

REPORT 3

ATASCADERO STATE HOSPITAL

October 15-19, 2007

**THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA**

NOTE

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

The Court Monitor is not in any way responsible for the services provided at Atascadero 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 Atascadero 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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Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, M.D.) and four expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; Elizabeth Chura, M.S.R.N.; and Monica Sage, OTR/L) visited Atascadero State Hospital (ASH) from October 15 to 19, 2007 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 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 (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

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

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

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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 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.

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)

In general, ASH appears to have made progress in adhering to the above definitions and in achieving more appropriate sampling methodology compared to the previous review. However, in a number of instances, this monitor found inconsistencies and calculation errors in the facility's data and the facility revised some of its calculations and clarified the data during and subsequent to the on-site tour. As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates..

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D. Findings

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

1. Key Indicator Data

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

- a. The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.
- b. ASH is now reporting data on all key indicators. There are an insufficient number of data points of some of the newly collected indicators to assess trends at this time (and data is typically not graphed and presented in the Appendix when only two data points were available), but by the next tour in April 2008, some analysis and insight should be feasible (with the exception of the data series for which the population temporarily changed, as noted below).
- c. ASH has now provided 16 months of key indicator data (June 2006 through September 2007) on some data series. This provides sufficient data to begin identifying patterns and outlier results more reliably.
- d. However, the facility has temporarily changed the population on which it measures some items (listed below) from hospital-wide to 20 percent of the population. Combining data based on two differently sized populations precludes meaningful trend analysis so graphs have not been provided in the Appendix for the following series:
 - i) Medication variances
 - ii) Bowel dysfunction
 - iii) Diabetes mellitus and related sub-categories
 - iv) Dysphagia
 - v) Fractures
 - vi) Osteoporosis
 - vii) Polydipsia
 - viii) Seizure disorder and related sub-categories
 - ix) PRN and Stat medications
- e. ASH's census is declining—it appears that the facility is serving more than 20% fewer individuals than at this time a year ago.
- f. The data provided as of September 2007 suggests positive trends that include:
 - i. The number of external hospitalizations has generally declined.
 - ii. The use of seclusion and restraint as interventions has declined.

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- g. At the same time, the data reveals patterns that should be noted, investigated and explained by the facility:
 - i. August saw a spike in individuals reporting abuse/neglect/exploitation that should be investigated and fully explained.
 - ii. The number of overweight/obese individuals is not declining at the same rate as the number of individuals served (patient days divided by days in the month). Is this due to better counting/tracking by the facility, to a shift in the characteristics of the patient population due to discharge, or other factors?
 - iii. Use of combined pharmacotherapy has risen noticeably over the past three months. This is not necessarily unjustified, but needs to be monitored and explained.
- h. The absence of street drug use at the facility is theoretically possible but should be evaluated and reconfirmed.

2. Monitoring, mentoring and self-evaluation

In general, ASH has made progress in self-monitoring, data gathering, aggregation and analysis since the previous assessment. The following observations are relevant to this area.

- a. Despite persistent and serious staffing shortages in some core clinical disciplines, ASH has initiated and put in place structures required for the processes of self-monitoring, mentoring and evaluation.
- b. ASH began implementation of all Wellness and Recovery Planning monitoring instruments that were developed by the California Department of Mental Health (DMH). As mentioned in the previous report, these tools were streamlined and standardized for use across hospitals and are well-aligned with EP requirements regarding the process and content of the Wellness and Recovery Plan (WRP).
- c. In several key areas in which no data were presented during the previous review, the facility initiated self-monitoring based on adequate tools and, in some cases (e.g. psychiatric assessments and medication management), the facility took appropriate initiatives in refining the monitoring process.
- d. The DMH has yet to finalize current efforts to streamline and standardize the tools used for disciplinary assessments and services. The current tools that are used to assess psychiatric assessments and reassessments, inter-unit transfer assessments, court assessments, nutrition assessments, high-risk medication uses (PRN medications, benzodiazepines, and anticholinergics) and some aspects of medical service delivery are generally aligned with requirements of the EP. However, not all the tools address the quality of services or include operational definitions and instructions that can standardize the use within and across the facilities.
- e. The facility's self-assessment report has, in general, improved compared to the previous review. However, there continues to be some difficulty in providing specific information in response to EP requirements and recommendations of the court monitor.

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- f. ASH has improved the sampling methodology during this review period, including a review of up to a 100% sample in some areas (e.g. court assessments). However, more work is needed to ensure at least a 20% sample of appropriately defined target populations.
- g. ASH reported mean compliance rates of 0% with many provisions of the EP. In many cases, the rates are calculated by evaluating compliance with multiple nested requirements. The facilities should conduct data analysis to assess specific areas of low compliance and identify and resolve obstacles to compliance.
- h. ASH has yet to ensure that the process of self-monitoring has a strong mentoring component and that the facility has sufficient complement of senior clinicians who can serve as mentors to the WRPTs.
- i. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each hospital. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
- j. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a) Structure of current and planned implementation:

i. ASH has made progress in the following areas

- 1) New administrative and clinical leadership team, including an Executive Director, Medical Director, Hospital Administrator, Clinical Administrator, Acting Chief Psychiatrist and Acting Director of Standards Compliance;
- 2) Several initiatives to prioritize implementation of the EP in one program (IV), serving as a model for planned facility-wide implementation;
- 3) Recent recruitment of needed psychiatrists on an emergency basis;
- 4) Format and quality of court assessments for individuals admitted under PC 1370;
- 5) New leadership of the Positive Behavior Support (PBS) team;
- 6) New formats for the admission and integrated psychiatric assessments and the integrated psychological assessment;
- 7) Timeliness of the psychological assessments and social work assessments (within seven days);
- 8) New structure for supervision of rehabilitation services;
- 9) Quality of nutritional assessments, despite staffing shortages;
- 10) Decreased use of seclusion/restraints;
- 11) Infection control monitoring tools that fit the system's needs;
- 12) Overall functions of the central PSR Mall; and

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- 13) Number of medication education groups on the Mall.
- ii. ASH needs to finalize a permanent position of Chief of Psychiatry. This position must have authority and responsibility regarding the clinical assignments of staff psychiatrists, the assignment of senior psychiatrists (yet to be recruited) to various mentoring and monitoring functions, the supervision of all psychiatrists and the responsibility for compliance with the EP in the areas of psychiatric assessments/services and leadership of the WRPTs.
 - iii. ASH has to remove several potential suicide hazards in its environment of care and to improve the process of abuse neglect investigations. The facility appears to have an adequate plan to address these issues.
- b) Function of current and planned implementation:
- i. ASH has yet to improve the process and content of Wellness and Recovery Planning. There is a strong need for facility mentors who can work with the facility consultant and are assigned to each program to provide ongoing feedback to the WRPTs. Discipline seniors should be trained to not only monitor, but also to mentor clinicians in their areas. The team meetings attended by the monitor showed that the facility has not made sufficient progress in integrating the principles and practice guidance in its WRP Manual into the day-to-day operations of the WRPTs.
 - ii. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
 - iii. ASH has yet to continue and make further progress in implementing a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
 - iv. A well-functioning PSR mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
 - 1) **Mall hours:** The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

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

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

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

- 2) **Progress notes:** None of the monitored facilities has a system that requires providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no data on which to base the revisions of an individual's objectives and interventions. This is unacceptable and not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies no later than October 1, 2007.
- 3) **Cognitive screening for PSR Mall groups:** PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that no later than January 1, 2008, cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

- 4) **PSR Mall, Vocational Services and Central Program Services (CPS):** The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that no later than January 1, 2008, there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
- 5) **Virtual PSR Mall:** Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that

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opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. This service should be available to this group of individuals no later than January 1, 2008.

4. Discharge

As of the date of the Court Monitor's tour, 30 individuals at ASH had been referred for discharge but remained in the facility. Fifteen of those individuals were awaiting a CONREP placement in the community. Currently there are insufficient spaces available statewide for CONREP community placement. It is severely disheartening for individuals who have worked diligently to be ready for discharge to find that they cannot be discharged because of a statewide shortage of CONREP placements. This situation should be resolved as expeditiously as possible.

5. Staffing

The ASH staffing table below shows the staffing pattern at the hospital as of September 25, 2007. These data were provided by the facility. The table shows that there is a major shortage of staff in several key areas: staff and senior psychiatrists, staff and senior psychologists, pharmacy personnel, social workers and rehabilitation therapists. Staffing shortages are also a concern for registered nurses, psychiatric technicians and dietetic personnel.

Atascadero State Hospital Vacancy Totals as of 9/25/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Assistant Director of Dietetics	3.00	3.00	0.00	0.00%
Audiologist I	0.00	0.00	0.00	0.00%
Chief Dentist, CF	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon, CF	1.00	1.00	0.00	0.00%
Chief Central Program Services	1.00	1.00	0.00	0.00%
Chief of Police Services & Security	1.00	1.00	0.00	0.00%

Atascadero State Hospital Vacancy Totals as of 9/25/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Clinical Dietician	11.40	5.80	5.60	49.12%
Clinical Laboratory Technologist (Safety)	4.50	2.50	2.00	44.44%
Clinical Social Worker (Health Facility/S)	71.70	45.00	26.70	37.24%
Communications Supervisor	1.00	1.00	0.00	0.00%
Communications Operator	9.00	8.00	1.00	11.11%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant D/MH & DS	3.00	3.00	0.00	0.00%
Dentist, D/MH & DS	1.00	0.00	1.00	100.00%
Dietetic Technician (Safety)	3.00	2.10	0.90	30.00%
E.E.G. Technician (Psych Tech)	1.00	1.00	0.00	0.00%
Food Service Technician I	58.50	51.50	7.00	11.97%
Food Service Technician II	33.00	25.00	8.00	24.24%
Hospital Police Officers	113.80	96.00	17.80	15.64%
Hospital Police Sergeant	15.00	13.00	2.00	13.33%
Hospital Police Lieutenant	4.00	4.00	0.00	0.00%
Hospital Worker	0.00	0.00	0.00	0.00%
Health Record Technician	7.30	7.00	0.30	4.11%
Health Record Technician II (Spec)	3.00	3.00	0.00	0.00%
Health Record Technician II (Supv)	1.00	1.00	0.00	0.00%
Health Record Technician III	1.00	0.00	1.00	100.00%
Health Services Specialist (Safety)	26.00	26.00	0.00	0.00%

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Atascadero State Hospital Vacancy Totals as of 9/25/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Institutional Artist Facilitator	1.00	1.00	0.00	0.00%
Licensed Vocational Nurse (Safety)	2.00	1.00	1.00	50.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	12.00	9.00	3.00	25.00%
Nurse Instructor	9.00	8.00	1.00	11.11%
Nurse Practitioner (Safety)	20.00	18.00	2.00	10.00%
Nursing Coordinator (Safety)	7.00	8.00	-1.00	-14.29%
Office Technician	57.30	38.30	19.00	33.16%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I, D/MH & DS	14.00	8.60	5.40	38.57%
Pharmacist II	2.00	1.00	1.00	50.00%
Pharmacy Services Manager	1.00	0.00	1.00	100.00%
Pharmacy Technician, D/MH & DS	15.00	13.50	1.50	10.00%
Physician & Surgeon (Safety)	12.00	11.00	1.00	8.33%
Podiatrist D/MH & DS	0.00	0.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician (Safety)	40.00	40.00	0.00	0.00%
Pre-Registered Clinical Dietician	0.00	0.00	0.00	0.00%
Pre-Registered Nurse (D/MH & DS)	0.00	0.00	0.00	0.00%
Program Assistant (Mental Dis. - Safety)	8.00	7.00	1.00	0.00%
Program Consultant (Psychology)	0.00	0.00	0.00	0.00%
Program Consultant (Rehab. Therapy)	1.00	1.00	0.00	0.00%

Atascadero State Hospital Vacancy Totals as of 9/25/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Program Consultant (Social Work)	1.00	0.00	1.00	0.00%
Program Director (Mental Dis. - Safety)	7.00	7.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician (Safety)	496.60	436.30	60.30	12.14%
Psychiatric Technician Trainee (Safety)	75.00	32.30	42.70	56.93%
Psychiatric Technician Assistant (Safety)	14.00	14.00	0.00	0.00%
Psychiatric Technician Instructor	2.00	2.00	0.00	0.00%
Psychologist-HF, Clinical (Safety)	47.30	30.50	16.80	35.52%
Public Health Nurse I (D/MH & DS)	1.00	1.00	0.00	0.00%
Public Health Nurse II	2.00	2.00	0.00	0.00%
Radiologic Technologist	0.00	0.00	0.00	0.00%
Registered Nurse (Safety)	298.10	192.20	105.90	35.52%
Rehabilitation Therapist S.F., Art-Safety	1.00	1.00	0.00	0.00%
Rehabilitation Therapist, S.F., Dance-Safety	2.00	2.00	0.00	0.00%
Rehabilitation Therapist, S.F., Music-Safety	14.00	10.00	4.00	28.57%
Rehabilitation Therapist, S.F., Occup-Safety	1.00	0.00	1.00	100.00%
Rehabilitation Therapist, S.F., Rec.-Safety	49.80	21.50	28.30	56.83%
Senior Psychiatrist (Specialist)	4.60	2.00	2.60	56.52%
Senior Psychiatrist, CF, (Supervisor)	2.00	2.00	0.00	0.00%
Senior Psychologist, H.F. (Specialist)	4.00	3.00	1.00	25.00%
Senior Psychologist, C.F. (Supervisor)	6.00	3.00	3.00	50.00%
Senior Psychiatric Technician (Safety)	109.00	90.00	19.00	17.43%

Atascadero State Hospital Vacancy Totals as of 9/25/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Sr. Radiologic Technologist (Specialist-Safety)	1.00	1.00	0.00	0.00%
Senior Special Investigator I, D/MH & DS	1.00	0.00	1.00	100.00%
Senior Vocational Rehab Counselor	2.00	1.00	1.00	50.00%
Special Investigator I, D/MH & DS	2.00	0.00	2.00	100.00%
Speech Pathologist I, D/MH & DS	0.00	0.00	0.00	0.00%
Staff Psychiatrist (Safety)	76.90	18.50	58.40	75.94%
Supervising Registered Nurse (Safety)	2.00	2.00	0.00	0.00%
Teacher-Adult Educ.	29.90	8.00	21.90	73.24%
Teaching Assistant	7.00	6.00	1.00	14.29%
Unit Supervisor (Safety)	33.00	32.00	1.00	3.03%
Vocational Services Instructor	4.00	4.00	0.00	0.00%
Vocational Rehabilitation Counselor	0.00	0.00	0.00	0.00%

As in other DMH facilities, the staffing shortage at ASH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. As mentioned in earlier reports, the staffing shortage at the DMH facilities has reached a level that may threaten the safety and security of individuals and staff. The DMH and the State have recently acted to increase salaries within five percent of parity with the CDCR in the classifications of psychiatry, psychology, social work, rehabilitation therapy and psychiatric technicians. These actions have the potential of resolving this crisis and reversing the negative impact on its mental health institutions. The state has yet to address the disparity in the salaries of pharmacists.

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be

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added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

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

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

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

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.

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F. Next Steps

1. The Court Monitor's team is scheduled to tour Patton State Hospital November 26-30, 2007 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital April 21-25, 2008.
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. ASH has a new administrative and clinical leadership structure that has resulted in a positive attitudinal shift, at both leadership and staff levels, towards full implementation of EP requirements. 2. ASH has implemented the full schedule of WRPs and associated WRP monitoring activities, in Program IV with plans for implementation roll-out in all other programs to be completed by June 2008. 3. ASH has responded to findings regarding insufficient WRP training of the WRPTs with a plan to strengthen training and to provide mentoring to the teams on an ongoing basis. 4. ASH has conducted monitoring of WRP processes and content based on adequate sample size (Program IV).
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. Robert Knapp, MD, Medical Director 2. Jean Dansereau, MD, Acting Senior Supervising Psychiatrist 3. Donna Nelson, Acting Director, Standards Compliance 4. Martha Staib, Treatment Enhancement Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. WRP Knowledge Assessment Test 2. WRP Post-Test Status Report 3. Objectives and lesson plan for Phase I WRP Training 4. Wellness & Recovery Training (Phase I) Attendance Report

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		<ol style="list-style-type: none"> 5. AD #414, Wellness and Recovery Planning, effective May 1, 2007 6. Revised draft of AD #414 (October 2007) 7. AD #507 (March 2007) 8. Department of Psychiatry Operating Manual 9. Psychiatry Team Leadership Monitoring Form 10. WRP Training Competency Database 11. DMH Clinical Chart Auditing Form 12. DMH Clinical Chart Auditing Form Instructions 13. DMH Clinical Chart Auditing monitoring summary data for Program IV (August and September 2007) 14. DMH Observation Monitoring Form 15. DMH Observation Monitoring Form Instructions 16. DMH Observation Monitoring summary data for Program IV (August and September 2007) 17. ASH data regarding staffing ratios on admissions and non-admission units <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program IV, unit 6) for 7-day review of PDV 2. WRPC (Program IV, unit 16) for monthly review of TJC 3. WRPC (Program V, unit 14) for monthly review of MM
C.1.a	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement the revised DMH WRP Manual.</p> <p>Findings: ASH began implementation of the WRP system that is codified in the in WRP Manual. The facility selected Program IV to serve as a model for the implementation. The rest of the hospital has yet to institute the full conference schedule, the conversion of Nursing Care Plans into Focus 6 objectives and interventions, or the WRP monitoring activities.</p>

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		<p>The following is an outline of the WRP implementation roll-out dates for different programs:</p> <table border="1" data-bbox="989 302 1493 496"> <thead> <tr> <th>Program</th> <th>Roll-out date</th> </tr> </thead> <tbody> <tr> <td>IV</td> <td>July 2007</td> </tr> <tr> <td>VI</td> <td>December 2007</td> </tr> <tr> <td>V</td> <td>February 2008</td> </tr> <tr> <td>II and III</td> <td>June 2008</td> </tr> </tbody> </table> <p>Recommendation 2, April 2007: Provide documentation that WRPT members have been trained to competency.</p> <p>Findings: The facility provided data regarding completion of Phase I didactic training of WRPTs. Completion of training is evidenced by a score of 95% or higher on the WRP Knowledge Assessment Post-Test, indicating that the WRPT member has been trained to competency. ASH plans to retest those who did not pass, follow up with the clinicians who did not submit their post-tests, and track the compliance rate per discipline monthly. Feedback will be provided by the program liaisons to the WRPTs. Discipline-specific issues will be addressed by the senior clinicians on each program.</p> <p>The following table outlines the facility's data regarding numbers and percentages of WRPT members who have been trained to competency in Program IV and in all other programs in September. The test scores are current as of October 5. Nursing staff (RNs and PTs) are not included since they were not designated as WRPT members until this week.</p>	Program	Roll-out date	IV	July 2007	VI	December 2007	V	February 2008	II and III	June 2008
Program	Roll-out date											
IV	July 2007											
VI	December 2007											
V	February 2008											
II and III	June 2008											

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	Program IV % Team Members Trained	Hospital-wide % Team Members Trained (except Program IV)
MD	5/8 (62%)	17/37 (46%)
PhD	3/6 (50%)	7/13 (54%)
SW	5/8 (62%)	17/34 (50%)
RT	5/8 (62%)	13/23 (57%)

Recommendation 3, April 2007:
Ensure that WRP training post-tests are aligned with the review questions included in the DMH WRP Manual.

Findings:
The WRP Phase I post-test is aligned with the review questions.

Recommendation 4, April 2007:
Continue and strengthen current WRP training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRPTs.

Findings:
The findings under recommendation #2 above address the status of Phase I WRP training. The second phase of training includes mentoring of staff in the implementation of the WRP process. Initial mentoring has been provided by the facility's consultant, Dr. Ronald Boggio. The facility recognizes that gains in WRP process and outcomes have not been evident thus far. According to ASH, one main reason for this has been that, except for Program IV, most other programs have limited experience in the WRP process. With the roll-out of the WRP process in other programs, ASH anticipates better performance of the WRPTs.

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		<p>As of September 24, 2007, ASH assigned a full-time psychologist to serve as Master WRP trainer during the consultant's absence. The master WRP trainer is currently working in collaboration with the consultant to finalize Phases II and III of the WRP training curriculum in alignment with the WRP Manual. ASH has identified 13 additional WRP trainers. Beginning in November 2007, the consultant is scheduled to train two WRP trainers per program. The plan is for these trainers to provide mentoring to the WRPTs in their programs until the teams achieve substantial compliance on WRP process and outcome measures.</p> <p>Additionally, senior clinicians (psychiatry, psychology, social work, rehabilitation and nursing) have been assigned to Program IV (September 2007). These individuals are responsible for reviewing the content of the WRPs for completeness and quality. Both the senior clinicians and Program Assistants observe the WRP process and provide feedback to the WRPTs on WRP issues, under the guidance of the DMH consultant. WRP training staff, senior clinicians and monitoring staff are beginning to work together to utilize data to identify team training needs and to provide WRPTs with feedback.</p> <p>Recommendation 5, April 2007: Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2.</p> <p>Findings: ASH recently started WRP monitoring activities on Program IV and has achieved at least 20% sample on that program. As mentioned earlier, ASH has yet to fully implement the WRP system and to begin WRP monitoring activities in other programs.</p> <p>Recommendation 6, April 2007: Consolidate the ADs regarding WRP and ensure alignment with all the</p>
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		<p>provisions in the DMH WRP Manual.</p> <p>Findings: ASH has consolidated AD #414, Wellness and Recovery Planning and AD #507, Wellness and Recovery Teams into one draft AD. The revised AD (#414) describes the policy for planning treatment, rehabilitation, and enrichment services according to the WRP Manual.</p> <p>Other findings: ASH provided monitoring data based on the WRP Clinical Chart Auditing Form. The facility reviewed an average sample of 64% of the number of WRPs due on Program IV (August and September 2007). The following is an outline of the relevant monitoring indicators and corresponding mean compliance rate:</p> <ol style="list-style-type: none">1. Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care (1%); and2. 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 (1%). <p>Based on these initial findings, ASH established the previously described plan to strengthen training of the WRPTs.</p> <p>The team meetings attended by the monitor showed minimal progress in the overall process of the team meetings. The following are examples:</p> <ol style="list-style-type: none">1. All meetings started on time.2. It was clear that the team psychiatrists were leaders of the process.3. The teams made some effort to review the individual's attendance
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		<p>at the assigned groups.</p> <ol style="list-style-type: none">4. The team members were respectful of the individuals and made an effort to elicit their input. <p>However, each of the three teams employed a different WRP process, none of which was consistent with the steps that appropriately outlined the WRP process and that were highlighted in posters in each meeting room. The following are examples of the deficiencies:</p> <ol style="list-style-type: none">1. Not all core members were present.2. The teams did not review their assessments of the individual as per WRP process steps.3. The teams did not review the risk factors as per WRP process steps.4. The discussion prior to the individual's arrival did not provide guidance regarding the areas that the teams needed to review with the individual.5. Some plans were completed in their entirety prior to the individual's arrival, resulting in a content that did not match the individual's current status.6. One team leader spent much time during the meeting to update the DSM-IV checklist and left no time for the interdisciplinary planning of services.7. The updates of the present status were incomplete and did not reflect the current status.8. The review of foci, objectives and interventions were generally not informed by the assessments, the case formulation and the review of progress in Mall groups.9. The foci did not address all of the individual's needs.10. There was no mechanism to review the progress of individuals in the Mall.11. In general, the teams struggled with the engagement of individuals in the review of objectives and interventions.
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		<p>In general, the above deficiencies indicate that the facility has not made any significant progress in integrating the principles and practice guidelines in its WRP Manual into the day-to-day operations of the WRPTs. There is a strong need for the facility to provide its WRPTs with increased training sessions, including ongoing feedback and mentoring by trainers/senior clinicians.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the revised DMH WRP Manual in all programs at ASH. 2. Continue and strengthen current WRP training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to provide ongoing mentoring for all members of the WRPTs. 3. Provide data regarding competency-based training of WRPT members in all phases of training. 4. Monitor this requirement based on a 20% sample and provide data analysis and corrective actions regarding areas of low compliance.. 5. Address and correct factors related to low compliance.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Monitor both presence and proper participation by the team leaders in all WRP meetings.</p> <p>Findings: ASH used the DMH Observation Monitoring Form to assess its compliance with this requirement of the EP. The facility reviewed an average sample of 32% in August and September 2007 (N= the total</p>

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		<p>number of 7-day, 14-day, monthly, quarterly and annual WRPs due in Program IV for the month). The mean compliance rate was 13%. The following is an outline of the compliance rates for each type of WRPC:</p> <table border="1" data-bbox="987 337 1312 570"> <thead> <tr> <th>WRPC</th> <th>Mean %C</th> </tr> </thead> <tbody> <tr> <td>7-day</td> <td>9</td> </tr> <tr> <td>14-day</td> <td>0</td> </tr> <tr> <td>Monthly</td> <td>19</td> </tr> <tr> <td>Quarterly</td> <td>6</td> </tr> <tr> <td>Annual</td> <td>0</td> </tr> </tbody> </table> <p>To assess the participation of the team leaders, the facility has a plan to use MSH's Psychiatry Team Leadership monitoring form and to have the facility's senior psychiatrists gather the information.</p> <p>Recommendation 2, April 2007: Develop and implement a peer mentoring system to ensure competency in team leadership skills.</p> <p>Findings: The facility has yet to formalize this process. Senior clinicians were assigned to Program IV as of August 2007. The senior psychiatrist has been providing feedback on the WRPC process and team leader responsibilities to the medical staff on the program.</p> <p>Recommendation 3, April 2007: The Department of Psychiatry manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRPT responsibilities that are outlined in the DMH WRP manual.</p> <p>Findings: ASH has implemented this recommendation. WRP Leadership</p>	WRPC	Mean %C	7-day	9	14-day	0	Monthly	19	Quarterly	6	Annual	0
WRPC	Mean %C													
7-day	9													
14-day	0													
Monthly	19													
Quarterly	6													
Annual	0													

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		<p>responsibilities are included in Section XI-100-IIA of the revised manual.</p> <p>Recommendation 4, April 2007: Continue and strengthen training regarding team leadership to ensure proper execution of the duties and responsibilities of the team leaders during the WRPT meeting.</p> <p>Findings: As mentioned previously, senior clinicians were assigned to Program IV (as of August 2007). The Acting Senior Psychiatrist has been providing feedback on the WRPC process and team leader responsibilities to the medical staff on the program.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor both presence and proper participation by the team leaders in all WRP meetings. 2. Implement a peer mentoring system to ensure competency in team leadership skills.
C.1.c	Function in an interdisciplinary fashion.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in C.1.a and C.1.b.</p> <p>Findings: Same as in C.1.a and C.1.b.</p> <p>Other findings: ASH implemented the DMH Observation Monitoring Form to assess its</p>

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		<p>compliance with this requirement of the EP, using the same process described in C.1.b. The mean compliance rate was 0%.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a and C.1.b.</p>
C.1.d	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Same as in C.1.a, C.1.b and C.1.c.</p> <p>Findings: Same as in C.1.a, C.1.b and C.1.c.</p> <p>Recommendation 2, April 2007: Conduct surveys to assess the views of team members regarding the functions of their designated leaders.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, April 2007: The Department of Psychiatry manual should include specific requirements regarding psychiatrists' role as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual.</p> <p>Findings: Same as in C.1.b.</p>

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		<p>Recommendation 4, April 2007: Implement the DMH WRP Clinical Chart Auditing Form.</p> <p>Findings: Same as in C.1.a.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a, C.1.b and C.1.c.</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 recommendations:</p> <p>Recommendation 1, April 2007: Same as in C.1.a through C.1.d.</p> <p>Findings: Same as in C.1.a through C.1.d.</p> <p>Recommendation 2, April 2007: Same as in D.1.a through D.1.e.</p> <p>Findings: Same as in D.1.a through D.1.e.</p> <p>Recommendation 3, April 2007: Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.</p>

