abuse of CM (7/16/10)

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		<p>cites eight prior abuse complaints for CM and no adverse actions for the named staff member.</p> <ul style="list-style-type: none"> The report of the investigation of the allegation of psychological abuse (7/14/10) notes that the alleged victim had made abuse allegations on three prior occasions and there were no prior abuse allegations made against the named staff member. <p>Current recommendations:</p> <ol style="list-style-type: none"> Continue to document the review of the incident history of the named staff member and alleged victim in the investigation reports of A/N/E incidents. Apply the same review criteria to each staff member, i.e. sustained A/N/E cases, adverse actions or prior abuse allegations made against the staff member.
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Link the determination with the relevant portion of the incident definition.</p> <p>Findings: As noted earlier, this recommendation has not yet been implemented.</p> <p>Other findings: The rationale provided for the substantiated determination in the investigation report of the allegation of verbal and psychological abuse of LJ (7/12/10) states "witnesses heard the verbal abuse." However, the investigation report cites only the reporting party (staff member) as having heard the offensive statement. Three other staff members were interviewed; two said they were not present when the alleged incident occurred and the third said he was present and did not hear the verbal abuse. In this investigation, the rationale for the determination does not match the finding of facts.</p>

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		<p>Current recommendation: Ensure that the summary of the findings provided to support the determination is accurate.</p>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Acknowledge conflicting evidence and take additional investigatory steps to reconcile the disparities whenever possible.</p> <p>Findings: The investigation of the physical abuse of MV (reported 6/1/10) failed to deal with irreconcilable evidence. The Program review of the SIR states that the named staff member was not on duty on the day the incident allegedly occurred. The HPO preliminary investigation stated that the staff sign-in sheet for the date of the incident was secured, but it does not state any findings from the review of the sign-in sheet. On 9/26/10, the named staff member was interviewed and made no mention that he was not present during the incident. He denied grabbing the victim's arm and said he believed the victim made the allegation in retaliation because he stopped her from passing a bottle through the courtyard fence to another individual. The OSI investigation appears to have missed the discrepancies entirely.</p> <p>Current recommendation: Acknowledge conflicting evidence and take additional investigatory steps to reconcile the disparities whenever possible.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Exercise vigilance in reviewing and approving investigation reports.</p>

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	<p>coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Findings: One investigation reviewed did not contain the signature of the investigator or the signature of the Supervising Special Investigator indicating approval: the investigation of alleged neglect of SP, closed on 7/22/10.</p> <p>Other findings: The investigation of the allegation of sexual abuse of two female individuals in care by a male staff member was approved by the Supervising Special Investigator, although it was substantially incomplete. Specifically, an individual (not one of the victims) made the allegation that the two named victims were engaged in sexual activity with a male staff member in exchange for cigarettes and a lighter. The reporting party was interviewed on 7/7/10 and again on 7/12/10 where he clearly acknowledged that this was only a rumor and that he had no first-hand knowledge that this activity was actually occurring. He further acknowledged that he asked one of alleged victims, TP, if the rumor was true and she would not confirm it. The investigator took no further actions. He did not interview TP or any other individuals and did not interview any staff. In short, the investigator took no action to investigate the rumor to see if it was founded in fact. Rather, the investigation was closed as not substantiated "based on the preponderance of the evidence because the allegation was not supported by evidence—only rumor."</p> <p>Current recommendation: Provide supervision/mentoring to investigators to ensure that investigations are complete.</p>
I.1.c	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, June 2010: Continue current practice.</p>

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		<p>Findings: According to HR, the named staff member in the investigation reports cited in I.1.a.ix has an adverse action pending for each of the incidents. The staff member named in the allegation of neglect of SP (5/6/10) was dismissed as a result of this and another incident. Similarly, the staff member named in the allegation of neglect of MK (7/29/10) was dismissed as a result of this and other incidents.</p> <p>Other findings: The facility reported that in nearly half of the investigations audited during the review period (36 of 74), neither disciplinary nor programmatic recommendations were necessary. Review of the IRC tracking form found that disciplinary action was reported as completed in response to several incidents: sustained verbal abuse closed on 6/15/10, exploitation and failure to follow standards for staff/patient relationship closed on 10/29/10, selling coffee and tobacco to individuals closed on 10/29/10. The IRC tracking form also noted that in response to one of the incidents cited above, the Hospital Administrator sent a memo on 10/15 to the Clinical Administrator requesting him to remind staff of their responsibility to report any suspicious behavior between individuals and staff to their supervisor.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Substantial.</p>

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I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice including monitoring of trends.</p> <p>Findings: The information in the table below was presented in a written memo dated November 19, 2010 from the Hospital Administrator to the IRC. As shown, there was a sizable increase in the number of allegations of neglect during this review period compared to the prior review period. This may be due to the facility's stand that inattentiveness while providing 1:1 observation constitutes neglect. The memo stated that two units (EB-11 and EB-12) accounted for 12 of the 28 neglect allegations. One individual on EB-11 accounted for six of the eight incidents that occurred there when the individual was able to swallow objects while on 1:1 or 2:1 observation.</p> <table border="1" data-bbox="953 782 1898 1166"> <thead> <tr> <th>Abuse type</th> <th>May-Oct2009</th> <th>Nov 2009-Apr 2010</th> <th>May-Oct 2010</th> </tr> </thead> <tbody> <tr> <td>Physical</td> <td>58</td> <td>41</td> <td>43</td> </tr> <tr> <td>Verbal</td> <td>21</td> <td>30</td> <td>38</td> </tr> <tr> <td>Psychological</td> <td>14</td> <td>15</td> <td>16</td> </tr> <tr> <td>Sexual</td> <td>15</td> <td>5</td> <td>8</td> </tr> <tr> <td>Neglect</td> <td>6</td> <td>11</td> <td>28</td> </tr> <tr> <td>Exploitation</td> <td>0</td> <td>1</td> <td>4</td> </tr> <tr> <td>Other</td> <td>2</td> <td>NA</td> <td>1</td> </tr> <tr> <td>Total</td> <td>116</td> <td>103</td> <td>138</td> </tr> </tbody> </table> <p>As shown below, triggers related to aggression to self increased during the current review period, while aggression to staff decreased.</p> <table border="1" data-bbox="953 1312 1898 1419"> <thead> <tr> <th>Trigger</th> <th>Nov 2009-April 2010</th> <th>May-Oct 2010</th> </tr> </thead> <tbody> <tr> <td>Aggressive act to self resulting in major</td> <td>18</td> <td>22</td> </tr> </tbody> </table>	Abuse type	May-Oct2009	Nov 2009-Apr 2010	May-Oct 2010	Physical	58	41	43	Verbal	21	30	38	Psychological	14	15	16	Sexual	15	5	8	Neglect	6	11	28	Exploitation	0	1	4	Other	2	NA	1	Total	116	103	138	Trigger	Nov 2009-April 2010	May-Oct 2010	Aggressive act to self resulting in major	18	22
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		<table border="1"> <tr> <td>injury</td> <td></td> <td></td> </tr> <tr> <td>Two or more aggressive acts to self in seven days</td> <td>16</td> <td>23</td> </tr> <tr> <td>Four or more aggressive acts to self in 30 days</td> <td>6</td> <td>11</td> </tr> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>26</td> <td>29</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>126</td> <td>71</td> </tr> <tr> <td>Two or more aggressive acts to others in seven days</td> <td>128</td> <td>106</td> </tr> <tr> <td>Four or more aggressive acts to others in 30 days</td> <td>46</td> <td>45</td> </tr> <tr> <td>Suicide attempts</td> <td>11</td> <td>16</td> </tr> </table> <p>Other findings: During the last review period, there were a total of 886 acts of physical aggression toward others. In this review period, the total was 802.</p> <p>Current recommendation: Continue to provide incident, trigger and aggression data to the IRC and the Quality Council and other parties who need it to address the facility's goal of reducing violence.</p>	injury			Two or more aggressive acts to self in seven days	16	23	Four or more aggressive acts to self in 30 days	6	11	Peer-to-peer aggression resulting in major injury	26	29	Aggression to staff resulting in major injury	126	71	Two or more aggressive acts to others in seven days	128	106	Four or more aggressive acts to others in 30 days	46	45	Suicide attempts	11	16
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I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that the IRC is able to review staff members' incident histories on a quarterly basis, since investigations do not address the incident history of staff members.</p> <p>Findings: During the current review period, some investigation reports reviewed</p>																								

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		<p>included documentation of the review of previous adverse actions related to A/N/E incidents for the named staff member. Please see I.1.b.iv.3 (vii).</p> <p>In a memo to the IRC dated August 31, 2010, the Hospital Administrator provided a list of two staff members named in three or more allegations of A/N/E. The memo was also provided to the Clinical Administrator for follow-up with Program Directors as needed.</p> <p>Current recommendation: Ensure that all investigations address the incident history of the named staff member.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Most of the investigations reviewed included mention of the alleged victim's history of A/N/E allegations. The exception was in the investigation of 6/16/10 allegation of exploitation in which the named staff member's A/N/E history was documented, but there was no documentation of the A/N/E history of either of the two individual victims. No review of the A/N/E history of the victim in the 5/6/10 neglect investigation was necessary, since the individual was asleep and did not make the allegation of neglect.</p> <p>Other findings: The August 31 memo from the Hospital Administrator to the IRC identifies five individuals who had been named as victims three or more times in A/N/E incidents in the review period. This information was also shared with the Chief Psychologist for follow-up with Senior Psychologists to address with the WRPTs as needed.</p>

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		<table border="1" data-bbox="961 191 1419 461"> <thead> <tr> <th>Individual</th> <th>Number of incidents listed as victim</th> </tr> </thead> <tbody> <tr> <td>SA</td> <td>7</td> </tr> <tr> <td>AV</td> <td>6</td> </tr> <tr> <td>BH</td> <td>4</td> </tr> <tr> <td>NM</td> <td>3</td> </tr> <tr> <td>SH</td> <td>3</td> </tr> </tbody> </table> <p data-bbox="953 500 1281 568">Current recommendation: Continue current practice.</p>	Individual	Number of incidents listed as victim	SA	7	AV	6	BH	4	NM	3	SH	3
Individual	Number of incidents listed as victim													
SA	7													
AV	6													
BH	4													
NM	3													
SH	3													
I.1.d.iv	location of incident;	<p data-bbox="953 613 1541 646">Current findings on previous recommendation:</p> <p data-bbox="953 688 1331 721">Recommendation, June 2010: Continue to provide incident location data to the IRC and in other appropriate forums.</p> <p data-bbox="953 834 1071 867">Findings: The minutes of the IRC meeting of September 14, 2010 document the Committee's review of incident data presented by the Hospital Administrator. This data related to staff and individuals involved in multiple A/N/E incidents, the increase in number of these incidents and the location of the greatest number of these incidents.</p> <p data-bbox="953 1094 1155 1127">Other findings: The facility provided the following data on physical aggressive acts to others by Program:</p> <table border="1" data-bbox="953 1237 1176 1414"> <tbody> <tr> <td>P1</td> <td>56</td> </tr> <tr> <td>P3</td> <td>108</td> </tr> <tr> <td>P4</td> <td>56</td> </tr> <tr> <td>P5</td> <td>59</td> </tr> </tbody> </table>	P1	56	P3	108	P4	56	P5	59				
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		<table border="1" data-bbox="957 196 1178 326"> <tr> <td>P6</td> <td>284</td> </tr> <tr> <td>P7</td> <td>146</td> </tr> <tr> <td>P8</td> <td>103</td> </tr> </table> <p>The data further revealed that a third of the total of 33 residential units (32, 01, 02, 09, 12, 70, 72, 73, 77, 24, and 25) were the site of more than 30 aggressive peer-to-others acts during the review period. Unit 72 had the highest number at 60.</p> <p>The facility data shows a monthly mean of 27 physical aggressive acts to others at the Mall during the review period. The monthly mean during transition was 15.</p> <p>Current recommendation: Continue current practice of gathering and distributing data.</p>	P6	284	P7	146	P8	103
P6	284							
P7	146							
P8	103							
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice including the review of the data in appropriate forums such as the IRC and the Quality Council.</p> <p>Findings: Please see I.2.c.</p> <p>Other findings: Sunday-Friday the mean number of incidents during the review period was 125, with a range of 118-149. Monday accounted for the highest number, while Saturday was well below the mean with 76 incidents.</p> <p>Current recommendation: Continue current practice of gathering and distributing data.</p>						

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I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Monitor HQ briefs for completeness and timeliness.</p> <p>Findings: The facility reported that during the review period, one staff member has been assigned to follow each HQ reportable incident from initiation of the SIR through to completion of the HQ brief.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice, including presenting this data to the IRC and at other appropriate forums.</p> <p>Findings: The data presented below was prepared by the Hospital Administrator and presented to the IRC in a written memo dated November 19, 2010.</p> <p>Other findings: Outcome data for the review period provided by the facility yielded these findings:</p> <ul style="list-style-type: none"> • Of 43 physical abuse allegations reported, none were sustained. • Of 38 allegations of verbal abuse, two were sustained. • Of 16 allegations of psychological abuse, none were sustained. • Of 8 allegations of sexual abuse, none were sustained. • Of 28 allegations of neglect, two were sustained. • Of 4 allegations of exploitation, two were sustained.