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		<p>Findings: ASH has assigned senior clinicians to Program IV to provide clinical oversight to improve staff competency in the WRP processes. As mentioned earlier, the plan is for these senior clinicians to work with the designated WRP trainers in each program (November 2007), use the information from the WRP auditors and provide feedback to the program clinicians individually and WRPTs as a group.</p> <p>Recommendation 4, April 2007: Ensure that the monitoring tools adequately address the quality of disciplinary assessments.</p> <p>Findings: ASH has yet to implement this recommendation. A statewide process is underway to refine monitoring of the quality of psychiatry, nursing, social work and rehabilitation assessments. The monitoring tool regarding psychology assessment has been finalized in compliance with this recommendation (see Section D.2).</p> <p>Recommendation 5, April 2007: Address and correct factors related to low compliance.</p> <p>Findings: ASH has yet to address this recommendation.</p> <p>Other findings: ASH used the WRP Observation Monitoring Form to assess compliance with this requirement. Reviewing an average sample of 27% of the WRPCs (7-day, 14-day, monthly, quarterly and Annual) that were due on Program IV in August and September 2007, the facility reported mean compliance rate of 0%. This compliance rate relates to the process of communicating assessment results during the team meetings and not the quality of disciplinary assessments.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 2. Monitor this requirement and analyze and correct factors related to low compliance.
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 recommendations:</p> <p>Recommendation 1, April 2007: Same as in C.1.a through C.1.e.</p> <p>Findings: Same as in C.1.a through C.1.e.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement using process observation.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form (7-day, 14-day, monthly, quarterly and annual), ASH reported a mean compliance rate of 0% for this requirement (August and September 2007 in Program IV).</p> <p>Recommendation 3, April 2007: Address and correct factors related to low compliance.</p> <p>Findings: ASH has yet to implement this recommendation.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a through C.1.e.</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 1, April 2007: Continue to monitor this requirement using process observation.</p> <p>Findings: ASH used the DMH Observation Monitoring Form to assess if the WRPTs identify someone to be responsible for implementation of this requirement. The facility reported a mean compliance rate of 2% (August and September 2007). The following table outlines the compliance rates for each type of WRPC:</p> <table border="1" data-bbox="989 894 1310 1125"> <thead> <tr> <th>WRPC</th> <th>Mean %C</th> </tr> </thead> <tbody> <tr> <td>7-day</td> <td>0</td> </tr> <tr> <td>14-day</td> <td>0</td> </tr> <tr> <td>Monthly</td> <td>1</td> </tr> <tr> <td>Quarterly</td> <td>3</td> </tr> <tr> <td>Annual</td> <td>0</td> </tr> </tbody> </table> <p>Recommendation 2, April 2007: Assess and correct factors related to the shortage of staff needed to implement the EP.</p> <p>Findings: Refer to the introduction regarding this recommendation.</p>	WRPC	Mean %C	7-day	0	14-day	0	Monthly	1	Quarterly	3	Annual	0
WRPC	Mean %C													
7-day	0													
14-day	0													
Monthly	1													
Quarterly	3													
Annual	0													

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement using process observation. 2. Address and correct factors related to low compliance. 																								
C.1.h	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop a database that includes information regarding the core membership of all teams in the facility.</p> <p>Findings: At the request of the monitor, ASH provided information regarding compliance with this requirement. The following table outlines the current status regarding number of teams that have a full complement of core members and other teams that are missing some core members:</p> <table border="1" data-bbox="989 894 1824 1203"> <thead> <tr> <th>WRPT status</th> <th>Non-admission</th> <th>Admission</th> </tr> </thead> <tbody> <tr> <td>Full Teams</td> <td>13 of 26</td> <td>7 of 8</td> </tr> <tr> <td>Missing MD</td> <td>4 of 26</td> <td>0 of 8</td> </tr> <tr> <td>Missing PhD</td> <td>22 of 26</td> <td>0 of 8</td> </tr> <tr> <td>Missing SW</td> <td>3 of 26</td> <td>0 of 8</td> </tr> <tr> <td>Missing RT</td> <td>7 of 26</td> <td>1 of 8</td> </tr> <tr> <td>Missing MD and PhD</td> <td>3 of 26</td> <td>0 of 8</td> </tr> <tr> <td>Missing PhD and RT</td> <td>1 of 26</td> <td>1 of 8</td> </tr> </tbody> </table> <p>Recommendation 2, April 2007: Address and correct the deficiencies regarding attendance by core members.</p>	WRPT status	Non-admission	Admission	Full Teams	13 of 26	7 of 8	Missing MD	4 of 26	0 of 8	Missing PhD	22 of 26	0 of 8	Missing SW	3 of 26	0 of 8	Missing RT	7 of 26	1 of 8	Missing MD and PhD	3 of 26	0 of 8	Missing PhD and RT	1 of 26	1 of 8
WRPT status	Non-admission	Admission																								
Full Teams	13 of 26	7 of 8																								
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Missing MD and PhD	3 of 26	0 of 8																								
Missing PhD and RT	1 of 26	1 of 8																								

		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, April 2007: Regularly monitor the attendance by core members in the WRPCs.</p> <p>Findings: Attendance of core members has been manually tracked from the Observation Monitoring Form. ASH anticipates an electronic application with the implementation of the WRPC module of the new software, WaRMSS. The facility plans to have program management and senior clinicians review the attendance reports on a monthly basis.</p> <p>Using information from the DMH Observation Monitoring Form, ASH developed a temporary tracking file in Word that includes both training competency and WRPC attendance on Program IV. The following table outlines the compliance rate regarding attendance by representatives of different core disciplines in the WRPCs. The data are based on a review of a 32% sample of the WRPCs due per month, and do not include the individuals.</p> <table border="1" data-bbox="982 966 1449 1274"> <thead> <tr> <th>Discipline</th> <th>%C</th> </tr> </thead> <tbody> <tr> <td>MDs</td> <td>86</td> </tr> <tr> <td>PhDs</td> <td>70</td> </tr> <tr> <td>SWs</td> <td>66</td> </tr> <tr> <td>RTs</td> <td>78</td> </tr> <tr> <td>RNs</td> <td>72</td> </tr> <tr> <td>PTs</td> <td>34</td> </tr> <tr> <td></td> <td>68</td> </tr> </tbody> </table> <p>Compliance: Partial.</p>	Discipline	%C	MDs	86	PhDs	70	SWs	66	RTs	78	RNs	72	PTs	34		68
Discipline	%C																	
MDs	86																	
PhDs	70																	
SWs	66																	
RTs	78																	
RNs	72																	
PTs	34																	
	68																	

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a database that includes information regarding the core membership of all teams in the facility. 2. Regularly monitor the attendance by core members, including the individuals, in the WRPCs. 3. Address and correct the deficiencies regarding core membership and attendance by core members. 															
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 1, April 2007: Same as in C.1.h.</p> <p>Recommendation 2, April 2007: Ensure consistent compliance with this requirement.</p> <p>Findings: ASH provided data regarding the case loads of core team members during the months of August and September 2007. The data show that the case loads exceed plan requirements for psychologists and social workers on the admission units, and for psychiatrists, social workers and recreational therapists on the non-admission units. The data do not include nursing staff.</p> <p>The following tables summarize the data in admission and non-admission units. The data identify the number of staff FTE/average daily census and staff/individual ratios (in parenthesis).</p> <table border="1" data-bbox="989 1227 1824 1421"> <thead> <tr> <th>Admission units</th> <th>August</th> <th>September</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>7/89 (1:13)</td> <td>7/91 (1:13)</td> </tr> <tr> <td>PhD</td> <td>5.25/89 (1:17)</td> <td>5.25/91 (1:17)</td> </tr> <tr> <td>CSW</td> <td>6/89 (1:13)</td> <td>6/91 (1:13)</td> </tr> <tr> <td>RT</td> <td>3/89 (1:30)</td> <td>3.5/91 (1:26)</td> </tr> </tbody> </table>	Admission units	August	September	MD	7/89 (1:13)	7/91 (1:13)	PhD	5.25/89 (1:17)	5.25/91 (1:17)	CSW	6/89 (1:13)	6/91 (1:13)	RT	3/89 (1:30)	3.5/91 (1:26)
Admission units	August	September															
MD	7/89 (1:13)	7/91 (1:13)															
PhD	5.25/89 (1:17)	5.25/91 (1:17)															
CSW	6/89 (1:13)	6/91 (1:13)															
RT	3/89 (1:30)	3.5/91 (1:26)															

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		<table border="1" data-bbox="989 228 1824 420"> <thead> <tr> <th>Non-Admission Units</th> <th>August</th> <th>September</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>27/859 (1:32)</td> <td>30.5/874 (1:29)</td> </tr> <tr> <td>PhD</td> <td>14.25/859 (1:60)</td> <td>14.25/874 (1:61)</td> </tr> <tr> <td>CSW</td> <td>35/859 (1:24)</td> <td>38/874 (1:23)</td> </tr> <tr> <td>RT</td> <td>27/859 (1:32)</td> <td>25.5/874 (1:34)</td> </tr> </tbody> </table> <p data-bbox="984 464 1856 751">At this time, ASH keeps individuals on the admission units for an average of 30 days, much less than the required 90 days. The facility is in the process of recruiting additional core staff to comply with EP requirements. In an effort to improve compliance, ASH has closed some units, consolidated staff and opened a fourth admission unit to meet the required ratios on some program. The facility has a plan to maintain a population census of less than 1000 and to open additional admission units in February 2008 and April 2008.</p> <p data-bbox="984 797 1136 862">Compliance: Partial.</p> <p data-bbox="984 907 1320 935">Current recommendations:</p> <ol data-bbox="984 946 1848 1049" style="list-style-type: none"> 1. Same as in C.1.h. 2. Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if needed. 	Non-Admission Units	August	September	MD	27/859 (1:32)	30.5/874 (1:29)	PhD	14.25/859 (1:60)	14.25/874 (1:61)	CSW	35/859 (1:24)	38/874 (1:23)	RT	27/859 (1:32)	25.5/874 (1:34)
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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 data-bbox="984 1096 1572 1123">Current findings on previous recommendation:</p> <p data-bbox="984 1169 1394 1234">Recommendation 1, April 2007: Same as in C.1.a through C.1.f.</p> <p data-bbox="984 1279 1356 1344">Findings: Same as in C.1.a through C.1.f.</p>															

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		<p>Recommendation 2, April 2007: Revise the current WRP Phase I post-test to include the WRP process expectations as outlined in the DMH WRP Manual.</p> <p>Findings: ASH has implemented this recommendation. The WRP Phase I post-test was revised in September 2007 to include all objectives noted in the DMH WRP Manual.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.1.a through C.1.f.</p>
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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donald Baumber, Vocational Counselor 2. Alec Black, MSW 3. Leslie Bolin, PhD, Neuropsychologist 4. Charles Broderick, PhD, Acting Senior Supervising Psychologist 5. Janet Bufford, Acting Chief of Social Work 6. Angela Burt, MD 7. Karen Dubiel, Assistant to Clinical Administrator 8. William Hallum, Supervisor, Substance Abuse Services 9. Matt Hennessy, PsyD, Mall Director 10. Diane Imrem, PsyD, Chief of Psychology 11. Charlie Joslin, Clinical Administrator 12. L. Lauffer, PhD, Psychologist 13. Christine Mathiesen, PsyD, Director C-PAS 14. Michael McLaughlin, Basic Dramatic Screen Writing, Guest Instructor 15. John Myers, SPT, Data Analyst 16. Donna Nelson, Director, Standards Compliance 17. J. Neville, Chief, Central Program Services 18. Sylvia Paolello, Nurse Practitioner 19. L. Ramos, Assistant Chief, Central Processing Services 20. Louis Santiago, SPT, BY CHOICE Coordinator 21. Cheryll Smith, PhD, Clinical Neuropsychologist, DCAT 22. Rich Summers, Teacher, Aztec School 23. Jeffrey Teuber, PhD, Senior Psychologist, PBS Team Leader 24. Michael Tomlin, PT 25. Oghenesume Umugbe, MD 26. William Watson, LCSW, Resource Coordinator 27. Five individuals (BH, WM, ES, AS, and MB)

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		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 109 individuals: ACH, AG, AHL, AJ, AM, AR, AW, BAL, BB, BL, BM, BWM, CB, CBC, CC, CF, CN, DAA, DB, DGM, DLT, DNM, , DQ, DT, DTM, EGW, EME, EO, ER, FH, FL, GAS, GKR, HN, IM, JAJ, JAR, JDM, JER, JFD, JH, JJC, JJS, JLR, JM, JN, JRH, JSR, JTG, KDB, KJ, KL, KM, KR, KRM, KS, KW, LA, LC, LJ, LLP, LP, LS, MAM, MBH, MBW, MC, MEB, MH, MK, MLD, MM, MMR, MN, MR, MV, MVB, MW, RB, RCD, RCT, RE, RG, RH, RJH, RNG, R, RTA, SAS, SBZ, SK, SNA, SR, SRB, SRD, SS, SZ, TAM, TAQ, TEB, TL, TR, TS, TSK, TW, WLB, WRH, WT, YM 2. WRP Knowledge Assessment Test 3. Objectives and lesson plan for Phase I WRP Training 4. DMH Observation Monitoring Form 5. DMH Observation Monitoring Form Instructions 6. DMH Observation Monitoring summary data for Program IV (August and September 2007) 7. DMH WRP Clinical Chart Auditing Form 8. DMH WRP Clinical Chart Auditing Form Instructions 9. DMH WRP Clinical Chart Auditing summary data for Program IV (August and September 2007) 10. DMH WRP Chart Auditing Form 11. DMH WRP Chart Auditing summary data for Program IV (August and September 2007) 12. DMH Mall Alignment Monitoring Form 13. DMH Mall Alignment Monitoring summary data for Program IV (August and September 2007) 14. ASH data regarding active treatment hours scheduled and attended (Program IV and facility-wide) 15. PSR Mall Facilitator Monthly Progress Note Instructions 16. Training for Enhancing Motivating of Pre-contemplative Substance Abusing Individuals 17. AD #414.1, Screening and Assessment for Substance Abuse Disorder
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		<ol style="list-style-type: none">18. Memorandum dated June 15, 2007 from Clinical Administrators to Program Managers regarding Substance Abuse Program Overview Training Video19. Outline of ASH training on Stages of Change, including Post-Test20. Enhancing Motivation for Change In-service Training, Tip 35, by US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment21. Substance Abuse Referral/Request for Consultation Form22. Substance Abuse Services Quarterly Data Report (April 1 to September 15, 2007)23. Substance Abuse Checklist24. Substance Abuse Checklist summary data for Program IV (August and September 2007)25. Substance Abuse Screening and Assessment26. ASH Mall Curriculum: Summer 200727. Lesson Plan for Introduction to Wellness and Recovery Planning Group28. ASH data regarding Program IV Medication Management Groups' Hours29. Mall Group Survival Kit30. New Admission Orientation Workbook31. Recovery Model Program, Minimum Treatment Hours, Memorandum32. AD #416 (PBS Services), Effective Date 9/4/200733. SO #131.00 (Clinical Services), Effective Date 8/13/200734. PBS/DCAT Training Roster35. Mall Course Cancellation List36. Nursing Policy/Procedure Manual for Individuals in Bed-Bound Status37. Enrichment Activity Participation List38. BMI Trigger List39. ASH Psychology Manual40. ASH BY CHOICE Manual
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		<ol style="list-style-type: none">41. ASH DCAT Manual42. Mail Provider List43. Patient Refusal Cancellation List44. List of all individuals admitted to ASH who were under age 23 at the time of admission45. List of individuals whose primary/preferred language is not English46. List of individuals with PBS plans in need of updating47. List of individuals on PBS plans48. List of individuals referred for/needing neuropsychological evaluation49. List of individuals referred to BCC50. List of individuals who have not made timely progress on PBS plans51. ASH BCC Attendance Record52. WRP Competency Training List53. DMH Psychosocial Rehabilitation Mail Manual54. List of Exercise Groups at ASH55. List of Enrichment Groups at ASH56. List of Individuals under 1:1, Monitoring, and or Seclusion and Restraint57. List of Individuals Receiving DCAT Services58. Substance Abuse Training Curriculum59. Substance Abuse Service Employee Competency Training Workbook60. Training Module for Enhancing Motivation of Pre-contemplative Substance Abusing Individuals61. Documentation of Pre-contemplation stage <p><u>Observed:</u></p> <ol style="list-style-type: none">1. WRPC (Program IV, unit 6) for 7-day review of PDV2. WRPC (Program IV, unit 16) for monthly review of TJC3. WRPC (Program V, unit 14) for monthly review of MM4. WRPC (Program I, unit 11) for DAH5. WRPC (Program I, unit 26) for MC6. WRPC (Program I, unit 11) for AEC
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		<p>7. Four Mall groups (Medication Management 1, WRAP, Medication Management II, Medication Management III, and Anger Management)</p>
<p>C.2.a</p>	<p>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Address and correct factors related to low compliance with this requirement. <p>Findings: ASH has yet to implement these recommendations. Phase I training curriculum and post-test are aligned with the WRP Manual, but the current draft does not specifically address the engagement of individuals.</p> <p>ASH is still in the process of developing a performance improvement structure to review and analyze data and assign corrective action regarding this requirement of the EP.</p> <p>Other findings: ASH used the DMH WRP Observation Monitoring Form to assess compliance with this requirement. The facility reviewed an average sample of 31% (August and September 2007) of WRPCs due on Program IV (7-day, 14-day, monthly, quarterly and annual). The mean compliance rate was 3%. As mentioned in C.1.a, the WRPCs attended by this monitor show that the facility has yet to make any significant progress in this area.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the current WRP training curriculum includes a module regarding the engagement of individuals. 2. Implement a performance improvement process to address and correct factors related to low compliance with this requirement.
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 recommendations:</p> <p>Recommendation 1, April 2007: Implement the A-WRP within 24 hours of the admission.</p> <p>Findings: ASH began implementing the full WRP conference schedule required by the EP on Program IV's Admission Unit effective August 1, 2007.</p> <p>Recommendations 2 and 3, April 2007:</p> <ol style="list-style-type: none"> 2. Monitor implementation of A-WRP within 24 hours of all admissions. 3. Ensure that monitoring of the A-WRP is based on a 20% sample of all admissions. <p>Findings: ASH completed the hiring process for Health Record Technicians (HRTs), and provided chart auditing training, in August 2007. The facility used the DMH WRP Chart Auditing Form to assess compliance. Reviewing an average sample of 28% of the A-WRPs due on Program IV, the facility reported a mean compliance rate of 93%.</p>

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		<p>Other findings: This monitor reviewed the charts of 10 individuals (TAM, AW, FL, KDB, MBW, JJC, LA, MV, MR and MVB). Three of these individuals resided on Program IV (KDB, MBW and LA). The review showed compliance in five charts (TAM, FL, MBW, LA and MR) and non-compliance in five.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the A-WRP within 24 hours of the admission. 2. Continue monitoring to ensure that A-WRPs are completed within 24 hours of all admissions.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue implementation of the master WRP within seven days of the admission.</p> <p>Findings: Same as findings for Recommendation #1 in C.2.b.i.</p> <p>Recommendation 2, April 2007: Continue to monitor the timeliness of the master WRP. Ensure that monitoring of the master WRP is based on a 20% sample of all admissions.</p> <p>Findings: Using the DMH Chart Auditing Form, the facility reviewed an average sample of 77% of the 7-day WRPs due on Program IV and reported a mean compliance rate of 69% (August and September 2007).</p>

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		<p>Recommendation 3, April 2007: Implement the DMH Clinical Chart Auditing Form.</p> <p>Findings: As mentioned in C.1.a, ASH has implemented the Clinical Chart Auditing Form. In July 2007, the facility completed the process to hire behavior specialists to implement the DMH Clinical Chart Auditing form. This staff was trained the week of August 20, 2007 by the state's consultant, Ms. Angela Adkins. Auditing began in August 2007. Training of the auditors will continue until inter-rater reliability is established.</p> <p>Other findings: Reviewing the charts of the above-mentioned 10 individuals, this monitor found compliance in all charts except one (JJC).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue implementation of the master WRP within seven days of the admission. 2. Continue monitoring to ensure that 7-day WRPs are completed within seven days of all admissions, based on at least 20% sample.
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 recommendations:</p> <p>Recommendation 1, April 2007: Implement the required WRP conference schedule on all teams.</p> <p>Findings: As mentioned earlier, ASH began implementation on Program IV. The</p>

		<p>facility has a plan to complete implementation on all programs.</p> <p>Recommendations 2 and 3, April 2007:</p> <ol style="list-style-type: none"> 2. Continue to monitor the implementation of the required WRP conference schedule on all admission and long-term teams. 3. Ensure that monitoring of the WRP reviews includes a 20% sample of all admissions. <p>Findings: ASH used the DMH Chart Auditing form to assess compliance. The facility reviewed an average sample of 76% of the 14 day, monthly, quarterly and annual WRPCs on Program IV (August and September 2007). The mean compliance rate was 0%.</p> <p>Recommendation 4, April 2007: Implement the DMH Clinical Chart Auditing Form.</p> <p>Findings: Same as in C.2.b.ii</p> <p>Other findings: This monitor reviewed 10 charts and found non-compliance in seven charts (TAM, AW, JJC, LA, MV, MR and MVB) and compliance in three (FL, KDB and MBW).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the required WRP conference schedule on all teams. 2. Continue to monitor the implementation of the required WRP conference schedule on all teams, based on at least a 20% sample.
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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 recommendations:</p> <p>Recommendation 1, April 2007: Implement the DMH Clinical Chart Auditing Form to monitor this requirement and address the deficiencies identified above.</p> <p>Findings: Using the Clinical Chart Auditing Form, ASH reviewed an average sample of 64% of the charts of individuals who have been hospitalized for 90 days or longer in Program IV (August and September 2007). The facility reported a mean compliance rate of 1% regarding this requirement.</p> <p>Recommendation 2, April 2007: Continue and strengthen training of WRPTs to ensure that:</p> <ol style="list-style-type: none"> a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. <p>Findings: ASH has developed posters that outline the required content of the case formulation and the posters have been placed in all team rooms for training purposes. However, the current draft of WRP Phase I training does not include specific modules to ensure that the case formulation and foci/objectives/interventions are completed in accordance with requirements of the EP and the DMH WRP Manual.</p> <p>Other findings: This monitor reviewed the charts of individuals suffering from a variety of cognitive impairments and seizure disorders. The reviews indicate that treatment and rehabilitation services still ignore some</p>
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		<p>important needs of these individuals. The following are chart examples of individuals in each category:</p> <ol style="list-style-type: none"> 1. Individuals diagnosed with cognitive impairments: <ol style="list-style-type: none"> a. The WRP does not include focus of hospitalization or objectives/interventions for individuals diagnosed with Dementia, NOS (MLD and JH), Dementia Due to General Medical Condition (DGM), Mental Retardation, Unspecified Severity (RTA), Cognitive Disorder, NOS (BAL, JTG, MEB-2) and Borderline Intellectual Functioning (DT). b. The WRP does not list the diagnosis of Cognitive Disorder, NOS, or include corresponding focus, objectives or interventions (BAL). c. The WRPs (and the psychiatric progress notes) do not track the status of cognition for individuals diagnosed with cognitive impairments, including Dementia, NOS (MLD) and Cognitive Disorder, NOS (BAL and MEB-2). d. The interventions do not include an assessment of the possible adverse effect of high-risk medications on individuals diagnosed with cognitive impairments, including Mental Retardation with Unspecified Severity (RTA), Dementia, NOS (MLD) and Cognitive Disorder, NOS (MEB-2). e. The objectives and interventions are not related to the focus of hospitalization regarding a diagnosis of Mental Retardation with Unspecified Severity (JAR). f. In general, the present status section does not address the status of these individuals' cognitive dysfunction. g. The interventions related to cognitive remediation are generally inadequate and/or insufficient. 2. Individuals diagnosed with seizure disorders: <ol style="list-style-type: none"> a. The WRP does not include a focus of hospitalization or any objectives or interventions for an individual diagnosed with a
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		<p>Seizure Disorder (JH).</p> <ul style="list-style-type: none">b. The WRPs contain objectives/interventions that are generic and focus on compliance with treatment, without documentation that this is an issue that is relevant for the individual (GKR, TAQ and JDM).c. The present status section of the WRP does not address the status of the individual's seizure activity during the previous interval in almost all cases.d. The WRPs do not include objectives/interventions to assess the risks of treatment with older anticonvulsant medications, and minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (MMR, GKR, DAA and DT), phenobarbital (CC) and primidone (TAQ and JDM). Some of these individuals suffer from documented cognitive impairment, which increases the risk (DT). <p>See monitor's findings in C.2.o. regarding the care of individuals who suffer from substance use disorders.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ul style="list-style-type: none">1. Continue and strengthen training of WRPTs and include specific modules to ensure that:<ul style="list-style-type: none">a. The case formulation:<ul style="list-style-type: none">i. Includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains; andii. Adequately addresses the requirements in C.2. d; andb. Foci of hospitalization and objectives and interventions:<ul style="list-style-type: none">i. Adequately address all identified needs of the individual in
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		<p>the above domains; and</p> <p>ii. Adequately address the requirements in C.2.e and C.2.f.i through C.2.f.vi.</p> <p>2. Monitor this requirement and provide data regarding the care of individuals with cognitive disorders, seizure disorders and/or substance abuse disorders.</p>
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: Partial.</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>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue and strengthen training of the WRPTs to ensure that the case formulation adequately addresses the requirements in C.2.d. 2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual. <p>Findings: Same as findings under Recommendation #2 in C.2.c.</p> <p>Other findings: ASH used the Clinical Chart Auditing Form to assess compliance with this requirement. Reviewing an average sample of 64% (August and September 2007, Program IV), the facility reported a mean compliance rate of 0% for this item. The mean compliance rates for requirements in C.2.d.ii through C.2.d.vi are listed in each corresponding sub-cell</p>

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		<p>below. ASH recognized that further training is needed to assist the teams to improve compliance in this section.</p> <p>Chart reviews by this monitor indicate that ASH has yet to make progress to address the following persistent general deficiencies:</p> <ol style="list-style-type: none">1. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. For example, the present status sections do not include needed information in the review of the use of restrictive interventions, the clinical progress of individuals suffering from a variety of disorders and high-risk behaviors, and individuals' progress towards discharge.2. The linkages among different components of the formulations are often missing.3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs.4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). <p>These deficiencies must be corrected in order to achieve substantial compliance with this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Increase case formulation training and ensure that the training includes clinical case examples, ongoing feedback and mentoring by WRP trainers/senior clinicians.2. Continue to monitor this requirement using the Clinical Chart Auditing Form and analyze and correct factors related to low compliance.
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C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	0%
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in S [III.B.4.b] above;	2%
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;	4%
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	9%
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.	0%
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>

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	<p>goals/objectives (interventions):</p>	<p>Findings: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p> <p>Other findings: Using the DMH WRP Chart Auditing Form, ASH reviewed an average sample of 77% (August and September, 2007) of the 14-day, monthly, quarterly and annual WRPs on Program IV. The facility reported a mean compliance rate of 1% with this requirement.</p> <p>Chart reviews by this monitor indicate that in general, ASH has yet to make progress to address deficiencies in the following areas:</p> <ol style="list-style-type: none"> 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). <p>Compliance: Partial.</p> <p>Current recommendation: Same as in C.2.c, C.2.f, C.2.g and C.2.o.</p>
C.2.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted</p>	<p>Please see sub-cells for compliance findings.</p>

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	<p>professional standards of care. Specifically, the interdisciplinary team shall:</p>	
<p>C.2.f.i</p>	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue and reinforce training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP Manual. 2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual. <p>Findings: Same as findings under Recommendation #2 in C.2.c.</p> <p>Recommendation 3, April 2007: Implement the Clinical Chart Auditing Form to monitor this requirement.</p> <p>Findings: ASH used the DMH WRP Chart Auditing form to assess compliance with this requirement. The facility reported a mean compliance rate of 1% based on a review of a sample of 76% (August and September, 2007, Program IV) of the 14-day, monthly, quarterly and annual WRPs on Program IV. Using this process, the facility reported the same compliance rate for each sub-cell in C.2.f.ii through C.2.f.v.</p> <p>In addition, the facility used the DMH WRP Observation Monitoring Form to assess the teams' practices regarding inclusion in the WRPs of the individuals' strengths related to each enrichment, treatment or rehabilitation objective. The mean sample was 32% of the number of WRPCs due on Program IV, including 7-day, 14-day, monthly, quarterly</p>

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		<p>and annual. The facility reported a mean compliance rate of 2%. These mechanisms are sufficient to monitor this requirement.</p> <p>Recommendation 4, April 2007: Address and correct factors related to low compliance with this requirement.</p> <p>Findings: ASH has yet to address this recommendation.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AHL, TEB, MBW, WLB, DTM and CF). Of these individuals, four (AHL, TEB, MBW and CF) resided in Program IV and the remaining two at other programs in the facility. The review showed non-compliance in three charts (MBW, DTM and CF), compliance in two (TEB and WLB) and partial compliance in one (AHL).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase training sessions regarding objectives and interventions, and provide ongoing feedback and mentoring by senior clinicians. 2. Continue to monitor this requirement and analyze and correct factors regarding low compliance.
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, April 2007: Same as above.</p>

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		<p>Findings: Same as above.</p> <p>Other findings: This monitor reviewed the charts of five individuals: three from Program IV (AHL, TEB and MBW) and two from other programs (WLB and DTM). This review showed compliance in all charts.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as above.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor reviewed the charts of six individuals (AHL, TEB, MBW, WLB, DTM and CF). These individuals were selected from Program IV (AHL, TEB, MBW and CF) and other programs (DTM and CF). There was non-compliance in four (TEB, MBW, DTM and CF), compliance in one (WLB) and partial compliance in one (AHL).</p> <p>Compliance: Partial.</p>

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		<p>Current recommendation: Same as above.</p>
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, April 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor's review of the same charts listed above showed non-compliance in all cases.</p> <p>Compliance: Non-compliance.</p> <p>Current recommendation: Same as above.</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, April 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Other findings: This monitor's review of the same charts listed above showed partial compliance in three (AHL, TEB and MBW) and non-compliance in three (MBW, DTM and CF).</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Same as above.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.</p> <p>Findings: ASH reports that in July 2007, it implemented a system that enabled individuals on Program IV to enroll in 20 hours of Mall courses a week. The individuals were reportedly assigned to courses based on their preferences, which resulted in Mall courses that were not always aligned with the individuals' WRPs. ASH has a plan to ensure that the WRPTs modify the schedules of the individuals to ensure better alignment.</p> <p>Recommendation 2, April 2007: Continue efforts to monitor hours of active treatment (scheduled and attended).</p> <p>Findings: ASH presented information regarding the number of individuals who were scheduled for Mall activities and are attending at least one group in the PSR Mall. The data are based on a review of a 100% sample of the individual census on Program IV. The following table summarizes</p>

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the data:

	Aug	Sep	Mean
N	171	180	
n	171	180	
%S	100	100	
0-1 hr	15	9	12
1-5 hrs	5	8	7
6-10 hrs	7	8	8
11-15 hrs	9	19	14
16-19 hrs	52	51	51
20+ hrs	13	5	9

The facility's data show that most individuals have yet to receive the required hours of active treatment.