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		<p>Current recommendation: Provide supervision and guidance to investigators so that timeliness issues do not negatively impact the quality of investigations and raise questions about the determinations (outcomes).</p>
I.1.e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: As shown in the table in I.1.a.iv, all of the staff members in the sample had cleared the background criminal history check prior to or in one instance shortly after their date of hire.</p> <p>The facility data indicates that all 90 persons hired during the review period had completed background and fingerprint checks.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Brown, Standards Compliance, Risk Manager 2. C. Luna, Executive Director 3. G. Richardson, Director of Standards Compliance 4. J. Malancharuvil, PhD, Clinical Administrator 5. N. Kulkarni, MD, Assistant Medical Director 6. R. Kornbluh, MD, Acting Chief of Psychiatry 7. T. Rojas, RN, Joint Commission Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Quality Council meeting minutes for the review period 2. Facility Review Committee minutes for the review period 3. Sentinel Event/Root Cause Analysis for JL 4. Report of Assault Reduction Team and Framework for an Action Plan in Response to a Sentinel Event (October 4, 2010) 5. PSH Stop A Algorithm 6. WRPs of three individuals involved in incidents 7. WRPs of 29 individuals on high risk lists 8. WRPs of nine individuals reviewed by FRC 9. WRPs of five individual reaching triggers 10. Trigger data 11. Aggression data <p><u>Observed:</u> ETRC</p>
I.2.a	<p>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</p>	<p>Compliance: Substantial.</p>

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	not be limited to:																						
I.2.a.i	<p>data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Include the review of this type of injury data when discussing initiatives to reduce aggression at the facility.</p> <p>Findings: The Quality Council minutes make one reference to injury data in the July minutes, which note that assaults on staff members in the last year had increased and injuries were more severe.</p> <p>Other findings: Trigger data for the previous and current review period shows an increase in SIB resulting in major injury during the current review period and a decrease in aggression to staff resulting in major injury. Other triggers related to aggression show no substantial change.</p> <table border="1" data-bbox="955 894 1843 1421"> <thead> <tr> <th data-bbox="955 894 1381 971"></th> <th data-bbox="1381 894 1612 971">November 2009 - April 2010</th> <th data-bbox="1612 894 1843 971">May-Oct 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 971 1381 1047">Peer-to-peer aggression resulting in major injury</td> <td data-bbox="1381 971 1612 1047">26</td> <td data-bbox="1612 971 1843 1047">29</td> </tr> <tr> <td data-bbox="955 1047 1381 1123">Aggression to staff resulting in major injury</td> <td data-bbox="1381 1047 1612 1123">126</td> <td data-bbox="1612 1047 1843 1123">71</td> </tr> <tr> <td data-bbox="955 1123 1381 1232">Individuals with two or more aggressive acts to self or others in seven days</td> <td data-bbox="1381 1123 1612 1232">128</td> <td data-bbox="1612 1123 1843 1232">129</td> </tr> <tr> <td data-bbox="955 1232 1381 1341">Individuals with four or more aggressive acts to others in 30 days</td> <td data-bbox="1381 1232 1612 1341">46</td> <td data-bbox="1612 1232 1843 1341">45</td> </tr> <tr> <td data-bbox="955 1341 1381 1386">Homicide threats</td> <td data-bbox="1381 1341 1612 1386">52</td> <td data-bbox="1612 1341 1843 1386">44</td> </tr> <tr> <td data-bbox="955 1386 1381 1421">SIB resulting in major injury</td> <td data-bbox="1381 1386 1612 1421">9</td> <td data-bbox="1612 1386 1843 1421">22</td> </tr> </tbody> </table>		November 2009 - April 2010	May-Oct 2010	Peer-to-peer aggression resulting in major injury	26	29	Aggression to staff resulting in major injury	126	71	Individuals with two or more aggressive acts to self or others in seven days	128	129	Individuals with four or more aggressive acts to others in 30 days	46	45	Homicide threats	52	44	SIB resulting in major injury	9	22
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		<p>The facility provided the following data on aggression that shows a 16% decrease in the total number of peer-to-peer altercations during this review period compared to the previous review period and a 20% decrease in the number of individuals involved in these incidents. (This latter figure is reliable, since the census shows very little fluctuation.)</p> <table border="1" data-bbox="955 451 1885 755"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Total</th> <th colspan="2">Mean</th> </tr> <tr> <th>Previous period</th> <th>Current period</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Peer altercations</td> <td>663</td> <td>559</td> <td>111</td> <td>93</td> </tr> <tr> <td>Individuals involved-victims and aggressors</td> <td>1018</td> <td>818</td> <td>170</td> <td>136</td> </tr> <tr> <td>1:1</td> <td>427</td> <td>453</td> <td>71</td> <td>76</td> </tr> <tr> <td>2:1</td> <td>52</td> <td>68</td> <td>9</td> <td>11</td> </tr> </tbody> </table> <p>Current recommendation: Continue current practice.</p>		Total		Mean		Previous period	Current period	Previous period	Current period	Peer altercations	663	559	111	93	Individuals involved-victims and aggressors	1018	818	170	136	1:1	427	453	71	76	2:1	52	68	9	11
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I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that WRPs consistently address triggers.</p> <p>Findings: Please see I.2.b.i.</p> <p>Review of the trigger history of JL (aggressor in the incident described in I.1.b.i) revealed triggers in July for two or more aggressive acts to others in seven days and in August for 2:1 for behavioral reasons and restraint for four or more hours. As a result of the October 4 incident, JL triggered for peer-to-peer aggression resulting a serious injury, 1:1 observation for behavioral reasons and 2:1 observation for behavioral reasons. This trigger</p>																													

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		<p>information was available for review by the ETRC.</p> <p>Current recommendation: Continue current practice.</p>						
I.2.a. iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: See findings in the cell above and in subsequent cells.</p> <p>Current recommendation: Continue current practice.</p>						
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Partial.</p>						
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The review of the records of five individuals at high risk for medical conditions found that objectives and interventions in the WRPs of four of the individuals address the high risk condition:</p> <table border="1" data-bbox="953 1344 1885 1417"> <thead> <tr> <th>Individual</th> <th>Issue</th> <th>WRP documentation</th> </tr> </thead> <tbody> <tr> <td>JH</td> <td>5/18/10 met</td> <td>WRP dated 9/13/10 discussed fall</td> </tr> </tbody> </table>	Individual	Issue	WRP documentation	JH	5/18/10 met	WRP dated 9/13/10 discussed fall
Individual	Issue	WRP documentation						
JH	5/18/10 met	WRP dated 9/13/10 discussed fall						

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			trigger 7.2 for three or more falls in 30 days	history and listed individual as at high fall risk. Open focus 6.1 for Parkinsonism with fall risk with nursing, OT, and PT objectives and interventions. Individual receiving Physical Therapy services to address underlying factors related to fall risk. Referral for OT and PT assessments done and CIPRTA completed 6/14/10 to assess ambulation, mobility and self care safety, and 24 hour support plan developed to address fall risk and promote independence.
		KDM	8/19/10- met trigger 7.1 for fall with major injury	No open focus to address factors underlying fall risk or prevent future falls found in WRP following incident dated 9/20/10, although incident was discussed. Physical therapy referral made on 9/17/10 and completed 9/30/10 to address complications of arm fracture but not to assess gait and balance (unsteady gait was reported).
		JHB	New diagnosis of diabetes	Database listed new diabetes diagnosis in 5/10, but another data source (email) listed diagnosis on 2/24/10. Diabetes listed as diagnosis and addressed in assessment findings and recommendations in most recent Nutrition Assessment dated 10/28/10, and most recent update dated 7/14/10. The 10/21/10 WRP has DM listed as an Axis III diagnosis; focus 6.11 objectives and intervention in place for diabetes management by nursing, and 6.13 is open