Other findings:

This monitor reviewed the charts of six individuals (AHL, TEB, MBW, WLB, DTM and CF) to determine the number of active treatment hours that were listed on the most recent WRP and the corresponding number of hours scheduled and attended per MAPP. The review showed that the facility has yet to make progress to ensure that the WRPs specify the hours and that these hours are consistent with MAPP data. In four of these individuals (AHL, WLB, DTM and CF), the WRPs did not specify any active treatment hours.

Compliance:

Partial.

Current recommendations:

1. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by

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		<p>individuals.</p> <ol style="list-style-type: none"> 2. Monitor hours of active treatment (scheduled and attended).
C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Monitor this requirement. 2. Assess and correct factors related to lack of programs. <p>Findings: At this time, ASH does not have any individuals whose legal status allows them to be off-facility for PSR Mall activities. Therefore, this requirement is currently not applicable to the facility.</p> <p>Current recommendations: None.</p>
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a mechanism to ensure proper linkage between type and objective of Mall activities and objectives outlined in the WRP, as well as documentation of this linkage. 2. Revise the WRP/Mall alignment check protocol to properly address this requirement. <p>Findings: A DMH statewide form to monitor Mall alignment was developed and approved effective June 2007. The hospital is currently utilizing this tool to assess linkage between Mall programs and the WRPs. In August 2007, the facility piloted the Mall Alignment Form and began to train the Program Directors in utilizing it. Inter-rater reliability has yet to be established. In August and September, the facility reviewed six and</p>

		<p>17 charts and reported compliance rates of 0% and 59% respectively. Recognizing the large discrepancy in results, the Mall Director has identified numerous issues regarding the monitoring tool, is addressing these issues at a statewide level, and will retrain ASH's monitors accordingly.</p> <p>Recommendations 3 and 4, April 2007:</p> <ol style="list-style-type: none"> 3. Implement electronic progress note documentation by all Mall and individual therapy providers. 4. Ensure that WRPTs integrate data from the Mall progress notes in the review and modification, as needed of the WRPs. <p>Findings: In August 2007, ASH began implementation of the progress note on a monthly basis in Program IV. The facility has a plan to implement the notes in the rest of the facility on a quarterly basis beginning in September 2007. At this time, the Mall progress notes are hand-written and delivered to and from facilitators and the WRTs. The progress note template is being integrated into the WaRMSS system for future use.</p> <p>Other findings: Reviewing the charts of six individuals, this monitor found non-compliance in four (AHL, WLB, DTM and CF) and compliance in two (TEB and MBW).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure proper linkage between type and objective of Mall activities and objectives outlined in the WRP, as well as documentation of this linkage.
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		<ol style="list-style-type: none"> 2. Monitor this requirement and analyze and correct factors related to inconsistent/low compliance. 3. Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. 2. Develop a written training curriculum that outlines the main elements of WRP trainings in reference to this requirement of the EP and align those elements with the DMH WRP Manual. <p>Findings: Same as in findings under Recommendation #2 in C.2.c.</p> <p>Recommendation 3, April 2007: Monitor this requirement using both process observation and clinical chart auditing.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, ASH reviewed an</p>

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		<p>average sample of 31% (August and September) of the WRPCs due on Program IV, including 7-day, 14-day, monthly, quarterly and annual. A mean compliance rate of 4% was reported. ASH also used the DMH Clinical Chart Auditing Form and reviewed an average sample of 63% of the charts of individuals with length of stay of 90 days or longer on Program IV. Using this process, the facility reported a mean compliance rate of 0%.</p> <p>Recommendation 4, April 2007: Add an indicator to address this requirement in the DMH Clinical Chart Auditing Form.</p> <p>Findings: The DMH has implemented this recommendation.</p> <p>Recommendation 5, April 2007: Address and correct factors related to low compliance.</p> <p>Findings: Same as in findings in C.1.a</p> <p>Other findings: This monitor reviewed the charts of five individuals who were selected from Program IV (TEB, MBW and CF) as well as other programs (WLB and DTM). There was non-compliance in four charts (TEB, MBW, WLB and CF) and compliance in one (DTM).</p> <p>Compliance: Partial.</p> <p>Current recommendation: Monitor this requirement using both process observation and clinical chart auditing, and analyze and correct factors related to low</p>
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		compliance.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Recommendation 2, April 2007: Revise current monitoring tool to include individuals whose functional status has improved.</p> <p>Findings: ASH has yet to address this recommendation.</p> <p>Recommendation 3, April 2007: Implement the DMH Clinical Chart Auditing Form.</p> <p>Findings: ASH used the DMH Chart Auditing Form to assess compliance with this requirement. The facility reviewed an average sample of 16% of the 14-day, monthly, quarterly and annual WRPs on Program IV (August and September 2007). The mean compliance rate was 4%. In addition, using the DMH WRP Observation Monitoring Form, the facility reviewed an average sample of 31% of the number of WRPCs due on Program IV, including 7-day, 14-day, monthly, quarterly and annual (August and September 2007). This review found a mean compliance rate of 5%. These monitoring mechanisms are sufficient to address this requirement.</p>

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		<p>Other findings: This monitor reviewed the charts of five individuals (DQ, RE, SNA, SRB and SRD) who have experienced the use of seclusion and/or restraints during this review period. The individuals were selected from Program IV (SRD and RE) as well as other programs (SNA, SRB and DQ). The following table outlines the individuals' initials, the date of seclusion and/or restraint reviewed, and the date of the WRPs that were completed following the use of seclusion and/or restraints.</p> <table border="1" data-bbox="991 522 1881 792"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of WRP</th> </tr> </thead> <tbody> <tr> <td>SRD</td> <td>08/21/07 to 08/24/07</td> <td>09/06/07</td> </tr> <tr> <td>RE</td> <td>08/03/07 to 08/04/07</td> <td>09/05/07</td> </tr> <tr> <td>SNA</td> <td>06/08/07, 06/10/07, 07/14/07, 08/07/07 and 08/28/07</td> <td>08/28/07</td> </tr> <tr> <td>SRB</td> <td>09/27/07 to 09/28/07</td> <td>10/03/07</td> </tr> <tr> <td>DQ</td> <td>09/17/07 to 09/18/07</td> <td>10/4/07</td> </tr> </tbody> </table> <p>This reviews showed the WRPs documented the use of seclusion and/or restraints in all cases except for that of SRD. However, none of the WRPs documented the circumstances that led to the use, or included modifications of interventions to reduce the risk for the individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement corrective actions to ensure: <ol style="list-style-type: none"> a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Continue to monitor this requirement using observation and chart auditing and analyze and correct factors related to low compliance. 	Individual	Date of seclusion and/or restraint	Date of WRP	SRD	08/21/07 to 08/24/07	09/06/07	RE	08/03/07 to 08/04/07	09/05/07	SNA	06/08/07, 06/10/07, 07/14/07, 08/07/07 and 08/28/07	08/28/07	SRB	09/27/07 to 09/28/07	10/03/07	DQ	09/17/07 to 09/18/07	10/4/07
Individual	Date of seclusion and/or restraint	Date of WRP																		
SRD	08/21/07 to 08/24/07	09/06/07																		
RE	08/03/07 to 08/04/07	09/05/07																		
SNA	06/08/07, 06/10/07, 07/14/07, 08/07/07 and 08/28/07	08/28/07																		
SRB	09/27/07 to 09/28/07	10/03/07																		
DQ	09/17/07 to 09/18/07	10/4/07																		

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		<p>3. Revise current monitoring tool to include individuals whose functional status has improved.</p>
<p>C.2.g.iii</p>	<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 recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue training of WRPTs to ensure proper implementation of this requirement. 2. Develop a written training curriculum that outlines the main elements of WRP training in reference to this requirement of the EP and align those elements with the DMH WRP Manual. <p>Findings: Same as in findings related to WRP training in C.1.a.</p> <p>Recommendations 3 and 4, April 2007:</p> <ol style="list-style-type: none"> 3. Continue to monitor this requirement using the Observation Monitoring Form. 4. Implement the DMH Clinical Chart Auditing Form. <p>Findings: Using this form, ASH reviewed an average sample of 32% of the WRPs due on Program IV, including 7-day, 14-day, monthly, quarterly and annual (August and September 2007). The facility reported a mean compliance rate of 0% with this requirement. This monitoring mechanism is sufficient.</p> <p>Other findings: This monitor reviewed the charts of six individuals who were selected from Program IV (AHL, TEB, MBW and CF) as well as other programs (WLB and DTM). All the charts included generic discharge criteria that were dictated by CONREP, but none included specific and/or individualized learning-based outcomes that relate to each individual's</p>

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		<p>profile of symptoms and functional needs. Furthermore, none of the charts included documentation in the present status section of the case formulation of the team's discussion of the individual's progress toward discharge.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that WRP training includes a specific module regarding discharge planning in accordance with requirements of the EP and the DMH WRP manual. 2. Monitor this requirement and analyze and correct factors related to low compliance.
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>Recommendation 1, April 2007: Same as in C.2.g.i.</p> <p>Findings: Same as in C.2.g.i.</p> <p>Recommendation 2, April 2007: Same as in C.2.f.viii.</p> <p>Findings: Same as in C.2.f.viii.</p> <p>Other findings: ASH used the Observation Monitoring Form to assess compliance with this requirement. The facility reviewed an average sample of 28% of the WRPCs due on Program IV, including 7-day, 14-day, monthly,</p>

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		<p>quarterly and annual (August and September 2007) and reported a mean compliance rate of 0%.</p> <p>This monitor reviewed the charts of the six individuals listed in C.2.g.iii. This review showed that three charts included data from the PSR Mall Facilitator Monthly Progress Note. However, no chart included evidence that this information was integrated into reviews of the WRPs.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Monitor this requirement using process observation and analyze and correct factors related to low compliance.</p>
C.2.h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Increase the number of PBS teams as specified in the Enhancement Plan.</p> <p>Findings: ASH does not have the required number of PBS teams to meet the Enhancement Plan criteria. ASH needs to have at least four PBS teams to fulfill the 1:300 ratio but currently has one full PBS team.</p> <p>Recommendation 2, April 2007: Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans.</p> <p>Findings: PBS psychologists at ASH have the authority to write orders for the</p>

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		<p>implementation of PBS plans. However, the Medical Executive Committees still needs to approve the revised Psychology Manual.</p> <p>Recommendation 3, April 2007: Ensure that all staff implement PBS plans and collect reliable and valid outcome data.</p> <p>Findings: PBS team members train staff responsible for implementing intervention plans and periodically collect fidelity data. Currently, ASH has only two active intervention plans. Both plans have fidelity data. However, the fidelity data is not collected regularly. Fidelity data should be collected more frequently (at least once a month or more frequently as determined by the data being collected).</p> <p>Recommendation 4, April 2007: Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed.</p> <p>Findings: PBS team members at ASH have and continue to receive training in PBS procedures such as PBS assessment, training and data collection/analysis from a variety of sources, including their consultant Angela Adkins (August 1 and 9, 2007), peers from other facilities (Susan Velasquez from Patton State Hospital, August 9, 2007), and from their own PBS team leader, Jeffrey Teuber (August 27, 28 and 29, 2007). Mary Garrett (nurse practitioner), PBS team member, provides monthly two-hour training to new employees in the facility on the principles, procedures and practices of PBS. Furthermore, new non-PBS staff continue to receive training through PBS team members. The table below showing the number of new staff who required PBS training (N), the number of staff who participated in the PBS training (n), and the percentage meeting competency (%C) is a summary of the facility's</p>
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data.

	Apr	May	Jun	Jul	Aug	Mean
N	7	9	44	21	55	
n	7	9	44	21	55	
%S	100	100	100	100	100	
%C	100	100	100	76	60	80

Two hours of training is inadequate to train staff to competency in all areas of PBS. ASH should use the full training schedule of eight hours to train staff to competency.

Recommendation 5, April 2007:

Develop behavioral guidelines for any individual who has severe maladaptive behaviors, as stated in the DMH WRP Manual.

Findings:

ASH writes behavioral guidelines for individuals with learned maladaptive behaviors. However, ASH does not track and monitor the number of individuals who meet criteria for behavioral guidelines or the number of individuals who receive services through behavioral guidelines. According to Diane Imrem, Chief of Psychology, ASH has decided to track individuals in need of behavioral interventions through the WRP Task Tracking Form. The process of using the Task Tracking form is appropriate, but the trigger data should also be considered for this purpose to ensure that individuals needing behavioral interventions are not missed.

Recommendation 6, April 2007:

Ensure that WRPT members understand when they should refer individuals to the PBS team.

		<p>Findings: ASH has trained WRPT members on PBS referral processes and procedures. In addition, PBS team members are embedded in WRPCs in Program IV to assist WRPTs. However, the number of referrals received by the PBS teams is low. ASH should identify the reasons for receiving so few referrals and take corrective actions.</p> <p>Recommendation 7, April 2007: Ensure that there is full administrative support for PBS team functions.</p> <p>Findings: ASH PBS teams receive full administrative support as evidenced by the restructuring of the administrative and clinical supervision of PBS, Neuropsychology, and BY CHOICE under the Chief of Psychology. Furthermore, individuals needing behavioral interventions now follow the PBS-BCC pathway, and PBS psychologists now have the authority to write orders in compliance with the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase the number of PBS teams as specified in the Enhancement Plan. 2. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 3. Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. 4. Develop behavioral guidelines for any individual who has severe maladaptive behaviors, as stated in the DMH WRP Manual. 5. Ensure that WRPT members understand when they should refer
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		individuals to the PBS team.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	Compliance: Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities.</p> <p>Findings: This monitor reviewed ASH's discipline-specific assessments. The statement on the "implications of the assessment for rehabilitation activities" was present only in the Psychology Integrated Assessment. As for the other disciplines, the discipline chiefs at ASH are said to be working with the discipline chiefs from the other facilities to address this requirement.</p> <p>Recommendation 2, April 2007: The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.</p> <p>Findings: ASH is training WRPTs to include relevant information from discipline-specific assessments into the Present Status section of the individual's WRPs. This monitor reviewed five Integrated Social Work and Psychology Assessments (JFD, JJS, MBH, DT, and DB) and their corresponding WRPs. DB's WRP was written using an older version of the template. The information in the Psychology and Social Work Integrated Assessments was not fully incorporated into the individuals' Case Formulations.</p>

		<p>Recommendation 3, April 2007: Ensure that group leaders are consistent and enduring for specific groups.</p> <p>Findings: ASH has not established a system to track and monitor this recommendation. ASH is in the process of setting up a system to track and monitor this recommendation through the use of the MAPP data.</p> <p>Recommendations 4 and 5, April 2007:</p> <ol style="list-style-type: none">4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.5. Track and monitor this objective. <p>Findings: ASH has yet to track and monitor individuals who frequently refuse to attend groups and therefore would qualify for referral for cognitive-behavioral interventions. As of September 2007, three staff members have received training in Motivational Interviewing, Narrative Restructuring Therapy and related cognitive-behavioral interventions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities.2. The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.3. Ensure that group leaders are consistent and enduring for specific groups.4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who
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		<p>refuse to attend groups as specified in their WRPs. 5. Track and monitor this objective</p>
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms. <p>Findings: ASH audited 23 charts using item #3 (Has documented objectives, measurable outcomes, and standardized methodology) from the DMH WRP Mall Alignment Monitoring Form to address this recommendation, reporting 35% compliance.</p> <p>This monitor reviewed eight charts (JFD, JJS, EGW, JRH, MC, MBH, DT, and DB). Three of them (EGW, JRH, and MC) had the objectives written in a way to inform what the individual will be doing and how the objective will be monitored objectively, and five of them failed to do so (JFD, JJS, MBH, DT, and DB).</p> <p>In some cases (for example, DB), the objectives were framed poorly. The same objectives were repeated (for example, objectives 10.1.1 and 10.1.2 for DB). Many of the objectives relied solely on the individual's verbal report as evidence, even when other means of objective monitoring were available.</p> <p>Three of them included interventions written in measurable terms (EGW, JRH, and MC), and the remaining five did not (JFD, JJS, EGW, DT, and DB). For example, for DB a number of interventions were simply stated as "Symptom management group", and "Mental illness awareness group."</p>

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		<p>Recommendation 3, April 2007: Ensure that each objective is directly linked to a relevant focus of hospitalization.</p> <p>Findings: This monitor reviewed eight charts (JFD, JJS, EGW, JRH, MC, MBH, DT, and DB). The objectives in all of them were linked to their specific foci of hospitalization. However, many of the objectives were framed poorly.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 2. When assigning individuals to Mall groups, the WRPT members should be familiar with the contents of the groups they recommend so that the groups are aligned with the individual's needs. <p>Findings: ASH reviewed 23 WRPs using item #4 (Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan) from the DMH WRP Mall Alignment Monitoring tool to address this recommendation, reporting 35% compliance.</p>

		<p>This monitor reviewed eight charts (JFD, JJS, EGW, JRH, MC, MBH, DT, and DB). Two of them (EGW and JFD) were assigned to therapies and rehabilitation services aligned with their needs. The remaining six failed to fully address the individuals' needs. For example, MBH had similar interventions and was assigned to the same treatment groups for different foci with multiple objectives. Additionally, individuals were assigned to symptom management groups for medication-related matters instead of to (or without complementary) Medication Management groups. None of them were assigned to 20 hours of PSR services.</p> <p>It appears that WRPTs do not know and/or understand the nature and content of PSR Mall services available at ASH, as evidenced by the restricted number of groups/activities that individuals are assigned to across foci and objectives. This should not be the case, as the Mall Director has compiled and distributed course contents to all WRPTs.</p> <p>Recommendation 3, April 2007: Group leaders should be held accountable for following the Mall curricula.</p> <p>Findings: ASH did not audit this recommendation. A number of Mall groups do not have a curriculum. Furthermore, a number of Mall groups also do not have fully developed lesson plans. According to the Mall Director, the Curriculum Committee at ASH meets twice a month to review the Mall curricula. Numerous lesson plans are in various stages of development. ASH has developed and implemented a PSR Mall Consultation checklist (September 2007) in Program IV to address this recommendation. The checklist includes questions asking if lesson plans were available and if they were being followed by the facilitator.</p>
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		<p>Recommendation 4, April 2007: Ensure that the Mall Director has the necessary staff to assist with Mall programming and management.</p> <p>Findings: The Mall Director does not have the full staffing. The Mall Director is assisted by two Mall Coordinators and a Mall Resource Coordinator. In discussion with this monitor, the Mall Director indicated the need for a Mall Coordinator and at least two Mall Coordinator Technicians for each program. ASH has posted for an Assistant Mall Director position.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. 2. When assigning individuals to Mall groups, the WRPT members should be familiar with the contents of the groups they recommend so that the groups are aligned with the individual's needs. 3. Group leaders should be held accountable for following the Mall curricula. 4. Ensure that the Mall director has the necessary staff to assist with Mall programming and management.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.</p> <p>Findings: ASH reviewed 23 charts using item #5 (<i>Utilizes the individual's strengths, preferences and interests</i>) from the DMH WRP Mall Alignment Monitoring tool to address this recommendation, reporting</p>

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		<p>18% compliance.</p> <p>This monitor reviewed 12 charts (JFD, JJS, EGW, JRH, MC, MBH, DT, DAH, WT, MAB, JAB, and DB). Three of them (EGW, WT, and MC) the majority of the interventions had the individuals' strengths specified. The remaining nine did not (JFD, JJS, JRH, MBH, DT, DAH, MAB, JAB, and DB).</p> <p>In general, many of the WRPTs used the same few factors as the individuals' strengths. For example, JAB had seven interventions with strengths listed as "utilizing his self-report that he enjoys unit socials as a strength." In some cases, the identified "strength" is in conflict with statements found in other sections of the case formulation. For example, one of DB's strengths in an intervention was identified as "desire to participate in treatment;" however, part of the statement in the Perpetuating Factors section read "...is not interested in treatment." A common strength identified across interventions both within and between WRPs is the "desire to return to court", and "desire to return to the community." These so-called strengths are not very helpful to facilitators. WRPT members should look for individuals' positive attributes to identify strengths.</p> <p>Recommendation 2, April 2007: Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</p> <p>Findings: This recommendation has yet to be fully implemented across all groups and activities. ASH has yet to automate the progress note process. A number of facilitators were not familiar with the strengths, preferences, and interests of the individuals attending their groups. At the present time, Mall progress notes are written monthly for</p>
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		<p>Program IV and quarterly for the rest of the programs.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
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 recommendations:</p> <p>Recommendation 1, April 2007: Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.</p> <p>Findings: This monitor reviewed 12 charts (JFD, JJS, EGW, JRH, MC, MBH, DT, DAH, WT, MAB, JAB, and DB). The documentation in these 12 charts did not show evidence that the clinical case formulation was conducted as a team. This monitor's observation of WRPCs showed that in a number of conferences there was team participation but the documentation does not reflect this. It is possible that this is also the case in at least a number of the 12 charts reviewed by this monitor. Individuals/teams responsible for training WRPTs should address proper documentation with the teams.</p> <p>Recommendation 2, April 2007: Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.</p> <p>Findings: ASH reviewed 23 WRPs using item #6 (focuses on the individual's</p>

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		<p>vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate) from the DMH WRP Mall Alignment Monitoring tool to address this recommendation, reporting 39% compliance.</p> <p>This monitor reviewed nine charts (JFD, JJS, JRH, DT, DAH, WT, MAB, JAB, and DB). Six of them (JFD, JJS, JRH, DT, MAB, and DB) included information on the individual's vulnerabilities in the Predisposing, Precipitating, and Perpetuating sections of the WRPs, and three of them (JAB, WT, and DAH) did not include sufficient information on the individual's vulnerabilities. For example, JAB's case formulation was incomplete and the section on Precipitating Factors was left out.</p> <p>Recommendation 3, April 2007: Update the present status to reflect the current status of these vulnerabilities.</p> <p>Findings: This monitor reviewed nine charts (EGW, JRH, MC, JFD, JJS, JRH, DT, MAB, and DB). None of them incorporated all the elements of the individual's vulnerabilities in the case formulation sections into the Present Status section of the WRP.</p> <p>Recommendation 4, April 2007: Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse.</p> <p>Findings: According to the Charlie Joslin, Clinical Administrator, ASH's Substance Abuse Services staff had developed and implemented a Trans-theoretical Stages of Change training curriculum (titled Enhancing Motivation of Precontemplative Substance Abusing</p>
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		<p>Individuals), based on SAMHSA's Manual. The four-hour training session used hand-outs, oral presentation, a post-test, and a training video. Thirty staff have completed training as of October 6, 2007. This training is to be conducted quarterly until all WRPT members have participated in it.</p> <p>Recommendation 5, April 2007: Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.</p> <p>Findings: ASH has yet to offer WRAP groups to all individuals in the facility. According to the Mall Director, Matt Hennessy, Program IV has been instructed to offer WRAP groups to all individuals in the Program. To date, 133 of the 217 individuals in Program IV (62%) have enrolled in the WRAP groups. This monitor's review of the Mall group schedule and participation list supports the facility's data. The Mall Director expects better monitoring and tracking of this service once the MAPP data becomes available.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse. 5. Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.
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<p>C.2.i.vi</p>	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: PSR mall groups should address the assessed cognitive levels of the individuals participating in the group.</p> <p>Findings: ASH has established a curriculum subcommittee to develop and implement a plan for addressing this recommendation. The subcommittee consists of the Mall Director, the Director of Centralized Psychological Assessment Services, the D-CAT PBS Team leader, a Neuropsychologist, and a Special Education teacher. The primary objective of the subcommittee is to assess and identify individuals' cognitive levels so that these individuals can then be assigned to Mall courses appropriate to their cognitive levels. Furthermore, the Mall Director felt that the process will permit modification of the Mall curriculum and address the needs of the individuals, as well as assist in the training of group facilitators.</p> <p>ASH monitored the Mall groups of 14 individuals using item # 7 (<i>Is provided in a manner consistent with each individual's cognitive strengths and limitations</i>) from the DMH WRP Mall Alignment Monitoring tool to address this recommendation, reporting 20% compliance.</p> <p>This monitor observed a number of Mall groups (Medication Management 1, WRAP, Medication Management II, Medication Management III, and Anger Management). The individuals in these groups displayed different levels of cognitive functioning. However, it appeared that the facilitators were not aware of the cognitive functioning of the individuals in their groups as evidenced by the lack of modification in material and oral presentation. For example, it was unclear if all the individuals in the Medication Management groups were</p>
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		<p>able to read the prescriptions/dosage instructions on their medication containers.</p> <p>Recommendation 2, April 2007: Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.</p> <p>Findings: According to Charles Broderick, Acting Senior Psychologist, the Psychologists' in ASH assess the cognitive levels of individuals upon admission using the Psychology Integrated Assessment (IAP). The IAP includes a section on an intellectual functioning screen and a cognitive screen. Individuals identified with low intellectual/cognitive levels are recommended for further assessments. In addition, the DCAT and Neuropsychologist address the cognitive levels of individuals whose cognitive status has changed as a function of medication, seizures, brain injury etc. If fully functioning, the system will capture the individuals in need of cognitive screening/assessments; however, at the present time a large number of individuals do not get their IAPs in a timely manner.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	Current findings on previous recommendations:

		<p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process. <p>Findings:</p> <p>ASH has instituted the progress note requirement on a monthly basis for Program IV, and on a quarterly basis for the rest of the programs. Progress notes are hand written and shared with the WRPTs. The facility is in the process of automating this process through the WaRMSS system. A review of charts showed that progress notes are not written consistently or in a timely manner, regularly reviewed by the WRPTs or integrated into the individual's Present Status section of the WRP.</p> <p>This monitor reviewed eight charts (MC, TK, SR, DM, JER, JSR, GR, and BWM). Five of them (MC, TK, SR, JSR, and BWM) contained one or more Mall progress notes. However, none of the progress notes were integrated into the Present Status section of the individual's WRP. It was also noted that a number of the progress notes merely had the boxes checked without any additional quantitative/qualitative information.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators
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		<p>and individual therapists to provide progress notes in a timely manner.</p> <p>3. Use the data from monthly Mall Progress Notes in the WRP review process.</p>
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 recommendations:</p> <p>Recommendation 1, April 2007: Provide PSR Mall groups as required by the EP, 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>Findings: ASH has set up three Central Malls in Program IV, and Unit Malls for the other programs. The Mall groups are scheduled for 50 minutes each, Mondays through Fridays, for four time blocks: 9.00AM - 9.50AM, 10.00AM - 10.50AM, 1.30-2.20PM, and 3.15-4.05PM. According to the Mall Director, the Central Malls are much better organized and conducted than the Unit Malls. This monitor's observation of both Central Malls and Unit Malls confirmed the Mall Director's report. This monitor found that when Unit Malls were in session, staff were in their offices and individuals were in the hallway or watching television. On the other hand, Central Malls were better organized; the individuals who attended the Central Malls were engaged in their respective PSR groups and no one was observed loitering in the hallways of the Central Malls. According to the Mall Director, units were instructed to not have televisions turned on in units during Mall hours.</p> <p>Recommendation 2, April 2007: Mandate that all staff at ASH, other than those who attend to</p>