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				<p>for diabetic foot clinic. Individual was previously seen quarterly for nutrition update and is now seen every six months as his acuity level changed when diabetes stabilized.</p>
		TLO	New diagnosis of diabetes	<p>The WRP dated 10/26/10 did not list DM as Axis III diagnosis; focus 6.8 objectives and interventions in place to address diagnosis by nursing and case manager. Dietitian referral made following new diagnosis and assessment completed 8/09/10; individual initially reviewed monthly as an acuity level of 4, but now assessed quarterly.</p>
		RWW	New diagnosis of diabetes	<p>The 10/14/10 WRP listed DM as Axis III diagnosis; focus 6.10 objectives & interventions in place for diabetes management by nursing and diabetes PSR mall group, and 6.12 for maintenance with diabetic foot clinic. Dietitian referral made following new dx. and assessment completed 8/10/10. Individual initially reviewed monthly as acuity level 4, now assessed quarterly; DM addressed in nutrition assessments and recommendations; individual enrolled in DM management group.</p>
		<p>Current recommendation: Continue to address high risk medical issues with appropriate objectives and interventions.</p>		

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I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice of addressing Risk Management committee recommendations in WRPs.</p> <p>Findings: Review of the WRPs of nine individuals reviewed by the Facility Review Committee which resulted in 13 recommendations found that 10 of the 13 recommendations were documented in the WRPs as completed or in process as shown below.</p> <table border="1" data-bbox="953 636 1898 1416"> <thead> <tr> <th data-bbox="953 636 1062 711">Individual</th> <th data-bbox="1062 636 1289 711">RM Committee</th> <th data-bbox="1289 636 1541 711">Recommendation</th> <th data-bbox="1541 636 1898 711">Response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 711 1062 860">JA</td> <td data-bbox="1062 711 1289 860">FRC 5/15/10</td> <td data-bbox="1289 711 1541 860">Continue 1:1, as no BCA available</td> <td data-bbox="1541 711 1898 860">WRP 5/25 addresses 1:1—will consider discontinuation after three months of no assaults.</td> </tr> <tr> <td data-bbox="953 860 1062 971"></td> <td data-bbox="1062 860 1289 971"></td> <td data-bbox="1289 860 1541 971">Refer to SAFE</td> <td data-bbox="1541 860 1898 971">WRP 5/25—will enroll in SAFE WRP 6/24—enrolled.</td> </tr> <tr> <td data-bbox="953 971 1062 1159">LJ</td> <td data-bbox="1062 971 1289 1159">FRC 6/15/10</td> <td data-bbox="1289 971 1541 1159">PBS staff will escort her to SAFE</td> <td data-bbox="1541 971 1898 1159">WRP 7/15—due to infrequent attendance she is no longer on the SAFE roster, but she can go with staff as a guest.</td> </tr> <tr> <td data-bbox="953 1159 1062 1308"></td> <td data-bbox="1062 1159 1289 1308"></td> <td data-bbox="1289 1159 1541 1308">Use various teaching materials for 1370 training</td> <td data-bbox="1541 1159 1898 1308">WRP 7/15—Working on 1370 materials and doing well with coaching.</td> </tr> <tr> <td data-bbox="953 1308 1062 1416">HMN</td> <td data-bbox="1062 1308 1289 1416">FRC 6/29/10</td> <td data-bbox="1289 1308 1541 1416">Reduce his mall groups to less than 20 hrs. to</td> <td data-bbox="1541 1308 1898 1416">WRP 7/16/10—FRC recommendation specifically addressed.</td> </tr> </tbody> </table>				Individual	RM Committee	Recommendation	Response	JA	FRC 5/15/10	Continue 1:1, as no BCA available	WRP 5/25 addresses 1:1—will consider discontinuation after three months of no assaults.			Refer to SAFE	WRP 5/25—will enroll in SAFE WRP 6/24—enrolled.	LJ	FRC 6/15/10	PBS staff will escort her to SAFE	WRP 7/15—due to infrequent attendance she is no longer on the SAFE roster, but she can go with staff as a guest.			Use various teaching materials for 1370 training	WRP 7/15—Working on 1370 materials and doing well with coaching.	HMN	FRC 6/29/10	Reduce his mall groups to less than 20 hrs. to	WRP 7/16/10—FRC recommendation specifically addressed.
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				reduce feelings of being overwhelmed	Mall groups reduced to 15 hours.
		GJD	FRC 9/15/10	Initiate a structural analysis for polydipsia	WRP 10/28/10—Analysis completed on 10/29 and GJD enrolled in a program specifically designed for persons with this condition.
		JD	9/28/10	Consider enrolling in Tai Chi Expand individual psychotherapy to twice a week.	WRP 9/30/10—enrolled in Qi-Gong. Implemented on 9/30/10.
		AB	FRC 9/28/10	Refer to RISE	WRP 11/16—referred and enrolled
		MK	FRC 9/28/10	Update BGs Consider enrolling in Drum Circle Group	WRP 10/14/10—updating in process Group schedule indicates he is not enrolled.
		RLG	FRC 9/16/10	Refer to HH for GED completion Refer to SAFE	WRP 10/28/10—no mention of FRC review or of either recommendation.
		TEM	FRC 5/25/10	Enroll in a substance abuse group	WRP 6/11/10—enrolled in New Hope Substance Recovery
<p>Other findings: Review of three choking incidents found that the individuals were assessed</p>					