		<p>emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff.</p> <p>Findings: The ED has directed all staff including the clinical, administrative, and support staff to provide services at the PSR mall, unless they attend to emergency medical needs of individuals. It appears that compliance to this directive is poor. This monitor accompanied by the Mall Director and the Clinical Administrator, witnessed a number of staff in their offices during the PSR Mall hours.</p> <p>Recommendation 3, April 2007: All Mall sessions should be 50 minutes in length.</p> <p>Findings: ASH has scheduled all Mall group activities for 50 minutes in length. ASH monitored this recommendation using the MAPP, reporting 98% compliance for Program IV. ASH should continue to monitor all groups in the facility for compliance with this recommendation.</p> <p>Recommendation 4, April 2007: Provide groups as needed by the individuals and written in the individuals' WRPs.</p> <p>Findings: The Mall Director has distributed "New Activity Request Forms" to Program IV. He has not received any request for new groups from WRPTs or individuals.</p> <p>This monitor heard from one individual who wished there were more groups, specifically a Home Economics group. This monitor learned that there is a Home Economics group, but it is available only to individuals who are ready for discharge. The restriction appears to be based on</p>
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		<p>limited space and resources. The Mall Director, Matt Hennessy, is aware of this restriction and will look into adding more Home Economic groups.</p> <p>The Mall Director also indicated that the 20-hour-a-week requirement for individuals in Program IV was instituted in July 2007. Apparently, due to the quick implementation of this directive, most individuals were assigned to groups solely based on their preferences without proper support from the WRPTs to understand the course content and their particular needs. Thus, the alignment between Mall courses and WRPs is poor.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. 2. Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. This includes clinical, administrative and support staff. 3. All Mall sessions should be 50 minutes in length. 4. Provide groups as needed by the individuals and written in the individuals' WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with

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		<p>scheduled Mall activities.</p> <p>Findings: ASH did not have any bed-bound individuals in the facility during this reporting period and the Mall Director has not developed a curriculum for bed-bound individuals. ASH provides services in locations most suitable for the individual following recommendations from the individual's WRPT.</p> <p>This monitor reviewed the section of the Nursing Policy/Procedure Manual (304.1, March 2007) pertaining to bed-bound individuals. The section includes definitions, procedures, and documentation for PSR services for these individuals. Contents in this section are aligned with the EP.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
C.2.i.x	routinely takes place as scheduled;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

		<p>Findings:</p> <p>ASH offers PSR Mall services to all individuals in the facility. According to data presented by the facility, Mall groups are also held with regularity, with rules and procedures for cancellation. ASH's Mall cancellation rate for the months of August and September, 2007 was 9% and 12% respectively. However, individuals' group assignments are not consistently well aligned with individuals' needs, preferences, and cognitive and functional status. This monitor reviewed six charts (MAB, DT, JSS, JFD, JAB, and WT). There is no indication in the Present Status section of the individuals' WRPs that any consideration was given to cognitive levels when assigning the individuals to groups. For example, MAB is diagnosed with Borderline Intellectual Functioning, cerebral palsy, spine brain injury at birth, and grand mal epilepsy; however, the groups MAB was assigned to did not offer appropriate levels of services. In addition, MAB has not been assigned to 20 hours of group services to maximize his learning opportunities.</p> <p>The failure to complete the individual's cognitive/intellectual screening in a timely manner further complicates the problem of group assignments that are not well aligned with the individual's needs and status. This monitor reviewed 16 charts (ADD, GR, JER, JSR, INK, TSK, RM, MN, SZ, BM, MAM, RCT, DT, RJH, RP, and JKS), and seven of them (ADD, GR, JSR, RM, SZ, BM, and MAM) did not contain their Integrated Psychology Assessment sections.</p> <p>The Mall Director has taken steps to ensure that Mall groups are not cancelled when facilitators were unavailable. These steps included having the group facilitators call in so a substitute provider can be assigned. The Mall Director also has prepared a "MALL GROUP SURVIVAL KIT" that contains essential elements of the particular groups to assist substitute providers to update themselves fairly quickly.</p>
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Recommendation 3, April 2007:
 Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
 The Executive Director and Clinical Administrator at ASH have directed all staff to support PSR Mall services. ASH has decided to use Program IV as a pilot program to achieve EP compliance. A letter to this effect, dated July 18, 2007, was sent out to all staff by the Clinical Administrator, Charlie Joslin. According to the letter, the goal was for ASH to meet all EP compliance by the end of next year, subject to resources and staffing.

The minimum hours per week expected by discipline are: Psychiatry 8 hours, Psychology 10 hours, Social Work 10 hours, Rehabilitation Therapy 15 hours, RN 12 hours, and PT 12 hours.

The table below is a summary of the Mall hours scheduled by disciplines in Program IV for September 2007.

Job Classification	# of staff with at least one group	# of scheduled hours	Avg scheduled hours/week
Clin Social Work (H/Cf-S)	10	208.2	6.94
Pre-Lic Psych Tech (S)	2	11	1.83
Psych Tech (S)	53	530.6	3.34
Prog Asst (Md-S)	1	15	5.00
Psych Tech Trainee(S)	6	8	0.44
Psychologist (S)	4	64	5.33
Registered Nurse (S)	21	201.7	3.20
Rehab Ther, Rec(S)	5	124.2	8.28
Sr Psych Tech (S)	10	60	2.0
Staff Psychiatrist(S)	5	35.3	2.35

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		Unit Supervisor(S)	4	18	1.50																																																												
<p>As shown in the table above, none of the disciplines meet the average weekly hours of services expected of them.</p>																																																																	
<p>Recommendation 4, April 2007: Ensure that administrators and support staff facilitate a minimum of one Mall group per week.</p>																																																																	
<p>Findings: ASH requires all administrative and support staff to facilitate a minimum of one Mall group per week. The table below is a summary of the Mall hours scheduled by the administrative and support staff for September 2007.</p>																																																																	
<table border="1"> <thead> <tr> <th data-bbox="989 748 1333 857">Job Classification</th> <th data-bbox="1333 748 1526 857"># of staff with at least one group</th> <th data-bbox="1526 748 1694 857"># of scheduled hours</th> <th data-bbox="1694 748 1879 857">Avg scheduled hours/week</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 857 1333 898">Asst Chief, Cps (Ed)</td> <td data-bbox="1333 857 1526 898">1</td> <td data-bbox="1526 857 1694 898">57.2</td> <td data-bbox="1694 857 1879 898">19.07</td> </tr> <tr> <td data-bbox="989 898 1333 938">Cea (Various)</td> <td data-bbox="1333 898 1526 938">2</td> <td data-bbox="1526 898 1694 938">4.6</td> <td data-bbox="1694 898 1879 938">0.77</td> </tr> <tr> <td data-bbox="989 938 1333 979">Chief Psychologist, Cf</td> <td data-bbox="1333 938 1526 979">1</td> <td data-bbox="1526 938 1694 979">3.00</td> <td data-bbox="1694 938 1879 979">1.00</td> </tr> <tr> <td data-bbox="989 979 1333 1019">Chief, Cent Prog Svc</td> <td data-bbox="1333 979 1526 1019">1</td> <td data-bbox="1526 979 1694 1019">2</td> <td data-bbox="1694 979 1879 1019">0.67</td> </tr> <tr> <td data-bbox="989 1019 1333 1060">Chief, Protect Svcs</td> <td data-bbox="1333 1019 1526 1060">1</td> <td data-bbox="1526 1019 1694 1060">3</td> <td data-bbox="1694 1019 1879 1060">1.00</td> </tr> <tr> <td data-bbox="989 1060 1333 1101">Clin Psych Intern</td> <td data-bbox="1333 1060 1526 1101">1</td> <td data-bbox="1526 1060 1694 1101">4</td> <td data-bbox="1694 1060 1879 1101">1.33</td> </tr> <tr> <td data-bbox="989 1101 1333 1141">Clinical Dietitian (S)</td> <td data-bbox="1333 1101 1526 1141">3</td> <td data-bbox="1526 1101 1694 1141">12</td> <td data-bbox="1694 1101 1879 1141">1.33</td> </tr> <tr> <td data-bbox="989 1141 1333 1182">Clothing Cntr Mgr</td> <td data-bbox="1333 1141 1526 1182">1</td> <td data-bbox="1526 1141 1694 1182">0.5</td> <td data-bbox="1694 1141 1879 1182">0.17</td> </tr> <tr> <td data-bbox="989 1182 1333 1222">Coord Nursing Svcs</td> <td data-bbox="1333 1182 1526 1222">1</td> <td data-bbox="1526 1182 1694 1222">5</td> <td data-bbox="1694 1182 1879 1222">1.67</td> </tr> <tr> <td data-bbox="989 1222 1333 1263">Custodian</td> <td data-bbox="1333 1222 1526 1263">5</td> <td data-bbox="1526 1222 1694 1263">237.6</td> <td data-bbox="1694 1222 1879 1263">15.84</td> </tr> <tr> <td data-bbox="989 1263 1333 1304">Food Serv Tech I</td> <td data-bbox="1333 1263 1526 1304">1</td> <td data-bbox="1526 1263 1694 1304">1</td> <td data-bbox="1694 1263 1879 1304">0.33</td> </tr> <tr> <td data-bbox="989 1304 1333 1344">Health Services Spec(S)</td> <td data-bbox="1333 1304 1526 1344">11</td> <td data-bbox="1526 1304 1694 1344">46</td> <td data-bbox="1694 1304 1879 1344">1.39</td> </tr> <tr> <td data-bbox="989 1344 1333 1385">Hosp Police Lt</td> <td data-bbox="1333 1344 1526 1385">1</td> <td data-bbox="1526 1344 1694 1385">3</td> <td data-bbox="1694 1344 1879 1385">1.00</td> </tr> <tr> <td data-bbox="989 1385 1333 1391">Hosp Police Officer</td> <td data-bbox="1333 1385 1526 1391">1</td> <td data-bbox="1526 1385 1694 1391">1</td> <td data-bbox="1694 1385 1879 1391">0.33</td> </tr> </tbody> </table>						Job Classification	# of staff with at least one group	# of scheduled hours	Avg scheduled hours/week	Asst Chief, Cps (Ed)	1	57.2	19.07	Cea (Various)	2	4.6	0.77	Chief Psychologist, Cf	1	3.00	1.00	Chief, Cent Prog Svc	1	2	0.67	Chief, Protect Svcs	1	3	1.00	Clin Psych Intern	1	4	1.33	Clinical Dietitian (S)	3	12	1.33	Clothing Cntr Mgr	1	0.5	0.17	Coord Nursing Svcs	1	5	1.67	Custodian	5	237.6	15.84	Food Serv Tech I	1	1	0.33	Health Services Spec(S)	11	46	1.39	Hosp Police Lt	1	3	1.00	Hosp Police Officer	1	1	0.33
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Nurse Practitioner (S)	7	30.6	1.47
Nursing Coord (S)	2	5	0.83
Office Tech (Type)	3	6	0.67
Pre-Lic Psych Tech (S)	8	21.3	0.89
Prog Asst (Md-S)	9	50.6	1.87
Prog Dir (Md-S)	6	19.6	1.09
Prog Dir - Med Ff	1	2	0.67
Pub Health Nurse I	1	2	0.67
Pub Health Nurse Ii	2	4	0.67
Res Prog Spec I	1	3.6	1.20
Soc Work Associate(S)	1	11	3.67
Sr Psychologist, Cf(Sup)	2	8	1.33
Sr Psychologist, Spec	1	6	2.00
Sr Voc Rehab Couns(S)	1	9	3.00
Staff Svcs Manager Ii	1	1	0.33
Supv Reg Nurse (S)	1	3	1.00
Teacher (S/H Lh/Md)	8	362	15.08
Teaching Asst (S)	3	133	14.78
Supv, Prog. Tech Ii	1	2	0.67
Voc Inst/Mill & Cab. Wrk	1	17	5.67
Voc Inst/Prnt-Graph	1	38	12.67
Voc Instr Lndscp Grd(S)	1	37	12.33

As shown in the table above, at least 13 administrative/support staff provide less than one hour of services per week.

Current recommendations:

1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status.
2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

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		<ol style="list-style-type: none"> 3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
C.2.i.xi	<p>includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 3. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. <p>Findings:</p> <p>ASH has compiled a list of enrichment activities available along with the names of staff facilitating the activities. ASH provides a wide variety of enrichment and exercise group/individual activities. ASH made available a total of 32 types of activities, comprising 1654 enrichment groups in August, 2007 and 1530 groups in September 2007 and amounting to 1866 and 1869 hours for each month respectively. The competency of these providers was not verified. According to the Mall Director, the activities are generally not of uniformed methodology. At present, there is no staff member assigned to track and monitor enrichment/exercise activities. ASH may want to consider assigning a staff member under the Mall arm of PSR services, with supervision by the Clinical Administrator and/or the Mall Director.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with

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		<p>generally accepted professional standards of care.</p> <ol style="list-style-type: none"> Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. 																																			
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units. Continue to monitor this requirement. <p>Findings: The facility used item #12 (<i>Staff are observed discussing Mall activities with the individuals</i>) from the Therapeutic Milieu Observation Monitoring tool, reporting 25% compliance. The table below showing the number of units in the hospital (N) by each month, the number of audits conducted (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1042 1814 1235"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>33</td> <td>32</td> <td>30</td> <td>30</td> <td>28</td> <td></td> </tr> <tr> <td>n</td> <td>6</td> <td>6</td> <td>7</td> <td>7</td> <td>6</td> <td></td> </tr> <tr> <td>%S</td> <td>18</td> <td>19</td> <td>23</td> <td>23</td> <td>21</td> <td></td> </tr> <tr> <td>%C #12</td> <td>0</td> <td>33</td> <td>29</td> <td>0</td> <td>67</td> <td>25</td> </tr> </tbody> </table> <p>This monitor reviewed eight charts (MAB, JFD, JJS, WT, DAH, JAB, MBH, and DB). Two of them (DAH and JAB) had the therapeutic milieu specified in the intervention section of the individuals' WRPs, and six of them (MAB, JFD, JJS, WT, MBH, and DB) did not specify the</p>		Apr	May	Jun	Jul	Aug	Mean	N	33	32	30	30	28		n	6	6	7	7	6		%S	18	19	23	23	21		%C #12	0	33	29	0	67	25
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		<p>therapeutic milieu in which the interventions were to occur.</p> <p>This monitor observed four Mall groups (Medication Management I, WRAP, Medication Management II, Medication Management III, and Anger Management). The staff in these settings reinforced the individuals frequently and appropriately.</p> <p>This monitor observed staff in the units. This monitor did not observe any staff conversing with individuals about their Mall activities. In one unit, there were five staff in the office area not attending to any individuals, yet they were not attending to any Mall groups as required. Most staff in the units attended to the individuals, answered their questions, and assisted them with their needs (water, medicine, etc.).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units. 3. Continue to monitor this requirement.
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 recommendations:</p> <p>Recommendation s 1-5, April 2007:</p> <ol style="list-style-type: none"> 1. Establish group exercises and recreational activities for all individuals. 2. Ensure that there is sufficient activity programming to keep individuals active and engaged. 3. Provide training to Mall facilitators to conduct the activities appropriately. 4. Track and review participation of individuals in scheduled group exercise and recreational activities. 5. Implement corrective action if participation is low.

Findings:

ASH audited individuals with a BMI \geq 25, to evaluate if the individuals participated in at least one exercise group, reporting 29% participation. The table below showing the number of individuals in the facility with a BMI \geq 25 (N), the number of individuals audited (n), and the participation rate obtained (C%) is a summary of the facility's data.

2007	Aug	Sep	Mean
N	703	728	
n	703	728	
%S	100	100	
% participating	28	29	29

ASH's census for the month of August and September was 957 and 975 individuals respectively. As the N in the table above shows, ASH has a large percentage—over 70 percent—of individuals with high BMIs. This monitor's review of the list of the individuals' BMIs showed the range to be from overweight to morbid obesity. These individuals are at risk for obesity-related health conditions. However, only 29% of the individuals participated in any exercise/recreational group.

ASH has set up more than 30 enrichment/recreational activities but is not tracking individuals' participation or addressing the low participation rate. ASH should continue to expand the types of activities offered to cater to the variety of preferences that can be expected in a large group of individuals.

Compliance:

Partial.

Current recommendations:

1. Establish group exercises and recreational activities for all

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		<p>individuals.</p> <ol style="list-style-type: none"> 2. Ensure that there is sufficient activity programming to keep individuals active and engaged. 3. Provide training to Mall facilitators to conduct the activities appropriately. 4. Track and review participation of individuals in scheduled group exercise and recreational activities. 5. Implement corrective action if participation is low.
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 recommendations:</p> <p>Recommendations 1-4, April 2007:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled. <p>Findings:</p> <p>ASH has developed and implemented a Family Survey Instrument, producing it in both English and Spanish. The instrument has been produced both in English and Spanish. One survey is for the individual to respond to and the other is for family members.</p> <p>According to the Acting Chief of Social Work, Janet Bouffard, ASH has just finished conducting a needs assessment survey with individuals and their families. The survey data are yet to be analyzed for presentation. She also said that WRPCs provide a means to identify individuals in need of family therapy services. She believes that the WRPTs can interview the individual and determine if the individual is in</p>

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		<p>need of family therapy.</p> <p>Janet Bouffard is also looking into working with Social Work Chiefs of the other facilities to investigate the feasibility of didactic training for families living close to the other facilities regardless of which facility the individual has been admitted to.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.
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 recommendation:</p> <p>Recommendation, April 2007: Implement monitoring system to track the elements of this requirement.</p> <p>Findings: From my interview with the Clinical Administrator, a tool will be developed by the end of October addressing this requirement and training will begin in November, 2007.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a monitoring system to track the elements of this requirement. 2. Provide data addressing this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because ASH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Implement AD #414.1 regarding Screening and Assessment for Substance Abuse Disorders.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has a plan to begin implementation for all individuals on the Admissions Units.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Implement AD #414.1 regarding Screening and Assessment for Substance Abuse Disorders for all individuals at ASH.</p>

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<p>C.2.o</p>	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Implement the DMH Clinical Chart Auditing Form to monitor this requirement, including the correct identification of the stages of change. 2. Ensure monitoring of a 20% sample of the target population. <p>Findings:</p> <p>ASH used the DMH Chart Auditing Form to assess compliance with the requirement to document Axis I diagnosis of substance abuse in focus 5, with at least one corresponding objective and intervention listed. The average sample (August and September 2007) was 71% of the 14-day, monthly, quarterly and annual WRPs on Program IV. The facility also used the Substance Abuse Checklist to assess compliance. This process was based on a review of a 100% sample of the individuals in Program IV with Axis I Substance Abuse Diagnosis. This N is more appropriate to the requirement than that used in the previous method. The following is an outline of the monitoring indicators and corresponding mean compliance rates reported using the checklist:</p> <table border="1" data-bbox="991 967 1864 1417"> <tr> <td>1.</td> <td>When substance abuse is diagnosed on Axis I, it is documented in Focus 5</td> <td>56%</td> </tr> <tr> <td>2.</td> <td>Substance Abuse is identified in the (case formulation's) 6-Ps</td> <td>62%</td> </tr> <tr> <td>3.</td> <td>There is an objective and corresponding intervention under Focus 5</td> <td>42%</td> </tr> <tr> <td>4.</td> <td>The individual's stage of change is identified in the WRP</td> <td>54%</td> </tr> <tr> <td>5.</td> <td>The stage of change is consistent with corresponding objectives and interventions</td> <td>33%</td> </tr> <tr> <td>6.</td> <td>There is a treatment referral to substance abuse services for assessment</td> <td>66%</td> </tr> </table>	1.	When substance abuse is diagnosed on Axis I, it is documented in Focus 5	56%	2.	Substance Abuse is identified in the (case formulation's) 6-Ps	62%	3.	There is an objective and corresponding intervention under Focus 5	42%	4.	The individual's stage of change is identified in the WRP	54%	5.	The stage of change is consistent with corresponding objectives and interventions	33%	6.	There is a treatment referral to substance abuse services for assessment	66%
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		<p>Recommendation 3, April 2007: Finalize and implement the training curriculum to include all phases of change and be aligned with the trans-theoretical model.</p> <p>Findings: A training curriculum, including a training video and post-test, regarding the trans-theoretical conceptualization of substance abuse was developed. All WRPT members are required to complete the training.</p> <p>In addition, a training curriculum, entitled <i>Enhancing Motivation for Pre-contemplative Substance Abusers</i>, was developed by ASH's Substance Abuse Services for staff providing pre-contemplative substance abuse services hospital-wide. This four-hour training was based on SAMHSA's Tip 35 Manual. According to ASH, all staff providing pre-contemplative services (#30) had received the training as of October 6, 2007. ASH reports that the training will be provided quarterly as new groups are added and facilitators are identified. At this time, ASH has multiple manuals that adequately address the five stages of change: Pre-contemplation, Contemplation, Preparation, Action and Maintenance</p> <p>Recommendation 4, April 2007: Develop and implement clinical outcomes for individuals and process outcomes for the program.</p> <p>Findings: ASH reports that clinical outcomes are measured through the progress notes and completed pre- and post-tests by the individuals. However, no data were presented regarding specific clinical outcomes. The facility's Substance Abuse Services Quarterly Report (April 1 to September 15, 2007) includes the following process outcomes:</p>
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	1.	Total individuals referred to SAS:	609
	2.	Total individuals screened by SAS:	409
	3.	Number of Substance Abuse Services (SAS) groups offered weekly to individuals:	67
	4.	Number of individuals receiving SAS services:	596
	5.	Number of individuals on waiting list to receive SAS services:	19
	6.	Total number of SAS Training Activities provided to staff	9
	7.	Number of SAS staff monitored for fidelity using the PSR Mall Facilitation Consultation Form:	4
<p>Recommendation 5, April 2007: Ensure that individuals under PC 1370 and PC 2684 continue to receive substance abuse services based on their assessed needs.</p> <p>Findings: ASH reports that Substance Abuse education and awareness groups specific to the PC 1370 and PC 2684 commitments are currently being offered. Also, individuals within these commitments are referred to SAS through regular protocols and are included as needed.</p> <p>Recommendation 6, April 2007: Same as C.2.n.</p> <p>Findings: Same as in C.2.n.</p> <p>Other findings: This monitor reviewed the charts of five individuals who were selected from Program IV (AHL, TEB, MBW and CF) and other programs (WLB). The review found the following:</p>			

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		<ol style="list-style-type: none"> 1. Substance abuse was listed as a diagnosis and a focus in all charts; 2. There was a corresponding objective/intervention in three charts (AHL, TEB and MBW); 3. Two charts included a generic and meaningless intervention listed as "Unit Sponsor will educate the individual;" and 4. No chart included objectives/interventions that were appropriately linked to the stage of change. <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of corresponding specific and individualized objectives and interventions. 2. Provide specific data regarding the facility's system of assessing clinical outcomes and results of this assessment. 3. Continue to track process outcomes regarding substance abuse services. 4. Collaborate with MSH to integrate indicators regarding SAS clinical and process outcomes. 5. Provide data to demonstrate that individuals under PC 1370 and PC 2684 are receiving substance abuse services based on their assessed needs.
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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Assess the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training

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<p>individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</p>	<p>of individuals to achieve their goals and objectives.</p> <p>Findings: ASH monitored 13 facilitators from Program IV using a PSR Mall Facilitator Consultation Checklist. The facilitators were from three disciplines: psychology, social work, and rehabilitation.</p> <p>This monitor reviewed the results. Observations had been conducted across various dimensions including knowledge of the facilitators, instructional techniques, presentation style, and individuals' response to the facilitator. The table below is a summary of the main categories and the average percentage compliance obtained by ASH, and the average percentage compliance obtained by this monitor from observation of four Mall groups:</p> <table border="1" data-bbox="991 743 1812 1208"> <thead> <tr> <th>Categories</th> <th>ASH</th> <th>Monitor</th> </tr> </thead> <tbody> <tr> <td>Lesson plan followed</td> <td>46%</td> <td>75%</td> </tr> <tr> <td>Facilitator familiar with lesson plan</td> <td>46%</td> <td>75%</td> </tr> <tr> <td>Presentation engaging and effective</td> <td>92%</td> <td>75%</td> </tr> <tr> <td>Presentation clear and orderly</td> <td>85%</td> <td>50%</td> </tr> <tr> <td>Brief review of previous session</td> <td>62%</td> <td>25%</td> </tr> <tr> <td>Summarize work at conclusion</td> <td>62%</td> <td>Not observed</td> </tr> <tr> <td>Evaluates participants understanding</td> <td>92%</td> <td>75%</td> </tr> <tr> <td>Engages each person in session</td> <td>92%</td> <td>75%</td> </tr> <tr> <td>Participants showed enthusiasm</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Participants demonstrate learning</td> <td>85%</td> <td>50%</td> </tr> </tbody> </table> <p>ASH evaluated the types of instructional techniques used by the facilitators, including modeling, shaping, multimedia instructions, prompting and coaching, positive reinforcement, and homework. Knowing the type of instructional techniques used is useful. An additional useful element would be to know if the instructional</p>	Categories	ASH	Monitor	Lesson plan followed	46%	75%	Facilitator familiar with lesson plan	46%	75%	Presentation engaging and effective	92%	75%	Presentation clear and orderly	85%	50%	Brief review of previous session	62%	25%	Summarize work at conclusion	62%	Not observed	Evaluates participants understanding	92%	75%	Engages each person in session	92%	75%	Participants showed enthusiasm	100%	100%	Participants demonstrate learning	85%	50%
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		<p>techniques used were appropriate to the domain of instruction and purpose of learning—for example, a written test for knowledge/ understanding of court procedures and role-playing/practice for social skills.</p> <p>This monitor's data are not representative of the Mall groups in ASH. Three out of the four groups observed were the Medication Management groups. The course content of this curriculum is more narrow and structured than other course curriculums. The providers in these groups happened to be contract staff. One of them was facilitating a group for the first time. In general, this monitor was impressed with the preparation, professionalism, and motivation of these providers.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives.
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>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change.