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		<p>reviewed, the WRPs documented implementation of the proposed actions in response to triggers. In ten of the eleven (types of) triggers reviewed, implementation was 90% or greater. In response to triggers related to suicide (threats and attempts), implementation of proposed response was substantially lower at 20%.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice of monitoring implementation of proposed responses to triggers. 2. Improve response to triggers related to suicide threats and attempts. 																		
<p>I.2.b. iii</p>	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: Review of the WRPs of 20 individuals at high risk for behavioral conditions found that the WRPs of 16 of the individuals address the behavior placing the individual at high risk as shown below.</p> <table border="1" data-bbox="961 971 1896 1421"> <thead> <tr> <th>Individual</th> <th>High Risk Category</th> <th>Addressed/ Cited in WRP?</th> </tr> </thead> <tbody> <tr> <td>EH</td> <td>SIB</td> <td>12/13/10 WRP focus 1</td> </tr> <tr> <td>RZ</td> <td>SIB</td> <td>11/24/10 WRP No focus 1 and no focus 3 related to SIB</td> </tr> <tr> <td>JT</td> <td>SIB</td> <td>12/3/10 WRP focus 3 addresses suicidal ideation</td> </tr> <tr> <td>RS</td> <td>SIB</td> <td>11/30/10 WRP focus 3</td> </tr> <tr> <td>CG</td> <td>SIB</td> <td>6/9/10 WRP 12/2/10 WRP Neither WRP addresses SIB</td> </tr> </tbody> </table>	Individual	High Risk Category	Addressed/ Cited in WRP?	EH	SIB	12/13/10 WRP focus 1	RZ	SIB	11/24/10 WRP No focus 1 and no focus 3 related to SIB	JT	SIB	12/3/10 WRP focus 3 addresses suicidal ideation	RS	SIB	11/30/10 WRP focus 3	CG	SIB	6/9/10 WRP 12/2/10 WRP Neither WRP addresses SIB
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		GB	Aggression	11/22/10 WRP focus 3.1
		GL	Aggression	11/30/10 WRP focus 3.1
		KG	Aggression	10/12/10 WRP focus 3.1
		JH	Aggression	11/22/10 WRP focus 3
		CP	Aggression	11/15/10 WRP focus 3
		JR	Aggression	12/6/10 WRP focus 3
		EC	Aggression	12/6/10 cites med review and change on 10/4/10
		BZ	Aggression	11/18/10 WRP focus 3
		AR	Aggression	10/29/10 WRP no focus 1, no focus 3
		AM	Aggression	11/12/10 WRP focus 3
		ES	Victimization	12/4/10 WRP Victimization not addressed
		RP	Victimization	12/4/10 WRP focus 2
		JT	Victimization	10/18/10 WRP -no specific mention of victimization but he lives in a "fragile" unit
		MH	Victimization	11/10/10 WRP focus 1, focus 2, focus 3
		SG	Victimization	12/6/10 WRP maintained on 1:1 observation
		<p>Review of individuals on High Risk lists for medical issues yielded the following mixed results.</p>		
		ER	At high risk for metabolic syndrome	WRP finalized 10/06/10 listed high risk for metabolic syndrome under risk factors; individual has been diagnosed with metabolic syndrome (7/10). Open focus 6.6 for hyperlipidemia, 6.9 for hypertension, 6.13 for obesity, 6.14 for DM, and 6.21 for metabolic syndrome. Nutrition Assessment dated 10/12/10 addressed factors underlying risk and individual is reassessed quarterly.
		TLH	At high risk	High risk identified in the present status

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			for metabolic syndrome	of the most recent WRP dated 9/27/10; open focus 6.1 for elevated BMI. Last Nutrition assessment was dated 3/23/10; no current assessments in record, despite the individual being identified as requiring quarterly reassessment.
		LMM	At high risk for metabolic syndrome	High risk identified in the present status of the WRP dated 10/07/10. Open focus 6.1 for elevated BMI, 6.3 for dyslipidemia, 6.5 for impaired fasting blood sugar, and 6.14 for metabolic syndrome with objectives and interventions. Nutrition assessment (8/12/10) addressed factors underlying risk.
		DVL	At high risk for falls	High risk identified in the present status of the most recent WRP (11/22/10. Open focus 6.1 for safety measures related to fall risk aimed at verbalizing safe mobility skills rather than practicing safe mobility, and currently attends a risk prevention group for fall risk. Individual referred for OT assessment to assess fall risk during ADL's during a previous review.
		RSW	At high risk for falls	High risk identified in the present status of the most recent WRP dated 11/10/10; no open focus to address fall risk. OT and PT referral did not appear to be clinically indicated based on review of fall risk assessment results.
		RD	At high risk for falls	High risk not identified in the present status of the most recent WRP 11/22/10 or 10/21/10 WRP. Open focus and objective 6.17.2 for physical therapy treatment for

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		<table border="1" data-bbox="953 190 1906 678"> <tr> <td data-bbox="953 190 1108 342"></td> <td data-bbox="1108 190 1325 342"></td> <td data-bbox="1325 190 1906 342">safe mobility. PT assessments completed 7/29/10 and 9/7/10 to assess mobility and need for safety training following lower extremity fracture on 6/27/10.</td> </tr> <tr> <td data-bbox="953 342 1108 456">MC</td> <td data-bbox="1108 342 1325 456">At high risk for impaired skin integrity</td> <td data-bbox="1325 342 1906 456">High risk not identified in the present status of the most recent WRP dated 11/17/10; no open focus to address risk.</td> </tr> <tr> <td data-bbox="953 456 1108 570">GS</td> <td data-bbox="1108 456 1325 570">At high risk for impaired skin integrity</td> <td data-bbox="1325 456 1906 570">High risk not identified in the present status of the most recent WRP dated 11/9/10; no open focus to address risk.</td> </tr> <tr> <td data-bbox="953 570 1108 678">HMD</td> <td data-bbox="1108 570 1325 678">At high risk for impaired skin integrity</td> <td data-bbox="1325 570 1906 678">High risk identified in the present status of the most recent WRP dated 11/9/10; no open focus to address risk.</td> </tr> </table> <p data-bbox="953 721 1906 1052">Other findings: In preparation for the ETRC/PSSC meeting, the recent incident history of each individual to be reviewed was made available to the committee members. The recent medication regimen, including dosages, and the recent restraint history as well as the current WRP for each individual were also made available. The Chair of the ETRC/PSSC committee agreed that the committee would be well served if each discipline summarized the action they will take at the close of the discussion of each individual and will suggest this to the committee.</p> <p data-bbox="953 1089 1906 1198">Current recommendation: Make any changes to the ETRC meeting structure that will facilitate the identification of recommendations and discipline responsible.</p>			safe mobility. PT assessments completed 7/29/10 and 9/7/10 to assess mobility and need for safety training following lower extremity fracture on 6/27/10.	MC	At high risk for impaired skin integrity	High risk not identified in the present status of the most recent WRP dated 11/17/10; no open focus to address risk.	GS	At high risk for impaired skin integrity	High risk not identified in the present status of the most recent WRP dated 11/9/10; no open focus to address risk.	HMD	At high risk for impaired skin integrity	High risk identified in the present status of the most recent WRP dated 11/9/10; no open focus to address risk.
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I.2.b. iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	<p data-bbox="953 1240 1906 1271">Current findings on previous recommendation:</p> <p data-bbox="953 1312 1906 1421">Recommendation, June 2010: Implement plans to review SIR injury codes once medical evaluations are complete and correct the codes as necessary to protect the integrity of the</p>												

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		<p>trigger data.</p> <p>Findings: The facility reports that it has implemented a system that provides a Standards Compliance staff member for each program who inputs the incident in WaRMSS from a fax copy of the incident, prepares the incident for PRC, attends the PRC review, makes any corrections to WaRMSS based on feedback from PRC and tracks the SIR through the Level 1 and Level 2 reviews and makes changes to WaRMSS if necessary.</p> <p>Other findings: As demonstrated in the cells in this section, PSH has an effective system for identifying individuals in high risk situations, advising WRPTs of this status, providing WRPTs with access to data that they use in reviewing these situations and has set expectations that risk management committees will respond with recommendations.</p> <p>Current recommendation: Continue current practice.</p>
I.2.b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Ensure that WRPs consistently address individuals' high risk status.</p> <p>Findings: See findings in I.2.b.iii.</p> <p>Current recommendation: Continue current practice, including monitoring.</p>
I.2.c	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess</p>	<p>Current findings on previous recommendation:</p>

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	<p>and address the facility's compliance with its identified service goals.</p>	<p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The facility states that data on violence is reviewed at every Quality Council meeting, as decreasing aggressive incidents is a central objective of the administration and the number one concern of the individuals in care. The QC minutes reference some limited aggression data and related factors and several proposals to reduce acts of aggression:</p> <ul style="list-style-type: none"> • May QC minutes note an increase in aggressive acts toward staff, five positive drug screens, and 505 refusals from a total of \approx 2000 appointments in April. • July QC minutes report an increase in assaults on staff and more severe injuries in the last year. The Medical Director provided a document describing proposals for reducing assault. Staff offered proposals and proposals would be solicited from individuals in the next few weeks. • Admission units were reported as having the highest number of assaults. The Admission Unit Pharmacological Algorithm Project was introduced to the Council. It represents the consensus of admission psychiatrists and pharmacological experts for the medication management of aggressive individuals. It was to be presented to the medical staff and admission psychiatrists "for refinement." • The Council was advised that the facility would be taking legal avenues to remove, through the revocation of parole, individuals with 2962 commitments who do not have an Axis I diagnosis and who are assaultive for reasons not related to mental illness. • A decision was announced to establish stricter rules on what is allowed through the sally ports in an effort to reduce aggression related to black market activity. • The August QC minutes stated that the Medical Director had received six proposals from staff for reducing violence. They further state that the facility will provide additional training and mentoring for select
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		<p>staff to work with individuals who have tendencies toward violence in an effort to encourage a more therapeutic approach.</p> <ul style="list-style-type: none">• A committee studied the issue of refusals of medical appointments and found that 50% of the problem is how staff approach the individual and lack of pre-planning re: scheduling.• The September minutes state that the Assault Reduction Taskforce (ART) had reviewed 16 proposal ideas. They will be prioritized by October 1 to allow planning for pilot project implementation. The Council reviewed violence data for the period April-June 2010, which showed that data on four or more aggressive acts to self in 30 days was significantly increased over the mean of the prior 12 months. Other aggression indicators were reported as showing no significant difference from the prior 12 months. It was also reported that peer-to-staff assaults show spikes at 11 PM and 3 AM. <p>The September meeting was the last one held during the review period. The minutes do not state that any of the proposals for reducing violence have yet been enacted, even on a pilot basis.</p> <p>The Clinical Administrator explained his proposal for the creation of a Pilot Project utilizing the concepts of the SAFE program with an emphasis on non-violence. The proposal states there is every reason to think the gains at SAFE (70% reduction of actual incidents for 77 individuals deemed most violent and maintained for at least six months) are generalizable to a specialized unit or program. The proposal rests, in part, on the premise that violence has increased or remained largely unchanged over the last four years. The proposal identifies staff training, milieu development and specialized program development consistent with the EP as crucial elements of success. The Clinical Administrator believes this proposal should be enacted as a pilot project within the next one to two months.</p> <p><u>Other findings:</u> This monitor assessed PSH's quality management/performance improvement</p>
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		<p>function regarding the management of aggression in the facility. In this regard, the monitor reviewed minutes of the Quality Council during this review period and interviewed members of the Quality Council. This assessment found the following:</p> <ol style="list-style-type: none"> 1. PSH initiated several adequate performance improvement processes to address some aspects of violence at the facility from a variety of disciplinary and inter-disciplinary perspectives. These processes included the following: <ol style="list-style-type: none"> a. A study by the Medical Director of trends, patterns and contributing factors in patient-to-staff aggression; b. A report by the Assault Reduction Team and a Framework for an Action Plan in response to a sentinel event (October 4, 2010) and c. Proposal for a Treatment Algorithm of Psychomotor Agitation-Stop A. 2. The facility's Quality Council did not perform some of its essential oversight functions, including review and analysis of facility-wide key indicator data pertaining to aggression and the development and implementation of systemic corrective actions, including recommendations to the DMH for specific systemic interventions, to minimize the risk of violence at the facility. Furthermore, the quality council did not address the processes outlined in #1 above. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. The facility's Quality Council must review and analyze facility-wide trends and patterns, in key indicator data, including but not limited to, aggression at the facility. This review and analysis must include systemic corrective measures both at the facility and DMH levels, as indicated and must address and coordinate other facility-wide interdisciplinary performance improvement activities.
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		2. Move those proposals that are believed most likely to reduce violence and for which resources are available to implementation stage. Keep data to use in evaluating the effectiveness.
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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Ray, Health and Safety Officer 2. B. Sherer, Hospital Administrator 3. D. Booth, Chief of Plant Operations 4. E. Halsell, Chief of Plant Operations, III 5. G. Richardson, Director of Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Health and Safety Environmental Inspection Data 2. WRPs of 13 individuals with the problem of incontinence 3. Clinical records of 10 individuals involved in sexual incidents 4. Sexual incident audits completed by Standards Compliance <p><u>Toured:</u> Units EB-02, EB-09, 35, 71 and 75</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Implement, as planned, Unit 20 accountability procedures for cords and adapters facility-wide.</p> <p>Findings: During the tour, Plant Operations staff pointed out environmental changes being made to make the hospital environment safer. Specifically, old-style metal lockers with padlocks and chains are being replaced with new shorter, wooden wardrobes with sliding doors and slanted tops. The sliding doors remove a ligature point as does the elimination of the chain and padlock. The slanted tops do not permit their use as a platform from which to jump. The new wardrobes are secured to the wall. The facility is installing the</p>

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		<p>new wardrobes at the rate of about 30 each week.</p> <p>Vents in bathrooms and bedrooms are being replaced with a finer mesh vent (3/16") in locations where they are situated over furniture or fixtures that would permit access to the vents.</p> <p>In each of the units visited, working flashlights were available for nighttime rounds and, similarly, a cut-down instrument was locked in a mounted box with a glass door to which all staff members had a key in the nurses' station.</p> <p>In one bedroom toured on Unit 35, there was a tiny space between the vents and the ceiling. The vents were directly above beds. This was pointed out to Plant Operations staff, who said they would ensure it was addressed immediately.</p> <p>A review of the 30-Minute Safety Check sheets on the units toured found that on EB-09 the sheet was four hours behind in completion and on Unit 71 it was completed five hours in advance.</p> <p>Other findings:</p> <p>The facility provided the data below indicating that during the review period, 36 areas of the facility (residential units) occupied by individuals were surveyed. [In any six-month period, all areas of the facility occupied by individuals are reviewed.] Of the 36 individual-occupied areas surveyed, 10 surveys resulted in a report to Program Management that required a response indicating correction of one or more problems. The facility reports that all of these 10 units responded.</p> <p>In addition to the formal environmental reviews, the facility reported that the Health and Safety Environmental Survey Team made 20 random spot checks.</p>
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		<table border="1" data-bbox="961 228 1717 534"> <thead> <tr> <th>2010</th> <th># of areas surveyed</th> <th>#of individual-occupied areas surveyed</th> </tr> </thead> <tbody> <tr> <td>May</td> <td>13</td> <td>2</td> </tr> <tr> <td>June</td> <td>18</td> <td>10</td> </tr> <tr> <td>July</td> <td>19</td> <td>8</td> </tr> <tr> <td>August</td> <td>14</td> <td>8</td> </tr> <tr> <td>September</td> <td>8</td> <td>0</td> </tr> <tr> <td>October</td> <td>13</td> <td>8</td> </tr> </tbody> </table> <p data-bbox="953 578 1104 643">Compliance: Substantial.</p> <p data-bbox="953 688 1755 753">Current recommendation: Clarify expectations regarding the completion of Safety Checks.</p>	2010	# of areas surveyed	#of individual-occupied areas surveyed	May	13	2	June	18	10	July	19	8	August	14	8	September	8	0	October	13	8
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I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p data-bbox="953 802 1541 834">Current findings on previous recommendation:</p> <p data-bbox="953 876 1335 941">Recommendation, June 2010: Continue current practice.</p> <p data-bbox="953 984 1881 1201">Findings: The facility reported that during the review period, 327 work orders were written related to temperature (too hot). Ninety-seven percent were responded to on the same or the next day. A new "chiller" was installed in the N Building and the roof on the 30 Building was replaced during the review period.</p> <p data-bbox="953 1243 1608 1308">Other findings: All units toured were of a comfortable temperature.</p> <p data-bbox="953 1351 1104 1416">Compliance: Substantial.</p>																					