		<p>Findings: ASHs policy is that all substance abuse service staff are certified or complete a one-year in-house certification process. Currently, ASH has 27 certified staff providing pre-contemplative groups, and four substance abuse staff with the one-year in-house certification. One staff is scheduled to enroll in a community certification class next month and another within the next six months. All other substance abuse service staff satisfy the discipline-specific licensure set by their professional regulatory bodies.</p> <p>ASH also uses continuing education in the field of substance abuse as part of the annual performance evaluation for those staff providing substance abuse services.</p> <p>ASH provides substance abuse training in the five stages of change, and monitoring and tracking their competency in core areas including:</p> <ul style="list-style-type: none"> • How and why the program exists. • Working effectively with dually diagnosed individuals. • Stages of change. • Motivational interviewing. • 12-step and trans-theoretical Model (TTM) philosophy and methodology. • Facilitation of group and one to one counseling activities. • Knowledge of alcohol and other drug interaction with mental illness. <p>Recommendation 4, April 2007: Establish a review system to evaluate the quality of services provided by these trained facilitators.</p> <p>Findings: ASH has established a review system using the PSR Mall Facilitator's</p>
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		<p>Checklist to evaluate the substance abuse service providers. ASH has tied the substance abuse service providers' performance evaluations to their substance abuse service.</p> <p>Recommendation 5, April 2007: Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.</p> <p>Findings: ASH continues to train all staff providing substance abuse services. The recent training (August 31, 2007, and September 27, 2007) was for staff providing service at the pre-contemplative stage.</p> <p>This monitor reviewed the training documentation. Training was conducted on August 31, 2007, and September 27, 2007. Twenty-eight staff participated in the two training sessions.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators. 5. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.
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C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Establish an automated system to track cancellation of scheduled appointments. 2. Continue to ensure that all medical appointments of individuals are completed as scheduled. <p>Findings:</p> <p>ASH has yet to automate the system to track cancellation of scheduled appointments. It appears that the Dental Department has purchased new software that could be used to automate the system but CMS has not looked into its feasibility. According to the Clinical Administrator, Charlie Joslin, for the time being tracking of cancellation of scheduled appointments is done through the Central Medical Services database. The table below showing the number of appointments completed, cancelled, and reason for the cancellations from April through September, 2007, is a summary of the facility's data.</p> <table border="1" data-bbox="989 894 1860 1395"> <thead> <tr> <th>Month/2007</th> <th>Number of Appointments Completed</th> <th>Number of Appointments Cancelled</th> <th>Reason Appointments Cancelled</th> </tr> </thead> <tbody> <tr> <td>Apr</td> <td>108</td> <td>0</td> <td></td> </tr> <tr> <td>May</td> <td>115</td> <td>0</td> <td></td> </tr> <tr> <td>Jun</td> <td>86</td> <td>0</td> <td></td> </tr> <tr> <td>Jul</td> <td>101</td> <td>1</td> <td>Police unable to transport individual to radiology for CT Scan. CT Scan is rescheduled- individual refused that appt.</td> </tr> <tr> <td>Aug</td> <td>92</td> <td>0</td> <td></td> </tr> <tr> <td>Sep</td> <td></td> <td>3</td> <td>3 appointments had to be rescheduled due to transportation issue-Handicap Van broke down.</td> </tr> </tbody> </table>	Month/2007	Number of Appointments Completed	Number of Appointments Cancelled	Reason Appointments Cancelled	Apr	108	0		May	115	0		Jun	86	0		Jul	101	1	Police unable to transport individual to radiology for CT Scan. CT Scan is rescheduled- individual refused that appt.	Aug	92	0		Sep		3	3 appointments had to be rescheduled due to transportation issue-Handicap Van broke down.
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		<p>As the data in the table above show, a total of four appointments were cancelled in the last six months, three of which were cancelled due to the lack of transportation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Establish an automated system to track cancellation of scheduled appointments. 2. Continue to ensure that all medical appointments of individuals are completed as scheduled.
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements. <p>Findings: ASH does not assign individuals to groups based on their cognitive levels, needs, and strengths. Rather, the individual's interest is the main criteria used for group assignments. This is especially so in Program IV because in July 2007, ASH decided to fully implement the EP requirement of 20 hours of PSR Mall services for all individuals. This created a need to assign individuals to groups before the WRPTs could be trained in the WRPC procedures.</p>

		<p>ASH has established a curriculum subcommittee to address this requirement. The subcommittee is said to consist of the Mall Director, the Director of Centralized Psychological Assessment Services, the D-CAT PBS Team leader, a neuropsychologist and a special education teacher. The task for the subcommittee is to come up with a process for the assessment and identification of the individuals' cognitive levels, assignment to Mall courses, modification of the Mall curriculum, and the identification of training needs for staff to properly implement the curriculum.</p> <p><i>ASH used item #10 (Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided 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) from the DMH WRP Clinical Chart Audit tool, reporting 0% compliance .</i></p> <p>Recommendation 4, April 2007: Continue the implementation of PSR Mall in all programs in the facility.</p> <p>Findings: ASH has not fully implemented all the elements of EP regarding PSR Mall services. According to the Mall Director and the Clinical Administrator, ASH developed a one-year plan to fully implement this recommendation. The table below showing the phases and timelines of AHS's proposed implementation plan is a summary of the facility's data.</p>
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Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="993 228 1850 719"> <thead> <tr> <th data-bbox="993 228 1241 269">Month</th> <th data-bbox="1241 228 1850 269">Location/Implementation</th> </tr> </thead> <tbody> <tr> <td data-bbox="993 269 1241 342">August 2007</td> <td data-bbox="1241 269 1850 342">Program IV</td> </tr> <tr> <td data-bbox="993 342 1241 415">October 2007</td> <td data-bbox="1241 342 1850 415">Add fourth admission unit and staff all four admission units at a 1:15 ratio.</td> </tr> <tr> <td data-bbox="993 415 1241 488">December 2007</td> <td data-bbox="1241 415 1850 488">Program VI</td> </tr> <tr> <td data-bbox="993 488 1241 561">February 2008</td> <td data-bbox="1241 488 1850 561">Program V, add fifth admission unit.</td> </tr> <tr> <td data-bbox="993 561 1241 634">April 2008</td> <td data-bbox="1241 561 1850 634">Program II and III, add sixth admission unit.</td> </tr> <tr> <td data-bbox="993 634 1241 719">June 2008</td> <td data-bbox="1241 634 1850 719">Program VII and I</td> </tr> </tbody> </table> <p data-bbox="993 760 1140 824">Compliance: Partial.</p> <p data-bbox="993 873 1325 898">Current recommendations:</p> <ol data-bbox="993 911 1850 1235" style="list-style-type: none"> 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements. 4. Continue the implementation of PSR Mall in all programs in the facility. 	Month	Location/Implementation	August 2007	Program IV	October 2007	Add fourth admission unit and staff all four admission units at a 1:15 ratio.	December 2007	Program VI	February 2008	Program V, add fifth admission unit.	April 2008	Program II and III, add sixth admission unit.	June 2008	Program VII and I
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C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments,	<p data-bbox="993 1284 1591 1308">Current findings on previous recommendations:</p> <p data-bbox="993 1357 1444 1382">Recommendations 1-2, April 2007:</p> <ol data-bbox="993 1395 1808 1422" style="list-style-type: none"> 1. Develop and implement monitoring tools to ensure the process 														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>and the individual's progress, or lack thereof;</p>	<p>outcomes of treatment and/or rehabilitation services.</p> <p>2. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.</p> <p>Findings: ASH has decided to use the DMH WRP Clinical Chart Audit Form to monitor this recommendation.</p> <p><i>ASH audited 199 charts using item #11 (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) from the DMH WRP Clinical Chart Audit form to address this recommendation, reporting 0% compliance.</i></p> <p>This monitor reviewed seven charts (MK, TSK, DT, DB, MBH, DAH, and MAB). None of the WRPs in the charts documented the individual's progress or lack of progress in the PSR Mall services, individual therapy, vocational, and enrichment activities. None of the charts had revised the objectives according to the individual's progress or lack of progress in the various activities/groups they participated in, or provided a justifiable reason for continuing with the objective. None of the charts had progress notes written for each active treatment in the individual's WRP. In some cases, Mall activities are not properly linked to the foci, objectives and interventions specified in the WRP. For example, WT's activity schedule includes depression and crisis management, stress management and relaxation training, music appreciation, walk and talk, stress management through music listening, and arts and craft, but the foci, objectives, and interventions in WT's WRP were not linked to these Mall activities.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.
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 recommendations:</p> <p>Recommendation 1, April 2007: Provide Mall groups to address this requirement.</p> <p>Findings: ASH implemented a Mall course entitled "Introduction to Wellness and Recovery Planning" to meet this requirement. In September 2007, 29 hours of group were scheduled, 20 were held, and 50 individuals participated.</p> <p>Recommendation 2, April 2007: Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities.</p> <p>Findings: ASH has implemented this recommendation.</p> <p>Recommendation 3, April 2007: Develop and implement a monitoring tool to address this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 4, April 2007: Provide data to support that that individuals are provided a copy of their WRPs based on clinical judgment.</p> <p>Findings: ASH has yet to implement this recommendation. The WaRMSS software has a system for recording the number of individuals who request a copy of their WRPs and the number of individuals who are provided a copy of the WRP. Until this system is operational, the ASH WRP observation monitors are expected to utilize a check box system to monitor this recommendation and supporting data should be tracked monthly.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Increase Mall groups to address this requirement. 2. Develop and implement a monitoring tool to address this requirement. 3. Provide data to support that that individuals are provided a copy of the WRP based on clinical judgment.
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 recommendations:</p> <p>Recommendation 1, April 2007: Increase the number of Mall groups that offer education regarding medication management.</p>

Findings:

ASH has implemented this recommendation on Program IV. The following table illustrates the number of medication management group hours on Program IV since April 2007. No data are available for July due to the power outage in the hospital during that time.

2007	Apr	May	Jun	Jul	Aug	Sep
# Scheduled	12	13	10	-	88	96
# Held	9	7	3	-	51	53

All Medication Management groups on Program IV are led by members of the Department of Psychiatry (physicians and/or nurse practitioners). The data show that there was a substantial increase in the number of groups offered in August and September. However, some groups had to be cancelled because of difficulties in setting up the mall groups, including psychiatry staff having to provide court testimony during Mall times and shortage of nurse practitioners.

Recommendation 2, April 2007:

Monitor implementation of this requirement.

Findings:

ASH has yet to implement this recommendation. The Clinical Administrator has set up a system for monthly review of the data with the Nursing Administrator, Medical Director and Acting Senior Psychiatrist.

Compliance:

Partial.

Current recommendations:

1. Increase the number of Mall groups that offer education regarding medication management facility-wide.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		2. Monitor implementation of this requirement.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.</p> <p>Findings: ASH recognizes that its data regarding this recommendation are unreliable due to data entry problems. The facility anticipates that this problem will be resolved by the next evaluation in April 2008.</p> <p>Recommendation 2, April 2007: Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has a plan to implement the following mechanism: upon identification of non-adherence to interventions in the WRP, the WRPT will investigate the reasons for non-attendance and offer the individual further choices to resolve his/her reluctance to attend scheduled or individual therapy. Actions taken will be documented in the Present Status section of the WRP. This will be reviewed at scheduled Trigger Meetings via the Clinical Administrators office.</p> <p>Recommendation 3, April 2007: Provide training to the WRPTs to ensure implementation of:</p> <ul style="list-style-type: none"> a) Appropriate individual therapy to individuals who do not adhere to their WRPs; and b) Clinical strategies to help individuals achieve readiness to engage in group activities.

		<p>Findings: ASH provided the same information regarding WRP training that was outlined in C.1.a. In addition, Narrative Restructuring Training was initiated the week of September 24, 2007 to three ASH staff. Additional staff will be trained to allow the treatment teams to engage this resource to address barriers to participation. DMH is contracting with a certified Motivational Interviewing trainer to train hospital staff in this treatment model.</p> <p>Recommendation 4, April 2007: Develop and implement monitoring tools to assess compliance with this item.</p> <p>Findings: There is a facility-wide system to monitor non-adherence via the Key Indicator system that also includes documentation of the remediation process, feedback from the WRPTs, MAPP schedule and attendance, and follow-up by the Clinical Administrator's office. This system does not require a new monitoring instrument.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.2. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation.3. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.
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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. ASH has made significant progress toward recruitment of needed psychiatrists on an emergency basis. 2. ASH has initiated a plan to comply with all requirements of the EP in the area of psychiatric assessments, including the performance of integrated assessments and weekly psychiatric progress notes as well as new formats for the assessments and reassessments. 3. There is recent evidence that a small number of the psychiatric assessments and reassessments on Program IV have improved, both in format and quality. <p>Summary of Progress on Psychological Assessments:</p> <ol style="list-style-type: none"> 1. Assignment of the Acting Senior Psychologist, Charles Broderick, PhD, to be responsible for bringing D2 in compliance with EP. Charles has the knowledge and commitment to support the psychologists responsible for conducting psychological assessments. Given the right authority and resources Charles should meet the challenge. 2. The quality of Neuropsychological assessments has improved. 3. Manuals and documents, including the Psychology Manual and the By-Choice Incentive Manual, have been revised to align with the EP as well as across DMH facilities. 4. Psychologists have improved precision and clarity in writing the clinical question/reasons for referral section. 5. Psychologists are increasingly using assessment data to address PSR Mail services. <p>Summary of Progress on Nursing Assessments:</p> <ol style="list-style-type: none"> 1. The statewide Nursing Committee has developed admission and integrated nursing assessments based on the Wellness and Recovery Model.

		<ol style="list-style-type: none"> 2. Implementation and training on the new admission assessments will begin November 2007 statewide. 3. In spite of staffing issues, ASH is currently completing the initial Nursing Admission Assessments in a timely manner. <p>Summary of Progress on Rehabilitation Therapy Assessments:</p> <ol style="list-style-type: none"> 1. Statewide meetings of Rehabilitation Service Chiefs are resulting in improved alignment of rehabilitation services with the Wellness and Recovery model. 2. ASH has yet to achieve full rehabilitation services integration, which contributes in part to uneven quality of assessments across disciplines. 3. Some progress has been made in revising assessment practices and tools; work remains so that the tools promote comprehensiveness, substantive qualitative findings, analysis and measurability. <p>Summary of Progress on Nutrition Assessments:</p> <ol style="list-style-type: none"> 1. Training regarding high-risk referral has occurred and the referral form has been incorporated into both Nursing and Nutrition Policies and Procedures. 2. Reorganization of caseloads should result in more comprehensive auditing and improved audit reliability. 3. Compliance regarding individualized and measurable goals and recommendations tends to lag compliance regarding nutrition assessment timeliness, completeness and diagnostic accuracy. <p>Summary of Progress on Social History Assessments:</p> <ol style="list-style-type: none"> 1. The Department has strong leadership in the Acting Chief of Social Work, Janet Bouffard. 2. Many of the needed structures, systems and assessment tools are being developed and implemented.
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Section D: Integrated Assessments

		<p>Summary of Progress on Court Assessments:</p> <ol style="list-style-type: none">1. ASH has developed and implemented a variety of mechanisms to ensure compliance with EP requirements regarding PC 1026 and 1370 reports, including administrative directives that contain the EP requirements regarding the format of the reports and the review of all reports by a functional Forensic Review Panel (FRP).2. ASH has strengthened the leadership and functions of the FRP.3. ASH has improved the format and quality of PC 1370 reports.
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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. Robert Knapp, MD, Medical Director 2. Jean Dansereau, MD, Acting Senior Psychiatrist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 47 individuals (AEM, AW, BAD, CAW, CBC, DB, DDM, DQ, DRF, FL, GC, GV, HCG, JGM, JH, JJC, JJM, JRC, JRD, JTG, JWW, KDB, LA, LCR, LLC, MBW, MC, MLD, MR, MV, MVB, NBH, PDV, RCM, RE, RGS, RSD, RW, SLM, SNA, SRB, SRD, TAM, TJS, TR, TWF, and VHC) 2. ASH Medical Staff Bylaws 3. ASH Department of Psychiatry Manual 4. ASH reports regarding current psychiatry staffing levels, board eligibility and certification status and recruitment activities 5. ASH draft of instructions regarding completion of initial and integrated psychiatric assessments 6. ASH dictation format for the Integrated Psychiatric Assessment 7. ASH format for the Integrated Psychiatric Reassessments 8. ASH Protocol #230, Standardized Procedure: Admission History and Physical Examination 9. ASH Department of Medicine Meeting Minutes of November 16, 2006 10. Department of Medicine Procedure Manual 11. ASH Initial Admission Assessment Monitoring Form 12. ASH Initial Admission Assessment Monitoring Form Instructions 13. ASH Initial Admission Assessment Monitoring summary data (September 2007) 14. ASH Admission Medical Evaluation and Treatment Monitor Tool 15. ASH Admission Medical Evaluation and Treatment Monitoring summary data (April to September, 2007)

Section D: Integrated Assessments

		<p>16. ASH Monthly Progress Notes Monitoring (Psychiatry) Form 17. Monthly Progress Notes Monitoring (Psychiatry) Form Instructions 18. Monthly Progress Notes Monitoring (Psychiatry) summary data (September 2007) 19. Physician Transfer Summary Monitoring Form 20. Physician Transfer Summary Monitoring Form Instructions 21. Physician Transfer Summary Monitoring summary data (September 2007)</p>										
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a monitoring instrument to assess accuracy/validity of psychiatric diagnoses.</p> <p>Findings: ASH used the current Initial Admission (Psychiatric) Assessment and Monthly Progress Notes Monitoring (Psychiatry) Forms to assess compliance. The data were based on samples of 96% of the number of admission assessments and 2% of the number of individuals who have been hospitalized for at least 90 days, respectively. The following tables outline the indicators and corresponding compliance rates. The facility has yet to provide monitoring data regarding diagnostic accuracy on the Integrated Assessments.</p> <table border="1" data-bbox="989 1117 1881 1234"> <tr> <td colspan="2">Initial Admission Assessment</td> </tr> <tr> <td><i>Admission diagnosis: Axis I-V</i></td> <td>95%</td> </tr> <tr> <td><i>DSM-IV diagnosis consistent with history and presentation</i></td> <td>92%</td> </tr> </table> <table border="1" data-bbox="989 1271 1881 1421"> <tr> <td colspan="2">Monthly progress notes</td> </tr> <tr> <td><i>Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.</i></td> <td>57%</td> </tr> </table>	Initial Admission Assessment		<i>Admission diagnosis: Axis I-V</i>	95%	<i>DSM-IV diagnosis consistent with history and presentation</i>	92%	Monthly progress notes		<i>Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred, and rule-out diagnoses, if applicable.</i>	57%
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Section D: Integrated Assessments

		<p>Recommendation 2, April 2007: Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across state facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least a 20% sample monthly, stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in Section D.</p> <p>Findings: The DMH is in the process of finalizing and approving current drafts of the following tools:</p> <ol style="list-style-type: none">1. DMH Admission Psychiatric Assessment Monitoring Form2. DMH Admission Psychiatric Assessment Monitoring Form and Instructions3. DMH Integrated Psychiatric Assessment Auditing Form4. DMH Integrated Psychiatric Assessment Auditing Form Instructions5. DMH Physician Progress Notes Auditing Form6. DMH Physician Progress Notes Auditing Form Instructions7. DMH Physician Transfer Note Auditing Form8. DMH Physician Transfer Note Auditing Form Instructions <p>This monitor provided feedback regarding these drafts in MSH Report 3. In recent months, ASH has initiated a combined format, with instructions, for the completion of initial and integrated psychiatric assessments. The facility's format and instructions provide further and improved delineation of:</p> <ol style="list-style-type: none">1. Risk factors and risk assessment;2. Substance abuse history;3. Psychiatric status at the time of offense, as applicable; and
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Section D: Integrated Assessments

		<p>4. Individual's strengths and assets.</p> <p>These elements can be integrated into the DMH drafts.</p> <p>These instruments, when finalized and implemented, are aligned with requirements of the EP and adequately address the deficiencies in the assessments and reassessments that were listed in the monitor's previous reports.</p> <p>Other findings: Chart reviews by this monitor showed that the format and quality of a small number of the initial psychiatric assessments, integrated psychiatric assessments and psychiatric reassessments that were completed on Program IV during September and October 2007 have provided adequate basis for diagnostic accuracy. Examples are found in the charts of PDV, AEM, TWF and GC. In general, these assessments represent improved practice at ASH since the baseline assessment. However, review of other charts indicate that much more work is needed to ensure that, facility-wide, the assessments and reassessments provide the information needed to reach the most reliable diagnosis and to establish individualized parameters for safe and effective treatment and rehabilitation of individuals.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric initial, integrated and transfer assessments and reassessments. 2. Continue to monitor this requirement based on sample sizes of at least 20% of the total target populations. 3. Provide monitoring data regarding diagnostic accuracy in the initial
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Section D: Integrated Assessments

		<p>and integrated assessments as well as reassessments (progress notes).</p> <p>4. Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).</p>
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Continue aggressive recruitment efforts to ensure adequate staffing in accordance with the required psychiatrist to individual ratios in admission and long-term units.</p> <p>Findings: ASH has continued aggressive efforts to recruit needed psychiatry staff. The facility has entered into six emergency psychiatrist contracts and five psychiatrist recruitment contracts which have resulted in the addition of 28 new psychiatrists to the ASH Department of Psychiatry since March 14, 2007, bringing the total to 45 (42.9 FTE) as of September 21, 2007. Additionally, six new psychiatrists are scheduled to start by mid-October 2007, and another 12 have been interviewed and are waiting for clearances. This represents significant improvement in staffing compared to the last review (ASH had 18.5 FTE staff).</p> <p>In addition, ASH advertises in multiple professional journals and on the internet. Board-certified staff psychiatrist salary ranges to be advertised in October 2007 include the Coleman raise, which is 5% less than CDCR psychiatrist salaries. ASH has also sent recruiters to three</p>

Section D: Integrated Assessments

		<p>national psychiatry conferences (AAPL, APA, and USP&MHC) in the past year.</p> <p>Recommendation 2, April 2007: Encourage all psychiatrists to obtain board certification.</p> <p>Findings: According to ASH Medical Staff Bylaws, a psychiatrist applicant requesting Department of Psychiatry privileges must have successfully completed at least three years of psychiatry residency training in an Accreditation Council for Graduate Medical Education-accredited program, and cannot be interviewed until this requirement is primary source-verified and the application is complete as noted on the credentialing checklist. Using the Psychiatrist Training/ Board Certification Audit Tool, a review of all psychiatrist credential files as of September 21, 2007, reveals 45 of 45, or 100%, are at least board-eligible (BE). The facility reports that all psychiatrists are encouraged, either through salary incentive or approved time off for training and examination, to obtain board certification (BC). ASH has consistently maintained a rate of BC=75% despite an extreme rate of attrition and turnover.</p> <p>Recommendation 3, April 2007: Ensure that Senior and Staff Psychiatrists provide full input into all processes that influence clinical care of individuals consistent with their expertise and professional interest.</p> <p>Findings: This is outlined in the Medical Staff Bylaws Section 9.4-1(a) and the staff psychiatrist and chief/senior psychiatrist duty statements.</p> <p>Compliance: Partial.</p>
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Section D: Integrated Assessments

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue aggressive recruitment efforts to ensure adequate staffing in accordance with the required psychiatrist-to-individual ratios in admission and long-term units. 2. Encourage all psychiatrists to obtain board certification.
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 1, April 2007: Refine quality indicators to be used in the performance evaluations/peer reviews of staff psychiatrists and ensure that the indicators clearly address the requirements of the EP in the areas of diagnosis, assessment and reassessment.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has a plan to implement, in November 2007, a Psychiatric Physician Quality Profile Program (PPQPP), utilizing elements of Atascadero Enhancement Plan Psychiatric Monitoring Program (AEPPMP). This program will gather data regarding the performance of Psychiatrists from the following sources:</p> <ol style="list-style-type: none"> 1. Psychiatric Admission Assessment Monitoring 2. Integrated Psychiatric Assessment Evaluation 3. Psychiatric Monthly Progress Note Monitoring 4. Psychiatric Transfer Summary Monitoring 5. Forensic PC 1026 Monitoring 6. Forensic PC 1370 Monitoring 7. High-Risk Anticholinergic Monitoring 8. High-Risk Benzodiazepine Monitoring 9. Stat/Emergency Monitoring 10. Antipsychotic PRN Monitoring

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		<ol style="list-style-type: none"> 11. Interclass, Intra-class Polypharmacy Monitoring 12. New Generation Antipsychotic Monitoring 13. Tardive Dyskinesia Monitoring 14. WRP Treatment Team Leadership 15. Attendance of Medical Staff/Committee Meetings; 16. Psychiatric Reassessments (weekly) *as applicable 17. CME 18. Seclusion/Restraint Review. <p>This system is aligned with requirements of the EP. The facility has yet to implement the system and utilize the information, as appropriate, in the processes of reprivileging and performance improvement.</p> <p>Recommendation 2, April 2007: Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP.</p> <p>Findings: ASH is in the process of implementing this recommendation. At present, the Department of Psychiatry Manual contains: 1) Initial and Integrated Psychiatry Assessment formats and examples; 2) DMH Psychotropic Medication Guidelines, effective June, 2007, with drug protocols and DUE monitoring forms; and 3) DMH WRP Manual. A new Initial Psychiatric Admission Assessment dictation format has been developed, and will be added to the Manual with instructions and the monitoring tool. A similar dictation format for the Integrated Psychiatric Assessment has been developed and will be added to the Manual in a similar fashion. ASH also plans to add expectations regarding completion of weekly and monthly progress notes to the manual.</p>
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Section D: Integrated Assessments

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the Psychiatric Physician Quality Profile Program and utilize data in the processes of reprivileging and performance improvement. 2. Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP. 												
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 recommendations:</p> <p>Recommendations 1 and 3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure completeness of the admission medical examination within the specified time frame. 3. Monitor this requirement based on at least a 20% sample. <p>Findings: ASH used the Admission Medical Evaluation and Treatment Monitoring Form to assess compliance with this requirement. The facility reviewed average sample of 17% of the number of admission medical examinations per month (April to September 2007). The following is an outline of the indicators and corresponding mean compliance rates.</p> <table border="1"> <tr> <td>1.</td> <td><i>Admission history within 24 hours</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Admission physical within 24 hours</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Admission review of system within 24 hours</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>All medical needs/conditions identified</i></td> <td>100%</td> </tr> </table>	1.	<i>Admission history within 24 hours</i>	99%	2.	<i>Admission physical within 24 hours</i>	99%	3.	<i>Admission review of system within 24 hours</i>	100%	4.	<i>All medical needs/conditions identified</i>	100%
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3.	<i>Admission review of system within 24 hours</i>	100%												
4.	<i>All medical needs/conditions identified</i>	100%												

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		<table border="1"> <tr> <td data-bbox="989 196 1045 228">5.</td> <td data-bbox="1045 196 1776 228"><i>Appropriate consultations ordered</i></td> <td data-bbox="1776 196 1881 228">92%</td> </tr> <tr> <td data-bbox="989 228 1045 305">6.</td> <td data-bbox="1045 228 1776 305"><i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i></td> <td data-bbox="1776 228 1881 305">97%</td> </tr> </table>	5.	<i>Appropriate consultations ordered</i>	92%	6.	<i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i>	97%	
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6.	<i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i>	97%							
		<p>These indicators are not well aligned with EP requirements in D.1.c.2 through D.1.c.5.</p> <p>Recommendation 2, April 2007: Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item.</p> <p>Findings: ASH's report did not address this recommendation.</p> <p>Recommendation 4, April 2007: Ensure that monitoring of the admission physical examination addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.</p> <p>Findings: ASH's report did not address this recommendation.</p> <p>Other findings: This monitor reviewed the charts of ten individuals who were selected from Program IV (KDB, MBW, LA, and MVB) and other programs (TAM, AW, FL, JJC, MV and MR). The review showed the history and physicals were completed within the required 24 hours in all cases, with substantial compliance regarding completion of the review of systems, medical history, diagnostic impressions and a management plan when acute problems are identified. However, there continues to be inconsistent compliance regarding completion of the genital/rectal/prostate examination. Review of the facility's</p>							

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		<p>documents indicates that the facility has ambiguous standards in this area. For example, minutes of the Medical Staff meeting (November 2006) give unclear direction regarding the specific age of individuals who should receive this examination. The reviews also showed evidence of lack of documentation of follow-up attempts to complete the physical examination for individuals who refuse all or parts of examination.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor specific requirements of the EP in D.1.c.i.1 through D.1.c.i.5. 2. Clarify facility's expectation regarding performance of genital/rectal examination of individuals and ensure alignment with generally accepted professional standards. 3. Ensure adequate documentation of subsequent attempts to complete the physical examination for individuals who refuse parts or all of the examination and follow-up by the WRPT, as appropriate, for individuals who continue to refuse.
D.1.c.i.1	a review of systems;	ASH reported a 97% compliance rate.
D.1.c.i.2	medical history;	ASH did not present data.
D.1.c.i.3	physical examination;	ASH did not present data.
D.1.c.i.4	diagnostic impressions; and	ASH did not present data.
D.1.c.i.5	management of acute medical conditions	ASH did not present data.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an	Current findings on previous recommendations:

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	<p>Admission Psychiatric Assessment that includes:</p>	<p>Recommendations 1-7, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement mechanisms to complete admission assessments within 24 hours of admission and an integrated assessment within seven days of an individual's admission to the facility. 2. The admission assessment must adequately address all the requirements in D.1.c.ii.1 to D.1.c.ii.6. 3. The integrated assessment must adequately address all the requirements in D.1.c.iii.1 to D.1.c.iii.10. 4. Ensure that the integrated assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 5. Ensure that the deficiencies outlined above are corrected as relevant to applicable requirements. 6. Monitor both admission and integrated assessments based on a 20% sample of the target population. 7. Ensure that monitoring of the all psychiatric assessments addresses completeness of the history and examination and that overall compliance rate accounts for the completeness of each item. <p>Findings:</p> <p>This section will address only those recommendations that relate to the Initial Admission Psychiatric Assessment. The recommendations were combined in the previous report to address both D.1.c.ii and D.1.c.iii.</p> <p>ASH has implemented Admission Psychiatric Assessments on Program IV in an effort to comply with requirements of the EP. ASH plans to ensure facility-wide implementation, but no time frame was provided. As mentioned earlier, the facility recently developed a form and instructions regarding the completion of both the initial and integrated Assessments (see Findings under Recommendation 2 in D.1.a). The facility used the Psychiatric Initial Admission Assessment Monitoring Form to assess compliance with this requirement. Reviewing a sample</p>
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		<p>of 88% of admission assessments completed in September 2007, the facility found that 100% of the assessments were completed within 24 hours of admission. A mean compliance rate of 82% was reported for all the items on this form. The compliance rates for each requirement in D.1.c.ii.2 through D.1.c.ii.6 are listed in each corresponding sub-cell, with the indicators listed only if they represented sub-components of the requirement.</p> <p>Other findings: This monitor reviewed the charts of ten individuals who were selected from Program IV (KDB, MBW, LA, and MVB) and other programs (TAM, AW, FL, JJC, MV and MR). The review showed a pattern of deficiencies that is essentially similar to that described in the previous report. The following are examples:</p> <ol style="list-style-type: none"> 1. Important components are missing, including: <ol style="list-style-type: none"> a. Diagnostic formulation (TAM, JJC, LA); and b. Differential diagnosis (TAM, JJC, LA, MV). 2. Important components are inadequately assessed, including: <ol style="list-style-type: none"> a. Risk assessment for aggression (MR and MVB); b. Risk assessment for suicide (TAM); c. Risk assessment for self-injury (JJC); d. Diagnostic formulation (MVB); and e. Strengths (FL and JJC). 3. Inadequate cognitive status examination (LA); 4. Generic assessment of insight and judgment (TAM and KDB); and 5. Inadequate management plan for identified risks (JJC, LA, KDB). <p>However, review by this monitor of the charts of other individuals for whom the initial assessments were completed on Program IV (September and October 2007) showed evidence of improved practice compared to the previous report. Examples are found in the charts of AEM, TWF, GC, PDV, NBH, JGM, DB, MC, CBC, HCG, RCM and RW.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure facility-wide implementation of the Initial Admission Psychiatric Assessments. 2. Monitor the Initial Admission Psychiatric Assessments relative to EP requirements in D.1.c.ii.1 through D.1.c.ii.6. 3. Correct the deficiencies outlined by this monitor above. 				
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	<table border="1"> <tr> <td><i>Pertinent history leading to admission</i></td> <td>96%</td> </tr> <tr> <td><i>Pertinent past history addressed</i></td> <td>96%</td> </tr> </table>	<i>Pertinent history leading to admission</i>	96%	<i>Pertinent past history addressed</i>	96%
<i>Pertinent history leading to admission</i>	96%					
<i>Pertinent past history addressed</i>	96%					
D.1.c.ii.2	complete mental status examination;	<table border="1"> <tr> <td><i>Mental status examination (MSE) completed</i></td> <td>99%</td> </tr> <tr> <td><i>Positive findings of the MSE addressed</i></td> <td>91%</td> </tr> </table>	<i>Mental status examination (MSE) completed</i>	99%	<i>Positive findings of the MSE addressed</i>	91%
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D.1.c.ii.3	admission diagnoses;	<table border="1"> <tr> <td><i>Admission diagnosis: Axis I-V</i></td> <td>95%</td> </tr> <tr> <td><i>DSM diagnosis consistent with history and presentation</i></td> <td>92%</td> </tr> </table>	<i>Admission diagnosis: Axis I-V</i>	95%	<i>DSM diagnosis consistent with history and presentation</i>	92%
<i>Admission diagnosis: Axis I-V</i>	95%					
<i>DSM diagnosis consistent with history and presentation</i>	92%					
D.1.c.ii.4	completed AIMS;	94%				
D.1.c.ii.5	laboratory tests ordered; and	96%				
D.1.c.ii.6	consultations ordered.	100% (if applicable)				

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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 recommendations:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH began implementation of the Integrated Psychiatric Assessment on Program IV on October 8, 2007. The facility has yet to fully implement this requirement. The facility plans to begin monitoring of the assessments next month.</p> <p>Other findings: This monitor's review of the Integrated Psychiatric Assessments that were recently completed on Program IV (AEM, TWF, GC and PDV) shows that these assessments are, in general, adequate to meet requirements of the EP.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure facility-wide implementation of the Integrated Psychiatric Assessments. 2. Monitor the Integrated Psychiatric Assessments relevant to EP requirements in D.1.c.iii.1 through D.1.c.ii.10.
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	ASH has no data at this time.
D.1.c.iii. 2	psychosocial history;	Same as above.
D.1.c.iii. 3	mental status examination;	Same as above.