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		<p>Current recommendation: Continue current practice.</p>																																	
I.3.c	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p> <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="955 638 1892 867"> <thead> <tr> <th>Criterion</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>Incontinence status is addressed in Present Status</td> <td>89%</td> </tr> <tr> <td>Incontinence identified in Focus 6</td> <td>100%</td> </tr> <tr> <td>Objectives promote dignity and self-reliance</td> <td>95%</td> </tr> <tr> <td>Individual is clean, dry and odor-free.</td> <td>100%</td> </tr> <tr> <td>Nursing staff explain how they assist the individual</td> <td>100%</td> </tr> </tbody> </table> <p>Other findings: As shown below, the WRPs of the 13 individuals sampled had an open Focus 6 dealing with the problem of incontinence. This data is consistent with the findings of the internal hospital audit presented above.</p> <table border="1" data-bbox="955 1089 1604 1393"> <thead> <tr> <th>Individual</th> <th>WRP Date</th> <th>Focus 6 related to incontinence</th> </tr> </thead> <tbody> <tr> <td>BA</td> <td>12/1</td> <td>6.30</td> </tr> <tr> <td>EH</td> <td>11/19</td> <td>6.10</td> </tr> <tr> <td>FB</td> <td>12/1</td> <td>6.2</td> </tr> <tr> <td>GD</td> <td>11/4</td> <td>6.6</td> </tr> <tr> <td>JAC</td> <td>11/22</td> <td>6.11</td> </tr> <tr> <td>JGC</td> <td>11/22</td> <td>6.23</td> </tr> </tbody> </table>	Criterion	Compliance rate	Incontinence status is addressed in Present Status	89%	Incontinence identified in Focus 6	100%	Objectives promote dignity and self-reliance	95%	Individual is clean, dry and odor-free.	100%	Nursing staff explain how they assist the individual	100%	Individual	WRP Date	Focus 6 related to incontinence	BA	12/1	6.30	EH	11/19	6.10	FB	12/1	6.2	GD	11/4	6.6	JAC	11/22	6.11	JGC	11/22	6.23
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I.3.d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Provide the findings from monitoring of WRPTs' responses to sexual incidents.</p> <p>Findings: Standards Compliance staff monitor sexual incidents through a review of SIR. Information in the SIR that states that the individual was counseled, supported, provided teaching, or was otherwise appropriately attended to is identified. Monitors then check the clinical record to ensure there is documentation of the actions reported.</p> <p>A randomly selected sample of six sexual incidents monitored by SC yielded findings that indicate that some but not all of the interventions presented as completed on the SIR were documented in the individuals' record.</p>																					

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		Incident type Date	Interventions cited in SIR	SC Monitoring findings
		Sex for money 6/24/10	Male counseled about the rules. Female counseled about the rules.	No documentation of incident, denial or counseling in male's chart. Counseling documented.
		Sexual contact between adults 5/13/10	Female educated about safe sex and STDs and WRP updated and educated. Safe sex counseling provided for male.	Female transferred to another hospital. No chart to review. Counseling documented.
		Inappropriate sexual behavior 10/23/10	Medication provided and restraint used. Debriefing completed.	Incident and all interventions documented in WRP.
		Consensual sexual contact 7/20/10	Female assessed by nurse and educated re: policy.	No IDNs for July in female's chart.
		Consensual sexual contact 5/12/10	Male counseled and WRP will be updated. Counseling provided for female.	WRP 5/26/10 notes incident. RN progress note and IDN document counseling.
		Male individual making inappropriate sexual comments to female staff 8/7/10	Treating physician notified. Assessments completed.	PPN completed 8/8/10. Meds assessed and adjusted. Recommendation to refer to PBS for BGs.