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D.1.c.iii. 4	strengths;	Same as above.						
D.1.c.iii. 5	psychiatric risk factors;	Same as above.						
D.1.c.iii. 6	diagnostic formulation;	Same as above.						
D.1.c.iii. 7	differential diagnosis;	Same as above.						
D.1.c.iii. 8	current psychiatric diagnoses;	Same as above.						
D.1.c.iii. 9	psychopharmacology treatment plan; and	Same as above.						
D.1.c.iii. 10	management of identified risks.	Same as above.						
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.						
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Provide continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders.</p> <p>Findings: During this review period, ASH has facilitated several educational events, provided by PhD psychologists employed by ASH. The following is an outline of the relevant programs, with dates and names of instructors. ASH did not provide data regarding attendance numbers, disciplines of those who attended or relevance to this recommendation.</p> <table border="1"> <thead> <tr> <th>Program</th> <th>Date(s)</th> <th>Instructor</th> </tr> </thead> <tbody> <tr> <td>Neuropsychology Seminar (1 hour)</td> <td>April 10, 17, 24, May 1, 8, 15, 22, 29, June 5,</td> <td>Charles Broderick,</td> </tr> </tbody> </table>	Program	Date(s)	Instructor	Neuropsychology Seminar (1 hour)	April 10, 17, 24, May 1, 8, 15, 22, 29, June 5,	Charles Broderick,
Program	Date(s)	Instructor						
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			12, 19, 26, July 10, 17, 24, 31 August 7, 14, 21, 28, and September 11, 2007	PhD
		Use of the Reynolds Intellectual Screening Test and Wide Range Achievement Test-4 in conducting Assessments at ASH (7.5 hours)	October 2, 2007	James S. Gyurke, PhD
		<p>Recommendations 2-4, April 2007:</p> <ol style="list-style-type: none"> 2. Ensure that diagnostic formulations and differential diagnoses address the clinically appropriate needs of all individuals and that the diagnostic process includes adequate interventions and follow up to finalize diagnoses. 3. Monitor this requirement based on at least a 20% sample. 4. Revise current monitoring tool to address justification of diagnosis, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate. <p>Findings: ASH has yet to address these recommendations.</p> <p>Recommendation 5, April 2007: Same as in D.1.c.ii.</p> <p>Findings: Same as in D.1.c.ii.</p> <p>Other findings: This monitor reviewed the charts of 14 individuals who have received diagnoses listed as NOS continuously for more than three months</p>		

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		<p>during the past year. The review showed a pattern of inadequate documentation, evaluation and updates of these disorders. The following is list of charts reviewed:</p> <table border="1" data-bbox="991 337 1879 914"> <thead> <tr> <th>Initials</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BAD</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>DPF</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>VHC</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>RSD</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>SLM</td> <td>Psychotic Disorder, NOS</td> </tr> <tr> <td>JH</td> <td>Dementia, NOS and Borderline Intellectual Functioning</td> </tr> <tr> <td>MLD</td> <td>Dementia, NOS</td> </tr> <tr> <td>LCR</td> <td>Dementia, NOS</td> </tr> <tr> <td>JJM</td> <td>Impulse Control Disorder, NOS and Mood Disorder, NOS</td> </tr> <tr> <td>DDM</td> <td>Mood Disorder, NOS and Psychotic Disorder, NOS</td> </tr> <tr> <td>TR</td> <td>Cognitive Disorder, NOS and Depressive Disorder, NOS</td> </tr> <tr> <td>JRD</td> <td>Cognitive Disorder, NOS</td> </tr> <tr> <td>LLC</td> <td>Depressive disorder, NOS</td> </tr> <tr> <td>RGS</td> <td>Depressive disorder, NOS</td> </tr> </tbody> </table> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the professionals who have received training. 2. Ensure that monitoring tool instructions address requirements for diagnostic formulation, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate. 	Initials	Diagnosis	BAD	Psychotic Disorder, NOS	DPF	Psychotic Disorder, NOS	VHC	Psychotic Disorder, NOS	RSD	Psychotic Disorder, NOS	SLM	Psychotic Disorder, NOS	JH	Dementia, NOS and Borderline Intellectual Functioning	MLD	Dementia, NOS	LCR	Dementia, NOS	JJM	Impulse Control Disorder, NOS and Mood Disorder, NOS	DDM	Mood Disorder, NOS and Psychotic Disorder, NOS	TR	Cognitive Disorder, NOS and Depressive Disorder, NOS	JRD	Cognitive Disorder, NOS	LLC	Depressive disorder, NOS	RGS	Depressive disorder, NOS
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		3. Monitor this requirement, based on at least a 20% sample and analyze and correct factors related to low compliance.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in D.1.a and D.1.d.i.</p> <p>Findings: Same as in D.1.a and D.1.i</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.a and D.1.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, April 2007: Same as D.1.d.i.</p> <p>Findings: Same as D.1.d.i.</p> <p>Other findings: ASH used the Monthly Progress Notes Monitoring (Psychiatry) Form to assess compliance. Based on a sample of 2% of individuals who have been hospitalized for at least 90 days, the facility found a compliance rate of 57% (September 2007). This monitor's findings were addressed in C.1.d.i.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations: Same as 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, April 2007: Same as above.</p> <p>Findings: ASH does not have data regarding this requirement.</p> <p>Other findings: Chart reviews by this monitor did not show any Axis I diagnosis listed as "no diagnosis."</p> <p>Current recommendations: Same as above.</p>
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Monitor this requirement based on at least a 20% sample. 2. Assess and correct factors related to low compliance with the requirement for weekly progress notes on the admission teams. <p>Findings: ASH has yet to implement these recommendations. The facility recently implemented weekly psychiatric reassessments utilizing Psychiatric Nurse Practitioners on Program IV as a pilot program.</p>

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		<p>Other findings: This monitor reviewed charts of seven individuals who were selected from Program IV (KDB, MBW and LA) and other programs (TAM, AW, FL and JJC) to assess the frequency of psychiatric notes during the first 60 days of admission. The review showed non-compliance in all charts. This monitor also reviewed a sample of the weekly psychiatric reassessments that have been completed (September and October 2007) on Program IV (e.g. JRC, MC, CBC, GC, RCM, HCG, JC and RW). The review indicated that the format is adequate to meet EP requirements.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Monitor this requirement based on at least a 20% sample and analyze and correct factors related to low compliance.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use.</p> <p>Findings: A statewide format has yet to be finalized and implemented. ASH anticipates implementation of a format aligned with the current Psychiatric Monthly Progress Note Monitoring Form in November 2007.</p> <p>Recommendation 2, April 2007: When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific</p>

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		<p>items:</p> <ul style="list-style-type: none"> a) Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b) Review of individual's progress in behavioral treatment; c) Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d) Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. <p>Findings: ASH has yet to implement this recommendation. The facility plans to utilize the current Monthly Progress Notes Monitoring (Psychiatry) Form to assess compliance with this requirement.</p> <p>Recommendation 3, April 2007: Update the Department of Psychiatry manual to include requirements regarding documentation of psychiatric reassessments.</p> <p>Findings: ASH has implemented this recommendation (Psychiatry Manual, Section XI-110-1.4).</p> <p>Recommendation 4, April 2007: (Recommendation #4 in ASH Report 2 inadvertently repeated Recommendation #3.)</p> <p>Findings: Same as above.</p> <p>Recommendations 5-6, April 2007:</p> <ul style="list-style-type: none"> 5. Monitor this requirement based on at least a 20% sample. 6. Ensure that monitoring instruments are clearly aligned with all of
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		<p>the above expectations.</p> <p>Findings: ASH has yet to implement these recommendations.</p> <p>Other findings: ASH used the Monthly Progress Notes Monitoring (Psychiatry) Form to assess compliance with the requirements in D.1.f.i to D.1.f.vii. The compliance rates for each of these requirements are listed in each corresponding sub-cell, with the indicators listed only if they represented sub-components of the requirement. The sample sizes varied depending on the requirement and are included in parentheses. The facility's data regarding D.1.f.v are based on the monitoring of the side effects of anticholinergics, benzodiazepines and new-generation antipsychotic medications as well as use of polypharmacy. These data are presented in Section F.1. Regarding this requirement, the Monthly Progress Notes Form includes the indicator "monitoring of side effects," but ASH did not present data from this indicator. ASH used an indicator that is insufficient to assess compliance with F.1.d.vii.</p> <p>Chart reviews by this monitor indicate that in general, the facility has yet to correct the deficiencies in the documentation of psychiatric reassessments that were listed (#1-8) in this monitor's previous report.</p> <p>As mentioned earlier, select charts on Program IV contain an improved overall format of documentation (e.g. JRC, MC, CBC, GC, RCM, HCG, JC and RW). Although this format is adequate to meet EP requirements, the content of this documentation requires more work to ensure the following:</p> <ol style="list-style-type: none"> 1. Appropriate documentation of events during the previous interval; 2. Adequate analysis of the risks and benefits of current treatment and attempts to use safer and effective treatment alternatives;
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		<ol style="list-style-type: none">3. Proactive evaluation of risk factors and timely modification of treatment to minimize the risk; and4. Critical review of the circumstances leading to PRN/Stat medication use and adjustment of regular treatment as a result of this review. <p>This monitor also reviewed the charts of five individuals (RE, SRB, DQ, SNA and SRD) who have experienced the use of seclusion and/or restraints. The purpose of this review was to assess the psychiatric reassessments of the appropriateness of the use of PRN/Stat medications prior to seclusion and/or restraint. This review is also relevant to the requirement in D.1.f.vi. The review showed that PRNs were not appropriately used when indicated and when used, there was no review of this use to ensure that regular treatment is adjusted in a timely and appropriate manner. Both of these situations can have negative impact regarding the need for seclusion/restraint. The following are examples:</p> <ol style="list-style-type: none">1. Multiple PRN medication regimens were ordered for generic indications (e.g. agitation, imminent danger), without clear delineation of the circumstances that would require the use of each of these medications (RE and SNA);2. PRN medications were administered, but not selected appropriately based on the type of target symptoms (SNA);3. In all charts, there was no documentation of the number and type of PRN medications that were used during the interval, the circumstances that led to their uses and/or adjustment of regular medications based on this use;4. There was no documentation of a face-to-face assessment by the psychiatrist within 24 hours following the administration of Stat medications (DQ and SRB).
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the new format of psychiatric reassessments facility-wide and ensure correction of the deficiencies outlined in this monitor's report and in the previous report. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: <ol style="list-style-type: none"> a. Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plans; b. Review of individual's progress in behavioral treatment; c. Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d. Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments 3. Monitor this requirement based on at least a 20% sample.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	<i>Progress toward objectives in the WRP. 15% (sample size: 3%)</i>
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	57% (sample size: 2%)
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	8% (sample size: 3%)
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of	12% (sample size: 3%)

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	individuals and interventions to reduce risks;	
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	See F.1.
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	17% (sample size: 3%)
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.	<i>Are all PBS plans specified within objectives and interventions section of the WRP?</i> 0% (sample size: 100%).
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	Current findings on previous recommendations: Recommendation 1, April 2007: Update the Department of Psychiatry manual to include requirements

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	<p>medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>regarding timeliness, completeness and quality of inter-unit transfer assessments.</p> <p>Findings: ASH has implemented this recommendation (Psychiatry Manual Section XI-110-1.5).</p> <p>Recommendation 2, April 2007: Monitor this requirement using current instrument and ensure that quality of clinical data is considered in the estimation of compliance.</p> <p>Findings: ASH used the Physician Transfer Summary Monitoring Form to assess compliance. The facility reviewed a sample of 13% of inter-unit transfers in September 2007. The following outlines the monitoring indicators and corresponding compliance rates:</p> <table border="1" data-bbox="991 820 1881 1166"> <tr> <td>1.</td> <td><i>Reason for transfer</i></td> <td>50%</td> </tr> <tr> <td>2.</td> <td><i>Five axis diagnosis</i></td> <td>7%</td> </tr> <tr> <td>3.</td> <td><i>Psychiatric course of hospitalization</i></td> <td>17%</td> </tr> <tr> <td>4.</td> <td><i>Medical history and current medical condition</i></td> <td>7%</td> </tr> <tr> <td>5.</td> <td><i>Current target symptoms</i></td> <td>21%</td> </tr> <tr> <td>6.</td> <td><i>Psychiatric risk factors</i></td> <td>10%</td> </tr> <tr> <td>7.</td> <td><i>Review of medications</i></td> <td>7%</td> </tr> <tr> <td>8.</td> <td><i>Current barriers to discharge</i></td> <td>3%</td> </tr> <tr> <td>9.</td> <td><i>Anticipated benefits of transfer</i></td> <td>10%</td> </tr> </table> <p>Recommendation 3, April 2007: Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.</p>	1.	<i>Reason for transfer</i>	50%	2.	<i>Five axis diagnosis</i>	7%	3.	<i>Psychiatric course of hospitalization</i>	17%	4.	<i>Medical history and current medical condition</i>	7%	5.	<i>Current target symptoms</i>	21%	6.	<i>Psychiatric risk factors</i>	10%	7.	<i>Review of medications</i>	7%	8.	<i>Current barriers to discharge</i>	3%	9.	<i>Anticipated benefits of transfer</i>	10%
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8.	<i>Current barriers to discharge</i>	3%																											
9.	<i>Anticipated benefits of transfer</i>	10%																											

		<p>Findings: ASH has yet to address this recommendation. The facility reports that individuals who present severe management problems will be identified utilizing trigger data and tracked at the bi-monthly trigger meeting. The need for these individuals to have adequately designed and implemented PBS plans prior to inter-unit transfer will reportedly be addressed at that meeting.</p> <p>Other findings: This monitor reviewed the following charts to evaluate inter-unit transfer assessments:</p> <table border="1" data-bbox="991 634 1476 902"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>TJS</td> <td>9/13/07</td> </tr> <tr> <td>GV</td> <td>9/6/07</td> </tr> <tr> <td>CAW</td> <td>8/1/07</td> </tr> <tr> <td>JJG</td> <td>9/10/07</td> </tr> <tr> <td>JTG</td> <td>8/15/07</td> </tr> <tr> <td>JWW</td> <td>7/27/07</td> </tr> </tbody> </table> <p>The review showed that few assessments (e.g. TJS) included some discussion of course of psychiatric hospitalization and a review of current diagnosis and medications. Other assessments (e.g. GV and JJG) failed to include most of the needed information in the assessment. The charts of CAW, JWW and JTG did not include any transfer assessments. The following table outlines the individuals reviewed and dates of inter-unit transfers.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 1. Provide ongoing feedback and mentoring by senior psychiatrists to</p>	Initials	Date of transfer	TJS	9/13/07	GV	9/6/07	CAW	8/1/07	JJG	9/10/07	JTG	8/15/07	JWW	7/27/07
Initials	Date of transfer															
TJS	9/13/07															
GV	9/6/07															
CAW	8/1/07															
JJG	9/10/07															
JTG	8/15/07															
JWW	7/27/07															

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		<p>ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.</p> <ol style="list-style-type: none">2. Monitor this requirement based on a review of at least 20% sample.3. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.
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2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Diane Imrem, PsyD, Chief of Psychology 2. Matt Hennessy, PsyD, Mall Director 3. Donna Nelson, Director, Standards Compliance 4. Karen Dubiel, Assistant to Clinical Coordinator 5. Charlie Joslin, Clinical Administrator. 6. Charles Broderick, PhD, Acting Senior Supervising Psychologist 7. Christine Mathiesen, PsyD, Director C-PAS 8. Leslie Bolin, PhD, Neuropsychologist 9. Jeffrey Teuber, PhD, Senior Psychologist, PBS Team Leader 10. Cheryll Smith, PhD, Clinical Neuropsychologist, DCAT Leader 11. John Myers, SPT, Data Analyst 12. Theresa George, PhD, PBS Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 70 individuals (ACH, AG, AJ, AM, AR, BB, BL, BM, CBC, CN, DB, DLT, DNM, DQ, DT, EGW, EME, EO, ER, FH, GAS, HN, IM, JAJ, JER, JFD, JJS, JLR, JM, JN, JRH, JSR, KJ, KL, KR, KRM, KS, KW, LC, LJ, LLP, LS, MAM, MBH, MC, MH, MK, MM, MN, MW, RB, RCD, RCT, RG, RJH, RM, RNG, RP, SAS, SBZ, SR, SS, TL, TR, TS, TSK, TW, WRH, WT, and YM) 2. SO #131. 3. ADs #408, #416, #417, #512, and #518 4. DMH Integrated Assessment, Psychology Section 5. List of Psychologists Undertaking Psychological Assessments 6. List of Individuals Admitted to ASH Prior to April 2007 7. Patient Care Monitoring Committee Meeting Minutes 8. Behavioral Consultation Committee Meeting Minutes 9. List of Current Census of Individuals 23 Years of Age or Under upon Admission

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		<ol style="list-style-type: none"> 10. DMH Psychological Assessment Instructions 11. List of Individuals Needing Cognitive and Academic Assessments 12. List of Individuals on PBS Plans 13. List of Individuals referred to the Behavioral Consultation Committee 14. List of Individuals referred to the Patient Care Monitoring Committee 15. Credentialing/Privileging Curriculum Vitae of Psychologists 16. ASH WRP Training Database 17. ASH WRP Training Post-test 18. PBS-BCC Checklist 19. Standard Psychological Assessment Protocols 20. List of individuals with a Rule-out diagnosis 21. List of individuals with no diagnosis 22. List of individuals with NOS diagnosis 23. List of individuals for whom English is not the primary language 24. Membership list of Behavioral Consultation Committee 25. Behavioral Consultation Committee Attendance Summary 26. Structural Assessments 27. Functional Assessments 28. Behavioral Guidelines 29. Psychological Assessments 30. Neuropsychological Assessments 31. List of Completed DSM-IV-TR Checklists 32. Psychology Assessment Inventory 33. List of Individuals Referred for Neuropsychological Assessments 34. Technical and Procedural manual for Developmental and Cognitive Abilities Teams (Draft Version) 35. DMH BY-CHOICE Program Manual <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for DAH, Program 1, unit 11 2. WRPC for MC, Program 11, unit 26
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		3. WRPC for AEC, Program 1, unit 11
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 recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that revised documents, where applicable, align across DMH hospitals. 2. Finalize and implement all applicable documents that codify the requirements of the EP. <p>Findings: ASH has revised a number of documents to align with other DMH hospitals, including the Psychology Manual, the Positive Behavior Support Manual, the BY CHOICE Incentive Manual, the Suicide Prevention directive, the Restraint and/or Seclusion directive, and the Medical Staff By-Laws. The revised documents incorporate substantive changes in a number of areas in meeting EP requirements; for example psychologists at ASH are currently awaiting approval by the Medical Executive Committee write orders for the implementation of PBS plans.</p> <p>Recommendation 3, April 2007: Conduct competency-based training for all psychologists regarding the new clinical information included in the revised documents.</p> <p>Findings: ASH has provided ongoing training to its staff on the revised documents. Training on IAPS and SRA was conducted on September 6, 2007; training on the DMH Psychology Manual was conducted on September 12, 2007; and training on the WRAT-4 and PAI was conducted on October 2, 2007. According to Diane Imrem, Chief of Psychology, the training sessions were videotaped to train newly hired psychologists during the New Psychology Orientation period.</p>

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		<p>This monitor reviewed the training documents, attendance rosters, Special Order #131.00, and ADs #416, #408, #417, #518, and #512. This monitor's findings are in agreement with the facility's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that revised documents, where applicable, align across DMH hospitals. 2. Finalize and implement all applicable documents that codify the requirements of the EP. 3. Conduct competency-based training for all psychologists regarding the new clinical information included in the revised documents.
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 1, April 2007: Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team.</p> <p>Findings: ASH admitted 43 individuals under the age of 23 from April to September 2007. ASH audited the records of 21 of these individuals, reporting 10% compliance.</p> <p>This monitor reviewed the census of individuals under 23 years of age, and the timeliness of their cognitive and academic assessments. This monitor's findings were in agreement with the facility's data. In some cases, the assessments were untimely (for example, JN); in others, the</p>

		<p>examiner attempted to assess but determined that the individual was psychiatrically unstable and the assessment was not completed (for example, WRH and KS). However, the examiners failed to indicate when and by whom a review should be conducted to determine if the individual is subsequently sufficiently psychiatrically stable to complete the assessments.</p> <p>Recommendation 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Develop and maintain an accurate count of individuals eligible to have their cognitive and academic assessments conducted within 30 days. 3. Develop and implement monitoring and tracking instruments to assess this requirement. <p>Findings: ASH has set up a system to track and monitor admissions of individuals under 23 years of age. This system involves the psychology department receiving a weekly admission list of individuals below 23 years of age. This information is then shared with the psychologists responsible for the evaluations in the Admissions unit. The Admissions unit psychologists are to review the status of these individuals for their academic and cognitive assessments. According to Diane Imrem, Chief of Psychology, psychologists at ASH have been briefed on the process and procedures for this requirement.</p> <p>Recommendation 4, April 2007: Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.</p> <p>Findings: ASH did not audit this recommendation. According to the Chief of</p>
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		<p>Psychology, the Clinical Administrator and the Medical Director have agreed to permit unit psychologists to assess individuals whose cognitive and academic assessments were not conducted in a timely manner. However, examiners seldom provide a timeline for review/assessment if an individual could not be evaluated for a justifiable reason. For example, WRH and KS were determined by the examiners to be untestable due to psychiatric instability. However, the examiners did not state who should conduct the review and when the review should be conducted to ascertain if the individuals have subsequently become sufficiently stable for completion of the evaluations.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team. 2. Develop and maintain an accurate count of individuals eligible to have their cognitive and academic assessments conducted within 30 days. 3. Develop and implement monitoring and tracking instruments to assess this requirement. 4. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are	Current findings on previous recommendation:

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	<p>verifiably competent in the methodology required to conduct the assessment.</p>	<p>Recommendation 1, April 2007: Ensure that all psychologist positions are filled.</p> <p>Findings: ASH has not filled all the vacant psychology staffing positions. ASH faces a critical shortage of Level of Care staff psychologists. Only half of the open units (15 out of 30) have psychologists on the WRPTs. There is a shortage of Senior Psychologists to monitor psychological assessments and support the unit psychologists. There is also a shortage of psychologists in the PBS teams. ASH has tried to manage this shortage through "quarter-time" staff, whereby full-time staff at ASH are requested to work 10 hours of overtime per week.</p> <p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training and evaluating other psychology staff. 3. Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff. <p>Findings: ASH has three designated Senior Psychologist positions. These positions have not been filled. These positions are currently filled by Acting Senior Psychologists. According to Diane Imrem, Chief of Psychology, the Acting Senior Psychologists have the necessary administrative support to teach, train, and evaluate other psychology staff. However, they do not have sufficient time to cover all the relevant activities in a timely manner.</p> <p>Recommendation 4, April 2007: Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP.</p>
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		<p>Findings: ASH has implemented the standardized statewide assessment format and report-writing template. According to the Chief of Psychology, these templates are available to the psychologists through both the Dictation Services and the computer.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychologist positions are filled. 2. Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training and evaluating other psychology staff. 3. Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Partial.</p>
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. 3. Ensure that all psychological assessments meet at least generally acceptable professional standards.

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Findings:

ASH used item #3 from the DMH Psychology Assessment monitoring Form (*Does the assessment expressly state the clinical question(s) for the assessment?*) to address this recommendation, reporting 94% compliance. The table below with its monitoring indicator showing the number of new admissions (N) estimated eligible for focused psychological assessments, the number of focused psychological assessments conducted per month (n), and the percentage of compliance obtained (%C), is a summary of the facility's data.

	Apr	May	Jun	Jul	Aug	Sept	Mean
N	198	231	214	288	400	360	
n	9	10	6	3	8	4	
%S	5	4	3	1	2	1	
%C #3	100	100	78	100	88	100	94

According to the Senior Psychologist, Charles Broderick, the high compliance rates may be due to the low sampling rate and may not reflect the status of all focused assessments conducted. Furthermore, ASH used probability statistics to determine the percentage of expected focused assessments per individual admitted for each month. Charles Broderick stated that in the future ASH will review the IAPS, the WRP task tracking form, and the Senior Psychologist audits in determining "N" values.

This monitor was very impressed with Dr. Broderick's understanding of the quality of psychological assessments and the proper monitoring methods and procedures on meeting compliance with EP.

This monitor reviewed ten charts (BL, CB, KL, LC, KR, TW, IM, AM, DQ, and KW). Five of them (BL, AM, DQ, TW, and KW) met this criteria for this recommendation, and five of them (CB, KL, LC, KR, and IM) failed to frame the clinical/referral question in a concise and clear

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		<p>manner with a rationale for the assessment. For example, CB's clinical question was stated as "Mr. B. was seen by this evaluator in order to clarify diagnostic presentation;" KL's clinical question instead documented the assessments used to address the clinical question; and LC's record contained the individual's background information in this section.</p> <p>The writeup of the results in seven of these focused assessments (KL, KR, TW, KW, DQ, AM, and BL) showed continuity across the various sections. Three of them (LC, IM, and CB) did not evidence proper continuity across the sections in addressing the referral question. For example, CB's write up did not tie the recommendations to the referral question or findings, and did not have sufficient information in the integrated interpretation sections.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. 3. Ensure that all psychological assessments meet at least generally acceptable professional standards.
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, April 2007: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p> <p>Findings: ASH used item #4 from the DMH Psychology Assessment Monitoring</p>

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		<p>Form (<i>Do the findings specifically address the clinical question(s), but not limited to diagnosis and treatment recommendations?</i>) to address this recommendation, reporting 61% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 488 1864 678"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #4</td> <td>33</td> <td>60</td> <td>89</td> <td>100</td> <td>63</td> <td>50</td> <td>61</td> </tr> </tbody> </table> <p>This monitor reviewed nine charts (CB, KL, KR, LC, BL, AM, DQ, TW, and KW). Six of the focused assessments in them (BL, AM, DQ, TW, KW, and KL) included sufficient information that informed the psychiatric diagnosis and treatment/rehabilitation needs, and three of them (CB, LC, and KR) did not meet criteria.</p> <p>Current recommendation: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #4	33	60	89	100	63	50	61
	Apr	May	Jun	Jul	Aug	Sept	Mean																																			
N	198	231	214	288	400	360																																				
n	9	10	6	3	8	4																																				
%S	5	4	3	1	2	1																																				
%C #4	33	60	89	100	63	50	61																																			
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, April 2007: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.</p> <p>Findings: ASH used item #5 from the DMH Psychology Assessment Monitoring</p>																																								

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Form (*Does the assessment specify whether the individual would benefit from individual or group psychotherapy in addition to attendance at mall groups?*) to address this recommendation, reporting 45% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Apr	May	Jun	Jul	Aug	Sept	Mean
N	198	231	214	288	400	360	
n	9	10	6	3	8	4	
%S	5	4	3	1	2	1	
%C #5	44	40	100	33	25	25	45

This monitor reviewed ten charts (CB, LC, KL, KR, AM, TW, IM, DQ, KW, and BL). Six of the focused assessments in them (CB, LC, AM, TW, KW, and BL) included recommendations as to whether the individual would benefit from group or individual therapy and the recommendations were aligned with the findings, and four of them (KL, KR, IM, DQ) did not include sufficient information.

Trainers should emphasize that the documentation be comprehensive and inclusive. The recommendations should be aligned with the findings and include a rationale for the recommendations. Furthermore, the anticipated benefits and expected outcome for the individual should also be reported.

Current recommendations:

Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.

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D.2.d.iv	be based on current, accurate, and complete data;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that all psychological assessments are based on current, accurate, and complete data.</p> <p>Findings: ASH used item #6 from the DMH Psychology Assessment Monitoring Form (<i>Is the assessment based on current, accurate, and complete data?</i>) to address this recommendation, reporting 58% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 743 1864 938"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #6</td> <td>33</td> <td>60</td> <td>50</td> <td>100</td> <td>63</td> <td>75</td> <td>58</td> </tr> </tbody> </table> <p>This monitor reviewed six charts (BL, AM, DQ, TW, KW, and CB). Four of the focused assessments in them (BL, AM, CB, and TW) met criteria, and two of them (DQ and KW) did not.</p> <p>Current recommendation: Ensure that all psychological assessments are based on current, accurate, and complete data.</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #6	33	60	50	100	63	75	58
	Apr	May	Jun	Jul	Aug	Sept	Mean																																			
N	198	231	214	288	400	360																																				
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%S	5	4	3	1	2	1																																				
%C #6	33	60	50	100	63	75	58																																			
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that all psychological assessments of individuals with</p>																																								

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maladaptive behavior meet this requirement.

Findings:

ASH used item #7 from the DMH Psychology Assessment Monitoring Form (*Does the assessment 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?*) to address this recommendation, reporting 53% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Apr	May	Jun	Jul	Aug	Sept	Mean
N	198	231	214	288	400	360	
n	9	10	6	3	8	4	
%S	5	4	3	1	2	1	
%C #7	56	90	50	0	50	0	53

This monitor reviewed ten charts (CB, LC, KR, KL, IM, TW, AM, DQ, KW, and BL). Three of the focused assessments in them (LC, KR, and DQ) made recommendations regarding behavior supports or interventions for the individual, and seven of them (CB, KL, IM, TW, AM, KW, and BL) did not include such recommendations or the rationale for the decisions.

When training psychologists on this recommendation ASH should emphasize the importance of not only addressing the behavior supports and interventions appropriate for the individual based on the results of the assessments but also of giving the reasons/rationale for their recommendations.

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		<p>Current recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.</p>																																								
D.2.d.vi	include the implications of the findings for interventions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p> <p>Findings: ASH used item #8 from the DMH Psychology Assessment Monitoring Form (<i>Does the assessment include the implications of the findings for interventions?</i>) to address this recommendation, reporting 82% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 933 1864 1123"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #8</td> <td>89</td> <td>90</td> <td>95</td> <td>67</td> <td>75</td> <td>50</td> <td>82</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (CB, DQ, LC, BL, KL, AM, KR, TW, KW, and IM). Six of the focused assessments in them (DQ, LC, BL, AM, TW, and KW) included the implications of the findings for PSR services and other interventions, and four of them (CB, KL, KR, and IM) failed to satisfy this requirement.</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #8	89	90	95	67	75	50	82
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%C #8	89	90	95	67	75	50	82																																			

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		<p>Current recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.</p>																																								
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that all focused psychological assessments meet this requirement.</p> <p>Findings: ASH used item #9 from the DMH Psychology Assessment Monitoring Form (<i>Does the assessment identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues?</i>) to address this recommendation, reporting 47% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1044 1866 1235"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #9</td> <td>56</td> <td>80</td> <td>45</td> <td>67</td> <td>13</td> <td>0</td> <td>47</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (CB, LC, KW, KL, DQ, KR, BL, TW, IM, and AM). Two of the focused assessments in them (KL and DQ) addressed the unresolved issues encompassed by the assessment. The remaining eight assessments (CB, LC, KR, BL, TW, KW, IM, and AM)</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #9	56	80	45	67	13	0	47
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%S	5	4	3	1	2	1																																				
%C #9	56	80	45	67	13	0	47																																			

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		<p>failed to identify unresolved issues, identified them but failed to include specifications for further workup, or failed to include timelines for resolution if specifications for further workup were included.</p> <p>Current recommendation: Ensure that all focused psychological assessments meet this requirement.</p>																																
D.2.d. viii	<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 recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. 2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. <p>Findings: ASH used item #10 from the DMH Psychology Assessment Monitoring Form (<i>Does the assessment use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Associations' Ethical Standards and Guidelines for Testing?</i>) to address this recommendation, reporting 95% compliance. The table below with its monitoring indicator showing the number of focused assessments expected per month (N), the number of focused assessments conducted per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1263 1866 1416"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> </tbody> </table>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1	
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		%C #10	100	90	100	100	88	100	95
		<p>According to Charles Broderick, a small number of psychologists perform the greater number of focused psychological assessments, and therefore were more familiar with the requirements of those assessments. The Psychology Department has plans to provide competency training to other psychologists who will be conducting focused psychological assessments.</p> <p>ASH reported two violations of the American Psychological Association Ethical Standards and Guidelines for testing related to failure to conduct assessments in the individual's preferred language and/or not using an interpreter. In both cases, the psychologists were counseled and have not repeated these errors. The Chief of Psychology and designee are continuing to monitor these staff as well. When such incidences become apparent, the facility's policy has been for the Supervising Assessment Monitor or Chief of Psychology to immediately contact the psychologist involved and to offer education /guidance/correction.</p> <p>This monitor reviewed ten charts (CB, LC, DQ, KL, AM, KR, BL, TW, KW, and IM). All ten focused assessments used appropriate tools for the individuals assessed, included a clear statement of confidentiality in the written assessment, and the instruments used were from the DMH Clinical Indicator List of approved instruments. This monitor did not directly observe any of the assessments to evaluate the administration of the instrument itself, and did not review the scoring of the individuals' responses.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and 							

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		<p>Guidelines for testing.</p> <ol style="list-style-type: none"> 2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.
<p>D.2.e</p>	<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>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Maintain a list of clinicians with demonstrated current competency in psychological testing and identify any resource shortages or allocation issues.</p> <p>Findings: ASH reviewed the competency of its staff involved in psychological testing and reported having verified 78% of them as competent. ASH is continuing to verify the competency of the remaining staff involved in psychological testing.</p> <p>ASH has a staffing shortage that imposes limitations on allocations of staff to provide all the psychological services needed by individuals in the facility. According to the Chief of Psychology, the staffing shortage is across the board including Senior Psychologists, PBS Psychologists, and psychologists in units.</p> <p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Develop a timeline (end date within the next 12 months) by which the psychological assessments of individuals admitted prior to June 1, 2006 will be reviewed. 3. Monitor compliance with the prepared schedule to stay abreast of bottlenecks or obstacles to completion. <p>Findings: ASH is unable to complete the review of the psychological assessments of all individuals admitted prior to June 1, 2006. In fact, ASH is</p>

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		<p>unable to keep up with timely IAP evaluation of individuals currently admitted to its facility. Staffing shortage is the barrier to completing these tasks in a timely fashion.</p> <p>This monitor reviewed the list of individuals admitted to ASH prior to June 1, 2006. There were 604 individuals remaining in September 2007 whose psychological assessments were yet to be reviewed. ASH managed to review less than 1% of the psychological assessments of these individuals in the last six months.</p> <p>According to the Chief of Psychology, the Clinical Administrator and the Medical Director have given approval for the unit psychologists to conduct the overdue assessments of individuals residing on their units. At least 15 units do not have unit psychologists. The Chief of Psychology has arranged for psychologists working overtime (quarter-time positions) to conduct the reviews in the units without psychologists.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Maintain a list of clinicians with demonstrated current competency in psychological testing and identify any resource shortages or allocation issues. 2. Develop a timeline (end date within the next 12 months) by which the psychological assessments of individuals admitted prior to June 1, 2006 will be reviewed. 3. Monitor compliance with the prepared schedule to stay abreast of bottlenecks or obstacles to completion.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be	<p>Compliance: Partial.</p>

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	<p>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>																																									
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 1, April 2007: Ensure that integrated psychological assessments are conducted in a timely manner as required.</p> <p>Findings: ASH used item #12 from the DMH Psychology Assessment Monitoring Form (<i>Integrated psychological assessments are provided in a timely manner</i>) to address this recommendation, reporting 6% compliance. The table below with its monitoring indicator showing the number of IAPS to be completed per month (N), the number of IAPS audited (n), and the percentage compliance obtained (%C), is a summary of the facility's data.</p> <table border="1" data-bbox="991 1117 1864 1312"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #12</td> <td>10</td> <td>3</td> <td>0</td> <td>1</td> <td>3</td> <td>16</td> <td>6</td> </tr> </tbody> </table> <p>This monitor reviewed 19 charts (AR, YM, JER, RJH, KM, MM, LP, MK, TSK, RM, MN, SZ, BM, MAM, RCT, DT, JSR, SAS, and SR). Four of the</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #12	10	3	0	1	3	16	6
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		<p>Integrated Assessment Psychology Sections (AR, YM, JER, and RJH) were completed in a timely manner, and the remaining 15 (KM, MM, LP, MK, TSK, RM, MN, SZ, BM, MAM, RCT, DT, JSR, SAS, and SR) were untimely or not found in the chart.</p> <p>The Senior Psychologist responsible for monitoring assessments has provided staff with training on completing the assessments. He has also been providing corrective feedback on the completed assessments. This process has shown an improvement in both the timeliness and quality of these assessments, as evidenced by the percentage of assessments completed for the month of September 2007. ASH should continue to maintain the momentum to ensure that all IAP's are completed in a timely manner.</p> <p>Recommendation 2, April 2007: Ensure adequate number of psychologists to provide timely psychological assessments of individuals.</p> <p>Findings: ASH does not have sufficient number of psychologists to conduct psychological assessments in a timely manner. According to the Chief of Psychology, only two psychologists were available to conduct assessments, when nearly 16 psychologists were needed to support the number of assessments to be completed. As of October 2007, ASH has 17 vacant psychology positions. The psychology department has been creative by re-allocating its current staffing, as well as using quarter-time positions to conduct psychological assessments.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that integrated psychological assessments are conducted in a timely manner as required. 2. Ensure adequate number of psychologists to provide timely psychological assessments of individuals.
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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, April 2007: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.</p> <p>Findings: ASH used item #13 from the DMH Psychology Assessment Monitoring Form (<i>Does the assessment address the nature of the individual's impairments to inform the psychiatric diagnosis?</i>) to address this recommendation, reporting 9% compliance. The table below with its monitoring indicator showing the number of IAPs to be completed per month (N), the number of IAPs audited (n), and the percentage compliance obtained (%C), is a summary of the facility's data.</p> <table border="1" data-bbox="991 784 1864 976"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #13</td> <td>0</td> <td>13</td> <td>0</td> <td>12</td> <td>8</td> <td>15</td> <td>9</td> </tr> </tbody> </table> <p>This monitor reviewed 15 charts (CBC, DLT, DB, JFD, YM, LLP, SS, KRM, MM, AR, JJS, JLR, RG, MBH, and ER). IAPs were not present in three of the charts (SS, JLR, and RG), and the IAPs for JJS and JFD were left blank. Six charts (CBC, DLT, MM, AR, MBH, and ER) addressed the nature of the individual's psychological impairments by describing the nature and extent of signs and symptoms of their diagnosis, including excesses and deficits, and the other four (DB, YM, LLP, and KRM) failed to satisfy this criteria.</p> <p>Current recommendation: Ensure that integrated psychological assessments address the nature</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #13	0	13	0	12	8	15	9
	Apr	May	Jun	Jul	Aug	Sept	Mean																																			
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%C #13	0	13	0	12	8	15	9																																			

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		of the individual's impairments to inform the psychiatric diagnosis.																																								
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. 2. Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals' rehabilitation service needs. <p>Findings: ASH used item #14 from the DMH Psychology Assessment Monitoring Form (<i>Does the assessment provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process?</i>) to address this recommendation, reporting 11% compliance. The table below with its monitoring indicator showing the number of IAPs to be completed per month (N), the number of IAPs audited (n), and the percentage compliance obtained (%C), is a summary of the facility's data.</p> <table border="1" data-bbox="991 971 1864 1161"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>198</td> <td>231</td> <td>214</td> <td>288</td> <td>400</td> <td>360</td> <td></td> </tr> <tr> <td>n</td> <td>9</td> <td>10</td> <td>6</td> <td>3</td> <td>8</td> <td>4</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>4</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%C #14</td> <td>18</td> <td>14</td> <td>25</td> <td>0</td> <td>5</td> <td>5</td> <td>11</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (ER, MBH, AR, KRM, LP, DLT, CN, RB, RCD, ACH, and CBC). Four of the charts (RCD, RB, CN, and ACH) did not contain the IAPs. Four of them (AR, LP, DLT, and CBC) provided information that the WRPT can use to determine the appropriate interventions/services needed for the individual's rehabilitation, and the remaining three (ER, MBH, and KRM) did not satisfy the criteria.</p>		Apr	May	Jun	Jul	Aug	Sept	Mean	N	198	231	214	288	400	360		n	9	10	6	3	8	4		%S	5	4	3	1	2	1		%C #14	18	14	25	0	5	5	11
	Apr	May	Jun	Jul	Aug	Sept	Mean																																			
N	198	231	214	288	400	360																																				
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%S	5	4	3	1	2	1																																				
%C #14	18	14	25	0	5	5	11																																			

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. 2. Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals' rehabilitation service needs.
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>a.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that Level of Care staff is familiar with criteria for referral to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to behavioral guidelines. 2. Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. <p>Findings:</p> <p>The Level of Care staff has received training from Theresa George, PBS Supervisor on referring individuals to the PBS. ASH uses the PBS-BCC checklist when referring individuals to the PBS team.</p> <p>ASH audited 11 PBS plans completed in the last six months. The average time taken by the PBS teams to respond to the referrals was a mean of 10 days, with a range of 5-33 days. Four referrals are yet to get a response.</p> <p>ASH's response to PBS referrals received is extremely slow. According to Theresa George, and Diane Imrem, staffing shortage is one reason for the slow response.</p>

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		<p>In speaking with a number of unit staff, this monitor learned that a majority of them, especially those in senior positions on the units were aware of the criteria for referral to the PBS team. This monitor is not sure that the evening and weekend shift staff are similarly aware of the criteria. The problem/uncertainty unit staff face appears to be when to refer rather than how to refer.</p> <p>Recommendation 3, April 2007: Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.</p> <p>Findings: According to Jeffery Teuber, PBS team leader and Theresa George, PBS team supervisor, structural and functional assessments are only conducted by trained PBS team members with credentials/privileges.</p> <p>The table below showing the number of individuals needing PBS plans for the month (N), the number audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>If behavioral interventions are indicated, was a structural and functional assessment performed by a professional with demonstrated competency in positive behavior supports?</i></p> <table border="1" data-bbox="991 1117 1761 1308"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>2</td> <td>No</td> <td>1</td> <td>5</td> <td>3</td> <td></td> </tr> <tr> <td>n</td> <td>2</td> <td>data</td> <td>1</td> <td>5</td> <td>3</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td></td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #15</td> <td>100</td> <td></td> <td>0</td> <td>20</td> <td>33</td> <td>36</td> </tr> </tbody> </table> <p>This monitor reviewed the two active PBS plans (AS and MB). These plans were implemented in October 2007. Both plans were completed</p>		May	Jun	Jul	Aug	Sept	Mean	N	2	No	1	5	3		n	2	data	1	5	3		%S	100		100	100	100		%C #15	100		0	20	33	36
	May	Jun	Jul	Aug	Sept	Mean																															
N	2	No	1	5	3																																
n	2	data	1	5	3																																
%S	100		100	100	100																																
%C #15	100		0	20	33	36																															

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following structural and functional assessments. Both assessments were also performed by PBS team members who were trained in conducting the assessments.

As shown through both the facility's data with older plans and the monitor's review of more recent plans, the more recent plans followed the guidelines required for the development and implementation of behavioral interventions.

Recommendation 4, April 2007:

Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC.

Findings:

The table below showing the number of referrals made to the PBS/BCC by month (N1), and the number of referrals made to the PCMC (N2), is a summary of the facility's data.

	Apr	May	Jun	Jul	Aug	Sept	Mean
N1 (PBS/BCC)	No data	8	7	9	9	9	
N2 (PCMC)	12	15	11	11	11	0	

As the table above shows, a good number of referrals were being made to the PCMC until August, 2007. However, this no longer is the case as explained to this monitor by Theresa George, PBS supervisor and Diane Imrem, Chief of Psychology.

This monitor reviewed minutes of the BCC and PCMC meetings. An insert in the August 14, 2007 PCMC meeting minutes read, "All the patients currently being followed by this committee have been discontinued since they no longer have active PCMC plans. Some of

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		<p>these patients are currently being followed by BCC.”</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Level of Care staff is familiar with criteria for referral to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to behavioral guidelines. 2. Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. 3. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. 4. Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC.
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 recommendations:</p> <p>Recommendation 1, April 2007: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, “rule-out,” “deferred,” “no-diagnosis,” and “NOS” diagnoses.</p> <p>Findings: ASH reviewed 39 Integrated Assessment Psychology Sections, reporting less than 2% compliance.</p> <p>This monitor reviewed 11 charts (JM, BB, MH, YM, MW, KJ, KL, MC, TL, WRH, and JN) containing IAPs with diagnostic uncertainties. Follow-up testing for diagnostic clarification was conducted on one of them (JN), and the remaining ten (JM, MC, MH, YM, TL, MW, KL, BB, WRH and KJ)</p>

		<p>did not have proper testing to resolve diagnostic uncertainties. In the case of WRH the IAP's examiner had proposed a change in diagnosis, but the WRPT had disagreed with the proposed change. The issue has not been resolved satisfactorily.</p> <p>Recommendation 2, April 2007: Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p> <p>Findings: ASH's monitoring instrument addressing "no diagnosis" has been aligned to indicate the need for clinical data when making such a diagnosis. According to the Chief of Psychology, ASH is using the newly revised DMH Monitoring Tool for this purpose.</p> <p>Recommendation 3, April 2007: Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent.</p> <p>Findings: ASH has established a process to ensure congruency between ASH's monitoring system and the diagnoses in the individuals' assessments. This monitor reviewed ADT print outs of two cases (JN and BB). Appropriate changes were made in the system on BB, but not for JN.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. 2. Ensure that the facility's monitoring instrument that addresses "no
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		<p>diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues.</p> <p>3. Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent.</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 recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers. <p>Findings:</p> <p>ASH used items #22, #23, and #24 (see below) to address this recommendation, reporting 50%, 20% and 20% respectively. The table below with its monitoring indicators showing the number of individuals assessed per month whose primary/preferred language was not English (N), the number audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <p><i>#22: For individuals whose primary language is not English, is there documentation that the psychologist has endeavored to assess them in their own language?</i></p> <p><i>#23: If assessment in their own language was not possible, was a plan to meet the individual's assessment needs (including but not limited to use of interpreters in the individual's primary language and dialect) put in place?</i></p>

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#24: *The plan is implemented to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individuals primary language and dialect, if feasible.*

	Apr	May	Jun	Jul	Aug	Sept	Mean
N	1	2	3	No	3	1	
n	1	2	3	data	3	1	
%S	100	100	100		100	100	
%C #22	100	100	33		33	0	50
%C #23	0	0	33		33	0	20
%C #24	0	50	0		33	0	20

This monitor reviewed the charts of nine individuals (EO, GAS, AM, LS, ASH, DNM, WT, HN, and FH) whose primary/preferred language is not English. Three of them (EO, AM, and HN) did not have the IAPS. Four of them (LS, DNM, ASH and FH) had their assessments conducted in their primary/preferred language. As for the remaining two of them, WT preferred Burmese, and a Burmese interpreter was used in the court, however the IAP did not indicate what language was used for the assessment, and the examiner for GAS was uncertain as to GAS's primary/preferred language, English or Spanish. The WRP noted GAS to be bilingual; however, the 30-day Social Work assessment noted GAS's primary language as Spanish.

ASH has used multiple methods of dealing with assessment/services when faced with individuals whose primary/preferred language is not English. For example, LS's primary language is Laotian and ASH used the language line for assessments. DNM's primary language is Spanish, and ASH used an interpreter to conduct his assessment.

Compliance:
Partial.

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		<p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English.2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.
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3. Nursing Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Vickie Vinke, HSS 2. Al Joachim, Acting Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Medical charts for the following 34 individuals: (NN, DM, DB, JR, RM, RC, CN, OM, RH, GP, SS, LJ, YM, MW, TN, NS, RA, DC, EH, HL, RS, MW, FN, AS, CW, MM, GH, AH, JM, VM, JF, RW, RH, AG) 2. Nursing Policy 203.0, Nursing Assessments dated 3/23/07 3. Admission Nursing Assessment form (draft) and instructions 4. Integrated Assessment Nursing Section (draft) and instructions 5. Revised Nursing Assessment Competency Validation form and instructions 6. Nursing Admission and Integrated Assessment Monitoring Form and instructions 7. Inter-Rater Reliability Plan and data 8. ASH's progress report and data
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: Partial.</p>
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure documentation addressing this requirement is specific and individualized.</p>

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		<p>Findings: The statewide Nursing Admission and Integrated Assessments will be implemented in November 2007. From a draft that I reviewed, information regarding presenting conditions should be individualized and specific.</p> <p>Based on samples ranging from 57% to 100% from April-September (no data were collected in May 2007 due to inter-rater reliability checks) of Nursing Admission Assessments, ASH reported a mean compliance rate of 87% regarding a description of presenting conditions.</p> <p>Recommendation 2, April 2007: Ensure that nursing staff is competent in the protocols addressing this requirement.</p> <p>Findings: A Nursing Assessment Competency Validation Form has been developed but will need revision to be in alignment with the new Nursing Admission Assessment. Data regarding this recommendation should be provided at the next review.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: From my review of the Nursing Administration Assessments of 34 individuals (NN, DM, DB, JR, RM, RC, CN, OM, RH, GP, SS, LJ, YM, MW, TN, NS, RA, DC, EH, HL, RS, MW, FN, AS, CW, MM, GH, AH, JM, VM, JF, RW, RH, AG), I found that all had individualized presenting conditions, although some were quite brief and additional information would have made the documentation more meaningful. I found that 27 of the assessments did not include all information regarding the individuals' current medications, especially the last dosage taken. In</p>
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		<p>addition, immediate alerts were not consistently elaborated on in the body of the assessments for five out of 12 assessments. These issues should be resolved using the new Nursing Admission Assessment form, which prompts the author to address specific information.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the statewide Nursing Admission Assessment. 2. Revise and implement the Nursing Assessment Competency Validation Form. 3. Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	Mean compliance: 42%
D.3.a.iii	vital signs;	Mean compliance: 98%
D.3.a.iv	allergies;	Mean compliance: 97%
D.3.a.v	pain;	Mean compliance: 98%
D.3.a.vi	use of assistive devices;	Mean compliance: 95%
D.3.a.vii	activities of daily living;	Mean compliance: 95%
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	Mean compliance: 77%
D.3.a.ix	conditions needing immediate nursing interventions.	Mean compliance: 91%
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing	Current findings on previous recommendations:

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	evaluation.	<p>Recommendation 1, April 2007: Continue to revise policies and procedures to include WRP language.</p> <p>Findings: The Nursing Administration at ASH has committed to implement a Wellness and Recovery Model of Nursing and has eliminated all other nursing models. The Nursing Policy 203 Nursing Assessments has been revised demonstrating implementation of the Wellness and Recovery Model. ASH has also begun training the HSSs on the Wellness and Recovery Plan Manual and needs to continue these efforts to the entire nursing department.</p> <p>Recommendation 2, April 2007: Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles.</p> <p>Findings: As noted above, new statewide Nursing Admission Assessments and Integrated Assessments have been developed in alignment with Wellness and Recovery principles. These assessment forms will be implemented in November 2007. If used correctly, these forms will assist nursing to move toward a Wellness and Recovery Model that should translate into the documentation found in the medical records. From my overall review of the nursing documentation contained in 34 medical records, this transition has not yet taken place.</p> <p>Recommendation 3, April 2007: Continue efforts to align current training of nurses with the WRP system.</p> <p>Findings: Although no data were provided during this review, ASH reported that</p>
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		<p>WRP competency-based training has begun for the level of care staff.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide data regarding staff training with WRP.
D.3.c	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a monitoring instrument and a tracking system to adequately address this requirement.</p> <p>Findings: The revised Nursing Assessment Competency Validation will begin in November 2007. From my interview with Nursing, the training will be provided by Vickie Vinke, HSS, at the statewide meeting October 20, 2007 for the new statewide nursing assessments, including the competency process. The new competency process will include an HSS observation of the RNs' interviewing and completion of the new Nursing Admission Assessment. Inter-Rater Reliability was completed in May 2007 and July 2007 demonstrating 85% and 93% respectively for this instrument.</p> <p>Recommendation 2, April 2007: Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.</p> <p>Findings: Since the Nursing Assessment Competency Validation form has not yet been implemented, this recommendation has not yet been addressed.</p>

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		<p>Other findings: No data was provided regarding the system for verification of nursing licenses.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the Nursing Assessment Competency Validation process. 2. Provide data regarding verification of nursing licenses. 3. Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Partial.</p>
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to the progress report from ASH, 99% of initial nursing assessments are completed within 24 hours of the individual's admission. From my review of 34 admission assessments, I found that all 34 were completed within 24 hours of admission.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic	<p>Current findings on previous recommendation:</p>

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	<p>and rehabilitation service plan within seven days of admission; and</p>	<p>Recommendation, April 2007: Implement monitoring instrument and tracking system to include all elements of this requirement.</p> <p>Findings: ASH's data for April, June, and July did not accurately reflect this requirement. The data for August and September indicated 77% and 82% compliance with completion of the integrated assessments within seven days of admission.</p> <p>From my review of 34 integrated assessments, I found that 28 of the integrated assessments were completed within seven days. ASH reported that the low compliance rate was due to staffing shortages and opening an additional admission unit in September 2007.</p> <p>Other findings: Data regarding nursing reviews and participation during team meetings could not be interpreted since the number of team meetings held was not accurately reflected in the data.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Provide accurate data regarding nursing participation in team meetings.
<p>D.3.d.iii</p>	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a monitoring system to address this requirement.</p> <p>Findings: ASH's progress report data indicated that the development of this</p>