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		<p>Other findings: The findings below from the review of the clinical records of ten individuals involved in sexual incidents are consistent with the findings from the facility's internal audit of sexual incidents. Both samples yielded findings that documentation of the incident and the response by staff was not present in some cases.</p> <table border="1" data-bbox="953 488 1885 1422"> <thead> <tr> <th data-bbox="953 488 1171 565">Individual Incident date</th> <th data-bbox="1171 488 1444 565">Incident type</th> <th data-bbox="1444 488 1885 565">Documentation of response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 565 1171 641">EG-victim 8/24/10</td> <td data-bbox="1171 565 1444 641">Sexual contact between adults</td> <td data-bbox="1444 565 1885 641">IDN states, "Given support and psychological comfort by staff.</td> </tr> <tr> <td data-bbox="953 641 1171 748">RR-aggressor 8/24/10</td> <td data-bbox="1171 641 1444 748">Sexual contact between adults</td> <td data-bbox="1444 641 1885 748">IDN states counseling provided for the victim. No mention of counseling or education for RR.</td> </tr> <tr> <td data-bbox="953 748 1171 899">DN 7/22/10</td> <td data-bbox="1171 748 1444 899">Allegation of sexual abuse</td> <td data-bbox="1444 748 1885 899">Note by physician cites an evaluation and interview with a second physician and the need to take the claims seriously.</td> </tr> <tr> <td data-bbox="953 899 1171 1050">DP 6/9/10</td> <td data-bbox="1171 899 1444 1050">Allegation of sexual abuse</td> <td data-bbox="1444 899 1885 1050">IDN states the RN assessed the individual and notified the physician. No mention of counseling.</td> </tr> <tr> <td data-bbox="953 1050 1171 1127">AV 5/28/10</td> <td data-bbox="1171 1050 1444 1127">Inappropriate sexual behavior</td> <td data-bbox="1444 1050 1885 1127">No IDN describing incident or the staff's response.</td> </tr> <tr> <td data-bbox="953 1127 1171 1203">LT 5/28/10</td> <td data-bbox="1171 1127 1444 1203">Inappropriate sexual behavior</td> <td data-bbox="1444 1127 1885 1203">No IDN describing incident or the staff's response.</td> </tr> <tr> <td data-bbox="953 1203 1171 1279">BF 7/26/10</td> <td data-bbox="1171 1203 1444 1279">Inappropriate sexual behavior</td> <td data-bbox="1444 1203 1885 1279">No IDN describing incident or the staff's response.</td> </tr> <tr> <td data-bbox="953 1279 1171 1422">AR 7/26/10</td> <td data-bbox="1171 1279 1444 1422">Inappropriate sexual behavior</td> <td data-bbox="1444 1279 1885 1422">Two IDNs describe the incident. Individual counseled. Educated about STDs and encouraged to use protection.</td> </tr> </tbody> </table>	Individual Incident date	Incident type	Documentation of response	EG-victim 8/24/10	Sexual contact between adults	IDN states, "Given support and psychological comfort by staff.	RR-aggressor 8/24/10	Sexual contact between adults	IDN states counseling provided for the victim. No mention of counseling or education for RR.	DN 7/22/10	Allegation of sexual abuse	Note by physician cites an evaluation and interview with a second physician and the need to take the claims seriously.	DP 6/9/10	Allegation of sexual abuse	IDN states the RN assessed the individual and notified the physician. No mention of counseling.	AV 5/28/10	Inappropriate sexual behavior	No IDN describing incident or the staff's response.	LT 5/28/10	Inappropriate sexual behavior	No IDN describing incident or the staff's response.	BF 7/26/10	Inappropriate sexual behavior	No IDN describing incident or the staff's response.	AR 7/26/10	Inappropriate sexual behavior	Two IDNs describe the incident. Individual counseled. Educated about STDs and encouraged to use protection.
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I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice, including monitoring.</p> <p>Findings: The facility reported the following training completion rates:</p> <table border="1"> <thead> <tr> <th>Course</th> <th>November 2009 - April 2010</th> <th>May-November 2010</th> </tr> </thead> <tbody> <tr> <td>PMAB</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>CPR</td> <td>97%</td> <td>98%</td> </tr> <tr> <td>First Aid</td> <td>97%</td> <td>97%</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>89%</td> <td>93%</td> </tr> <tr> <td>By Choice</td> <td>96%</td> <td>99%</td> </tr> <tr> <td>Patients Rights</td> <td>97%</td> <td>98%</td> </tr> <tr> <td>Neglect and Abuse</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Mean Compliance Rate</td> <td>96%</td> <td>97%</td> </tr> </tbody> </table>			Course	November 2009 - April 2010	May-November 2010	PMAB	99%	99%	CPR	97%	98%	First Aid	97%	97%	Recovery (Chapter 1)	89%	93%	By Choice	96%	99%	Patients Rights	97%	98%	Neglect and Abuse	99%	99%	Mean Compliance Rate	96%	97%
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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Section J: First Amendment and Due Process

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The Council continues to engage in a constructive process that results in the identification of issues that directly affect individuals' quality of life, suggestions for the remediation of these issues and the acknowledgement of successful solutions. 2. The ED recently reported to the Central Council his intent to install a second incoming telephone line for each unit. Individuals believe that this will have a positive effect on the reduction of violence. 3. The Central Council Senate has recently released an impressive seven-page document entitled, "Our Roadmap for 2011." The first section provides a current and historical perspective on the issues that most concern individuals at PSH. The second section is an annotated listing of "those things we see as having made the hospital a better place for which we are grateful and which deserve recognition." The third section presents the four issues the Senate will be working on in 2011.
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.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Clark, Administrative Liaison to Individuals 2. Leaders of the Council Senate <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Roadmap for 2011 2. Results of Individuals' survey 3. Central Council meeting minutes
J		<p>Current findings on previous recommendation:</p> <p>Recommendation, June 2010: Continue current practice.</p>

		<p>Findings:</p> <p>The Central Council meeting minutes reveal the presence of facility leadership at the meetings. Several monthly minutes document the response of the Executive Director to questions put to him at the meeting. In addition, the July minutes note the presence of the Medical Director explaining the Assault Reduction Taskforce. The August minutes describe the presence of the Clinical Administrator recommending that individuals who have consistently earned "full participation" in Mall groups should receive special recognition.</p> <p>The Senate leadership noted progress in the addressing the issues below during the meeting which took place during the tour:</p> <ul style="list-style-type: none"> • Staff members are making an effort to notify individuals about their appointments in a timely manner—not too early so they forget and not too close to the appointment so that it is an unanticipated intrusion. • Staff are effectively encouraging individuals not to refuse their appointments. • Individuals are providing input into the development of a policy governing ward government. • AD 1207 addresses Access to Medical Records and represents attention to input from individuals into the Senate Policy Committee. • The cleanliness and maintenance of the units are much improved. • The efforts of the medical staff to bring specialists to PSH are much appreciated. This facilitates individuals receiving needed care and avoids the unpleasant conditions under which the individuals had to wait for services in outside clinics and hospitals. <p>The Roadmap for 2011 lists the Central Council's Top Nine Concerns:</p> <ul style="list-style-type: none"> • Unchecked violence continues to affect the quality of life at the facility. • Generally poor quality of the Mall groups and in some cases, the Mall
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		<p>facilitators.</p> <ul style="list-style-type: none"> • There is not an active Ward Government on every unit in the facility. • Staff who are not at all recovery-minded. • "Alternate Mall" is an excuse to occupy our time during Mall hours when prescribed treatment cannot be provided for any reason. • With preoccupation with the EP, there is scarcely time or resources left over for our needs. • Telephone system with few or no restrictions. • We believe we ought to be able to spend our own money as and when we choose. • Treatment teams who need to be more sensitive to and respectful of individuals' spiritual needs and interests. <p>The second portion of the Roadmap identifies nearly 30 issues under the heading Heartening Progress. The four issues in the third section of the document that will receive the Senate's attention in 2011 include:</p> <ul style="list-style-type: none"> • Supporting the growth and development of patient government at the unit level; • Completing the Patient Government Administrative Directive; • Convincing lawmakers to support an increase in the \$12.50 monthly allowance for Personal and Incidental Expenses; and • Continuing to be "actively involved in decision-making and all manner of business that impacts our interest, needs and the quality of our lives." <p>Other findings: As shown below, there is little change in the percent of positive responses to selected survey items.</p> <table border="1" data-bbox="961 1263 1896 1414"> <thead> <tr> <th rowspan="2">Item</th> <th colspan="2">Percentage of positive responses</th> </tr> <tr> <th>February 2010</th> <th>August 2010</th> </tr> </thead> <tbody> <tr> <td>Feel safe?</td> <td>67%</td> <td>69%</td> </tr> <tr> <td>Treated with respect?</td> <td>71%</td> <td>72%</td> </tr> </tbody> </table>	Item	Percentage of positive responses		February 2010	August 2010	Feel safe?	67%	69%	Treated with respect?	71%	72%
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Section J: First Amendment and Due Process

		Environment clean?	71%	74%
		Encouraged to be of service to others?	55%	60%
		Staff make sure rules are followed?	74%	75%
		Unit's rules are fair?	70%	70%
		Staff believe I can get better?	75%	77%
		I have input into hospital rules and policies.	53%	57%
		<p>The entire survey is composed of 20 questions; 15 of these questions received positive responses above 65% during the August survey.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>		