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		<p>system was in process.</p> <p>Current recommendations: Develop and implement a monitoring system to address this requirement.</p>
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ladonna DeCou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Supervising Rehabilitation Therapist 3. Terry Devine, Physical Therapist (contract) 4. Mary Jo Waugh, Nurse Supervisor for Central Medical Services 5. Alan Arebalo, Program Assistant, Central Program Services 6. Marna Scarry-Larkin, Speech Language Pathologist (contract) <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Proposed 2007 Rehabilitation Therapy Organizational Chart 2. DMH Integrated Assessment- Rehabilitation Therapy Section 3. DMH Integrated Assessment- Rehabilitation Therapy Section Instructions 4. DMH Integrated Assessment- Rehabilitation Therapy Section Monitoring Form 5. DMH Integrated Assessment- Rehabilitation Therapy Section Monitoring Form Instructions 6. Rehabilitation Therapy Documentation Audit Form 7. ASH Rehabilitation Therapy Audit Form Instructions 8. Statewide Rehabilitation Therapy Chiefs Workgroup Agenda 9. DMH Rehabilitation Therapy Service Manual (draft, September 2007) 10. IRTA Documentation Training sign-in sheets for May, June, and August 2007 11. Qualitative Profile- Rehabilitation Admission Assessment Monitoring data for 7/27/07- 8/27/07 12. Qualitative Profile- Rehabilitation Admission Assessment Monitoring data for 8/27/07- 9/27/07 13. List of Rehabilitation Therapy Standardized Assessments 14. ASH Nutrition Policy/Procedure 804- Adaptive Feeding Equipment

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		<p>(effective 9/1/07)</p> <ol style="list-style-type: none"> 15. ASH Dysphagia Workgroup Meeting Minutes for 4/5/07, 7/24/07 and 8/14/07 16. ASH Memorandum to Quality Council from Erin Dengate to request Bailey and Associates dysphagia training 17. ASH Dysphagia Management and Staff Roles dated 4/10/07 18. List of Individuals with Adaptive Dining Equipment 19. Dysphagia High Risk List as of 8/24/07 20. List of individuals who have had an Integrated Rehabilitation Therapy Assessment in the past three months 21. Records of the following individuals who have had Integrated Rehabilitation Assessments in the past three months: JG, MK, DS, TC, SN, RM, GB, TC, CS, RG, EC, RT, CB, JM 22. Integrated Assessment-Rehabilitation Therapy Section Pilot assessments and corresponding WRPs for the following individuals: HG, PV, AM, AS, KR, KB, WG, AS, GC 23. List of individuals who have had Physical Therapy assessment/consultation in the past six months 24. Records of the following individuals who have had Physical Therapy assessment/consultation in the last six months: CB, RT, SL, LS, AW, RG, AP, RZ, JR, MR, JW 25. Speech Therapy Swallow Follow list for individuals last followed by SLP in July and August 2007 26. Records of the following individuals who have had Swallow Follow assessment/re-assessment/consultation in the past six months: JS, JN, LM, RD, AM 27. List of individuals who have had Speech Language Therapy assessment/consultation in the past six months 28. Records of the following individuals who have had Speech Therapy assessment/consultation in the last six months: PD, RC, RF, SH, JP, MM, EM, JB 29. Records for the following individuals who have had Vocational Assessments in the last six months: DR, RG, KJ, TH, SJ, OM, HA,
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		<p>TL, ST, DT</p> <ol style="list-style-type: none"> 30. Adaptive Equipment List for Programs 1-7 for October 2007 31. State of California ASH Occupational Therapy contract packet 32. State of California ASH Physical Therapy contract packet 33. Central Program Services Procedure Manual Directive 201-Vocational Rehabilitative Services 34. Referral/assessment for Supported Work Program 35. Central Program Services Referral for Treatment for Independent Work Program 36. ASH Central Program Services Language and Cognitive Services Policy and Procedure Manual 37. ASH Credentialing and Privileging Process for Medical Staff 38. Credentials Verification for Rehabilitation Therapy 39. Rehabilitation Therapy Service Credentials Committee (proposed draft) 40. Rehabilitation Service Staff Credentials Review list dated 8/01/07 41. Peer Review Competency Report form 42. Rehabilitation Services Staff Documentation Training list dated 8/01/07
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 recommendations:</p> <p>Recommendation 1, April 2007: Obtain OT services.</p> <p>Findings: This recommendation has not been met. The facility has initiated the process of advertising for Occupational Therapy positions by posting an advertisement with the American Occupational Therapy Association on 10/02/07 and running an ongoing advertisement on a Recreation Therapy website. No response has been received as a result of these efforts. One OT application has been received since April and a position was offered but not accepted. In July, Administration</p>

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		<p>approved a position and advertised for a Recruitment Coordinator to assist department chiefs with recruitment of qualified staff. Applications for this position are currently under review. On 9/25/07, an OT Contract was drafted and submitted to Accounting for processing.</p> <p>Recommendation 2, April 2007: Integrate OT, PT, and Speech Therapy into the Rehabilitation Therapy Services.</p> <p>Findings: Upon interview and review of procedures, it does not appear that integration of Physical, Occupational, and Speech Therapy into the Rehabilitation Services department as evidenced by practice is occurring at this time. Current Speech Therapists (2), Speech Assistant, and Physical Therapist are contracted, and have not received training regarding the Enhancement Plan, the WRP process, the proposed organizational restructuring of the Rehabilitation Services department, or any corresponding practices and procedures. A draft of a Rehabilitation Services organizational chart has been developed but requires some revisions to ensure Physical Rehabilitation Therapy (OT, SLP, and PT) and Vocational Rehabilitation integration into the Rehabilitation Services department. Currently, there are separate Central Program Services manuals for Speech Therapy and Vocational Rehabilitation, as well as contract packets for Physical and Occupational Therapy. The DMH Rehabilitation Services Manual draft is a good start in the integration of OT, PT, ST, and Vocational Rehabilitation into the Rehabilitation Services department, though specific content regarding assessments and protocols, consultations, and documentation requirements for these disciplines is currently pending.</p>
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		<p>Recommendation 3, April 2007: Continue to evaluate the revised IRTA to ensure that it provides a comprehensive Rehabilitation Therapy assessment.</p> <p>Findings: A state-wide meeting of Rehabilitation Services Chiefs was conducted on 9/21/07. The Chiefs collaborated and received input and guidance from the state's consultant, Dr. Singh, to revise the Integrated Assessment--Rehabilitation Therapy Section (IA-RTS) and instructions to ensure that the content/process is consistent with Wellness and Recovery model standards of practice. A Rehabilitation Integrated Assessment Team (RIAT) was established to pilot the revised IA-RTS with a sample of new admissions.</p> <p>A follow-up Chief workgroup for IA-RTS and monitoring tool to discuss pilot results and subsequent revisions to assessment, instructions, and monitoring tool and instructions is scheduled for November 6-7.</p> <p>The current IA-RTS and instructions were reviewed and revised tools are a significant improvement over previous versions. The addition of Structured Activity groups to the assessment process enables the Rehabilitation Therapist to make clinical observations and findings in addition to interview and chart review. However, while the current assessment instructions mention the use of Structured Activity groups, the process and procedure are not described. There is not currently an appendix to the assessment and instructions which lists structured assessment activities and focused assessments utilized by Rehabilitation Therapists, though a draft of a list of standardized assessments for Rehabilitation Therapy assessments has been initiated. It is reported that Rehabilitation Therapy Chiefs are in the process of reviewing and identifying discipline-specific assessments to be used as focused assessments. There is not a section on the current assessment in which to document details related to specific activities, setting(s),</p>
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		<p>contexts, and conditions of structured activity groups.</p> <p>Recommendation 4, April 2007: Continue to revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement.</p> <p>Findings: A draft of the Rehabilitation Services Manual was reviewed and found to include wellness and recovery language and principles. The Rehabilitation Services manual draft does not currently include specific procedural requirements and/or appendices of assessment tools, instructions, and monitoring tools/instructions for Occupational, Physical, and Speech Therapy, Comprehensive Rehabilitation (POST) assessments, and Vocational Rehabilitation Services as these protocols/tools have not yet been developed. Physical, Speech and Vocational Rehabilitation assessments are not consistent with corresponding assessments at the other state hospitals. The due date for a proposed final draft of the Rehabilitation Services Manual is 12/01/07.</p> <p>The CPS Language and Cognitive Services Policy and Procedure Manual does not specify a time frame for response to or completion of referrals for Speech Therapy (Speech Language) assessment. It does state that referrals for evaluation related to dysphagia are to be initiated within 24-36 hours (weekends excluded). A list of standardized assessments comprising the Language and Cognitive Services Test Battery was reviewed and found to be consistent with generally accepted professional standards of care. Assessment shells were reviewed for Speech Language and Dysphagia assessments and appeared to be comprehensive, though no instruction tools are currently in place for assessment shells.</p> <p>According to Physical Therapy and Occupational Therapy contract</p>
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		<p>packets, assessments are to be completed within two months of referral for individuals with long-standing or chronic rehabilitation needs, and within two weeks of referral for individuals with urgent or acute needs. Upon review of the Physical Therapy assessments, it is noted that assessments are brief and based primarily on quantitative findings, with minimal focus on documentation of narrative findings related to qualitative clinical observations and function (e.g., quality of movement, daily activities affected by pain), or individual goals, strengths, motivation, and skills/supports needed to transfer to the next level of care. No consistent protocol or instructions for Physical Therapy assessments have been developed or implemented.</p> <p>No comprehensive and consistent format and protocol for Occupational Therapy assessments has been developed or implemented as ASH does not currently provide Occupational Therapy Services.</p> <p>According to interview and review of CPS procedure for Vocational Rehabilitation services, the assessment process for Vocational Rehabilitation currently begins with a referral from the WRPT, which generates a Vocational Assessment for Independent Work Program, or a Vocational Assessment for Supported Work Program. Vocational Assessments generate a recommendation for one of the following Vocational Service Assignments: Transitional Supported Work, On-Program Assessment, Independent Work Experience, Vocational Awareness Class, Vocational Instruction Class, Vocational Workshop Class, or Vocational Discharge Planning. Assessments for Independent Work Programs are completed by a Senior Vocational Rehabilitation Counselor, and assessments for Supported Work Program are completed by a Job Coach.</p> <p>Timelines for completion of the Vocational Assessment following referral are not specified in current procedure. Upon review of Vocational Assessments, it is noted that the Supported Work</p>
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		<p>assessment tool is too general and does not include documentation of findings related to functional status, skills/supports needed to transfer to the next level of care, or individual goals, strengths, and motivation.</p> <p>Recommendation 5, April 2007: Implement a monitoring system to address the elements of this requirement.</p> <p>Findings: A state-wide meeting of Rehabilitation Services Chiefs was conducted on 9/21/07. The Chiefs collaborated to revise the IA-RTS Monitoring Tool and instructions, to ensure that the audit tool adequately measures quality and content of the revised IA-RTS. A draft of the monitoring form and instructions for IA-RTS was completed on 9/21/07. The draft was reviewed, and appears to be an improvement over the previous monitoring tool. However, the draft requires revisions to ensure that it is user-friendly, is not redundant, and provides line-item information for analysis of performance trends. While the current draft monitors for documentation of objective findings, it does not include a measure of RT interpretation and analysis of findings.</p> <p>There are no protocols written or in place for Physical Therapy, Occupational Therapy, Speech Therapy, Comprehensive Physical Rehabilitation (POST) Assessments, or Vocational Rehabilitation Assessments audits. There is a system in place to document timeliness of Physical and Speech Therapy assessments and consultation response, as well as informally list therapy objectives, though there is no audit tool in place to assess for quality of content.</p> <p>Recommendation 6, April 2007: Develop, review and revise OT, PT, and Speech Pathology Manuals to</p>
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		<p>include Wellness and Recovery language.</p> <p>Findings: See D.4, Recommendations 2 and 4 for findings regarding this recommendation.</p> <p>Compliance: Partial</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise and implement the Rehabilitation Therapy Manual to reflect changes including departmental integration and re-structuring, a description of collaboration among disciplines and therapy teams within the department, and any revised or new Rehabilitation Therapy Services procedures. 2. Revise and implement the Integrated Rehabilitation Therapy Assessment and instructions based on findings of pilot of Integrated Assessment-Rehabilitation Therapy Section and collaboration with other state facilities. 3. Develop and implement Rehabilitation Therapy protocols/ instruction sheets for Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy, and Comprehensive Physical Rehabilitation (POST) assessments that correspond with assessment tools/instructions at other state facilities. 4. Obtain Occupational Therapy Services. 5. Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Integrated Rehabilitation Assessment are referred for this service by the WRPT.
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p>Compliance: Partial</p>

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D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue to revise appropriate policies, procedures and manuals to be aligned with this requirement. 2. Develop and implement a system for monitoring and tracking this requirement. <p>Findings: Current Rehabilitation Services monitoring data for this review from August and September 2007 is based on results from the previous IRTA monitoring tool. This data provides a measure of completion and timeliness of the initial IRTA (now called IA-RTS), but does not capture quality and comprehensiveness of assessments. According to facility report, 31 IRTA audits were completed in August out of 125 new admissions/assessments, and 82 IRTA audits were completed in September out of 110 new admissions/assessments. See D.4.a for additional findings regarding these recommendations.</p> <p>Recommendation 3, April 2007: Continue to include indicators related to OT, PT, and Speech Therapy in the Rehabilitation Assessments to trigger referrals to these therapy specialties.</p> <p>Findings: The Integrated Assessment Rehabilitation Therapy Services contains a section to recommend referral for OT, ST, and PT focused assessment as well as for a Comprehensive Physical Rehabilitation Therapy (POST) assessment. The WRPT receives recommendations and generates referrals based on team discussion of recommendations.</p>
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		<p>Recommendation 4, April 2007: Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs.</p> <p>Findings: Please see F.4 for findings regarding this recommendation.</p> <p>Recommendation 5, April 2007: Integrate OT, PT, and Speech Therapy assessments and interventions into the individual WRPs.</p> <p>Findings: Please see F.4 for findings regarding this recommendation.</p> <p>Recommendation 6, April 2007: Assess and develop 24-hour, proactive interventions for individuals at-risk and high-risk for choking and aspiration.</p> <p>Findings: See F.4 for findings regarding this recommendation.</p> <p>Recommendation 7, April 2007: Provide ongoing training to all team members regarding dysphagia.</p> <p>Findings: Rehabilitation Therapy Services staff has not yet received dysphagia training; this recommendation has not been met. Informal plan is for Rehabilitation Therapy Services to receive dysphagia training either in-house from current contract Speech Therapists or from Rehabilitation Therapists from MSH and/or NSH.</p> <p>Recommendation 8, April 2007: Assess the mobility needs and provide individual wheelchairs that</p>
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		<p>promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their mobility.</p> <p>Findings: Due to the lack of Occupational Therapy Services at this time and limited Physical Therapy services (one part-time contract Physical Therapist), this recommendation has not been met. Currently, when an individual is in need of a wheelchair, an order is sent to Central Medical Services, which provides the prescribed equipment. No assessment is done for customized fitting based on individual needs and level of support required. According to interview, one individual was assessed and fitted for a custom wheelchair on 9/6/07 by an outside Occupational Therapist not affiliated with ASH.</p> <p>According to the facility's progress report as of 9/6/07, 48 individuals currently have wheelchairs. It is not clear how many of these individuals use wheelchairs for transport, mobility, and/or positioning, or use wheelchairs at all. Upon interview, it was reported that many individuals use wheelchairs to "push their belongings around" rather than as a mobility device. A cart, an individualized exercise program, and/or a Wellness/Fitness Mall group would be better options for these individuals who may be independent in walking, but limited in endurance/balance when carrying necessary belongings.</p> <p>Recommendation 9, April 2007: Streamline the process of obtaining adaptive equipment.</p> <p>Findings: The current process for obtaining adaptive equipment involves assessment of need by the Dietitian for adaptive dining equipment, and by the Physician for all other adaptive equipment. Orders for equipment are sent to Central Medical Services, which obtains and provides equipment to the individual. Nutrition Services has drafted a</p>
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		<p>procedure for obtaining adaptive dining equipment.</p> <p>Recommendation 10, April 2007: Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment.</p> <p>Findings: See F.4 for findings regarding this recommendation.</p> <p>Recommendations 11 and 12, April 2007:</p> <ol style="list-style-type: none"> 11. Develop a monitoring system to ensure that individuals have access to their adaptive equipment, that it is in proper working condition, and that it is being used appropriately. 12. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. <p>Findings: See F.4 for findings regarding this recommendation.</p> <p>Recommendation 13, April 2007: Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices.</p> <p>Findings: Individuals with significant vision and hearing problems are identified upon Nursing 24-hour and Physician 24-hour admission assessments. Please see F.4 for additional findings.</p> <p>Recommendation 14, April 2007: Provide augmentative/adaptive communication devices for individuals</p>
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		<p>with communications issues.</p> <p>Findings: The Physical Health Indicator List is currently being piloted. Monthly tracking will assist in identifying individuals who have ongoing need for assessment/intervention related to augmentative/adaptive devices. Individuals in need of Speech Language assessment and treatment are referred for this service. According to review of Adaptive Equipment database, no individuals are currently using augmentative/assistive communication devices. However, based on review of Speech Therapy caseload and the population of the facility, it appears that functional communication foundational skills with focus on receptive and expressive language, attention, processing and pragmatics, as well as staff training to understand individuals' communication needs, may be a more appropriate focus than adaptive or augmentative communication devices.</p> <p>Other findings: Data reported from ASH audits for August and September 2007 indicate that 13% of August Integrated Rehabilitation Therapy Assessments and 24% of September Integrated Rehabilitation Therapy Assessments were completed within specified time frames (five days for initial evaluations and seven days for transfers) according to procedure. According to report, 60% of assessments for August and 57% of assessments for September were comprehensive, with all sections addressed.</p> <p>Upon record review of assessments done from July-September 2007, it was noted that 100% contained an Integrated Rehabilitation Therapy Assessment, 21% of assessments were completed within appropriate time frames, 86% were complete, with all sections addressed, 0% were comprehensive and 0% contained specific measurements of functional status.</p>
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		<p>Upon record review of pilot assessments, it was noted that 100% contained an Integrated Rehabilitation Therapy Assessment, 78% of assessments were completed within appropriate time frames, 100% were complete, with all sections addressed, 100% were comprehensive, and 0% contained specific measurements of functional status.</p> <p>According to facility report from the Physical Therapy Services database, 42 Physical Therapy assessments were completed from April-September 2007, though 63 individuals are listed on the database. It is unclear if these individuals received PT evaluation prior to the last six months, as no referral date was listed. The database did not separate referrals and assessments for acute and chronic rehabilitation needs, so compliance with two-week and two-month standards is not possible to determine based on data provided. Record review of Physical Therapy Assessments revealed that 100% of Physical Therapy assessments were complete, and 11% contained functional and measurable objectives and findings.</p> <p>According to the Swallow Follow database, six individuals received Swallow Follow assessment/follow-up, out of seven referred for this service. The procedure regarding Speech Language assessments does not specify the timeframe in which Swallow Follow assessments are to be completed, and therefore it is not possible to determine a compliance finding related to timeliness of these assessments.</p> <p>According to the Speech Language assessment database, 28 individuals were referred for Speech Therapy Assessment, and 22 assessments were completed. Four were not done secondary to refusals, one was not completed secondary to being a "previous patient", and one was not done due to individual discharge three days after referral was made. The Speech Therapy procedure regarding assessments does not specify a required timeframe in which Speech Therapy assessments are to be</p>
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		<p>completed, and thus no finding regarding compliance with timeliness can be made at this time.</p> <p>Review of Speech Therapy Assessments showed that 86% were complete, 100% contained functional communication objectives, and 0% contained measurable objectives. Review of Swallow Follow assessments revealed that 100% of assessments were completed and 100% had individualized recommendations.</p> <p>According to facility report, 86 Vocational Assessments were completed from March to the present. No information was provided regarding date of referral or date of completion of Vocational Assessments. The current procedure for Vocational Services does not specify a timeframe in which the assessment should be completed. Upon record review of Vocational Assessments, it was noted that 90% of records had referrals for assessment, and 100% contained complete Vocational Assessments.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement monitoring tool(s) for Physical, Occupational, and Speech Therapy Assessments, Vocational Rehabilitation Assessments, and Comprehensive Physical Rehabilitation Assessments (POST) to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability.2. Revise and implement the Integrated Assessment--Rehabilitation Therapy Section Monitoring Tool and instructions based on findings from pilot and collaboration with other state facilities.3. Ensure that all individual objectives are functional, meaningful, and measurable.4. Establish inter-rater reliability for all audit/monitoring tools prior to implementation.
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<p>D.4.b.ii</p>	<p>Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and</p>	<p>Findings:</p> <p>According to ASH Integrated Rehabilitation Assessment audit data for August 2007, 72% addressed functional status, 66% identified life skills, and 39% identified skills and supports needed to transfer to the next level of care. According to ASH Integrated Rehabilitation Assessment audit data for September 2007, 60% addressed functional status, 61% identified life skills, and 41% identified skills and supports needed to transfer to the next level of care.</p> <p>Upon record review of IRTA assessments from July -September, it is noted that 21% of assessments identify current functional status, and 14% of assessments identify skills and supports needed to facilitate transfer to the next level of care.</p> <p>Upon record review of pilot IA-RTS assessments, it is noted that 100% of assessments identify current functional status, and 100% of assessments identify skills and supports needed to facilitate transfer to the next level of care.</p> <p>Upon record review of Vocational Rehabilitation assessments, it is noted that 0% of assessments identify current functional status, and 70% of assessments identify skills and supports needed to facilitate transfer to the next level of care.</p> <p>Upon record review of Speech Therapy assessments, it is noted that 100% of assessments identify current functional status, and 0% of assessments identify skills and supports needed to facilitate transfer to the next level of care.</p> <p>Upon record review of Physical Therapy assessments, it is noted that 0% of assessments identify current functional status, and 0% of assessments identify skills and supports needed to facilitate transfer to the next level of care.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.</p>
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Findings: According to ASH audit data for August 2007, 65% of assessments identified the individual's life goals, 45% addressed strengths, and 52% identified motivation for engaging in wellness activities. According to ASH audit data for September 2007, 59% of assessments identified the individual's life goals, 40% addressed strengths, and 43% identified motivation for engaging in wellness activities.</p> <p>Upon record review of Integrated Rehabilitation Therapy Assessments, it was noted that 86% of assessments identified the individual's life goals, 57% addressed strengths, and 71% identified motivation for engaging in wellness activities.</p> <p>Upon record review of pilot IA-RTS assessments, it was noted that 100% of assessments identified the individual's life goals, 100% addressed strengths, and 100% identified motivation for engaging in wellness activities.</p> <p>Upon record review of Speech Therapy assessments, it was noted that 100% of assessments identified the individual's life goals, and 100% addressed strengths.</p> <p>Upon record review of Physical Therapy assessments, it was noted that 0% of assessments identified the individual's life goals, and 0%</p>

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		<p>addressed strengths.</p> <p>Upon record review of Vocational Rehabilitation assessments, it was noted that 100% of assessments identified the individual's life goals, and 70% addressed strengths and 100% identified motivation for engaging in wellness activities.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.</p>
D.4.c	<p>Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible.</p> <p>Findings: All Rehabilitation Therapists (36) have been verified as competent in performing the assessments for which they are responsible, according to facility report. Four Admission RT staff members were trained on the Draft IA-RTS procedure in May, and 32 Rehabilitation Therapists were trained in the draft IA-RTS Procedure. However, competency-based trainings for revised Integrated Assessment for Rehabilitation Services and instructions are pending final approval and subsequent implementation of these tools.</p> <p>According to current Rehabilitation practice, competency for Physical Therapy and Speech Pathology is established by verification and proof</p>

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		<p>of licensure.</p> <p>Recommendation 2, April 2007: Develop and implement a monitoring system to adequately address the elements of this requirement.</p> <p>Findings: Ongoing training is documented in the ASH Training Database, which monitors mandatory training requirements. Assessment audits are conducted for Integrated Assessment- Rehabilitation Therapy Services, but individual and departmental feedback and incidental training has not yet commenced. Annual Reviews are conducted for all Rehabilitation Therapy Staff and reported quarterly.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures, and to appropriate staff regarding developed/revised assessment protocols and instructions on a discipline-/team-specific basis.</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 § [IV.D.2], above.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to ASH are reviewed by qualified clinicians and, as indicated, revised.</p> <p>Findings: This process was initiated with the first draft of the Integrated Rehabilitation Therapy assessment on 4/07/07. According to facility</p>

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		<p>report, 233 out of 732 individuals admitted prior to March 31, 2007 have received a Rehabilitation Therapy assessment with a version of the Integrated Rehabilitation Therapy Assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Ensure that all individuals admitted to ASH prior to March 1, 2007 receive an Integrated Rehabilitation Therapy Assessment within the next six months.</p>
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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Erin Dengate, Assistant Director of Dietetics 2. Dawn Hartman, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Nutrition Care Monitoring Tool and Instructions 2. Nutrition High Risk Referral 3. ASH Nursing Policy/Procedure 208.0 Physical Survey 4. ASH Nutrition Services Procedure 808: Nutrition Referral Process (revised 9/1/07) 5. ASH Nutrition Services Procedure 800: Nutrition Care Process (revised 9/1/07) 6. Nutrition Care Manual 2007 Updates 7. Nutrition Assessment Update 8. Nutrition Assessment Update Instructions (revised 8/13/07) 9. Nutrition Assessment Documentation Training sign-in sheets for April-September 2007 10. Nutrition Care Manual Update Training sign-in sheets for May, July and August 2007 11. Nutrition Assessment Update Training sign-in sheets for 6/07 and corresponding competency-based "quizzes" 12. Monthly Dietitian Report and Instructions (revised 8/07) 13. Monthly RD report data for September 2007 with attached explanation of discrepancies with six-month progress report 14. ASH Nutrition Services Performance Improvement Indicators-Clinical 15. Nutrition Diagnostic Terminology List 16. Records for the following individuals receiving type a. assessments from April-September 2007: JG, GC, RA, HL, DM 17. Records for the following individual receiving type b. assessment

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		<p>from April-September 2007: LH</p> <p>18. Records for the following individuals receiving type d. assessments from April-September 2007: LS, CP, DN, TR, TM, AS, DC</p> <p>19. Records for the following individuals receiving type e. assessments from April-September 2007: GB, AM, MW</p> <p>20. Record for the following individual receiving type f. assessment from April-September 2007: GB</p> <p>21. Records for the following individuals receiving type g. assessments from April-September 2007: AH, MC, KG, KL, PC, JG, CB, FL</p> <p>22. Records for the following individuals receiving type i. assessments from April-September 2007: CH, JP, OP, DM, RH, TC, SD, SK, RD</p> <p>23. Records for the following individuals receiving type j.i. assessments from April-September 2007: JB, RM, DW, PD, AS, GR, DM, LM, AM</p> <p>24. Records for the following individuals receiving type j.ii. assessments from April-September 2007: RL, PD, BC, RW, JP, OR, DG, PG, DR</p>
D.5.a	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue to ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p> <p>Findings: Training and feedback is provided to RD staff both in a group format during departmental meetings and on an individualized basis as indicated by results of Nutrition Care Monitoring Tool audits. Group feedback on deficiencies/appropriate procedures is verified by review of Nutrition Assessment Documentation sign-in sheets from April-September 2007. All 10 clinical RDs and the Assistant Director of Dietetics, Clinical were present, according to the sign-in sheets.</p>

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		<p>Recommendation 2, April 2007: Provide training and implementation of the Statewide Nutrition High-Risk Referral Form as planned.</p> <p>Findings: Training was provided to all units and HSS committee for high-risk referral criteria as a component of Nutrition Care Manual update training 5/07-8/07. New RNs since May 2007 have received training as part of the New Employee Orientation Nutrition class. High Risk Referral form was added to Nursing Policy and Procedure 208 on 8/14/07 and to Nutrition Policy and Procedure 808 on 9/1/07. Nutrition High Risk Referral form was implemented on 9/1/07. This is verified by review of procedures and training sign-in sheets.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, seven individuals had type a. assessments between April-September 2007, and five records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 75% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 67% had individualized and measurable goals, and 50% had appropriate recommendations.</p> <p>Record review of individuals receiving type a. assessments from April-September 2007 indicated that 75% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 20% had individualized and measurable goals, and 60% had appropriate</p>
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		<p>recommendations.</p> <p>Other findings: It was noted upon chart review and interview that one individual met criteria for a type a. assessment but the Dietitian received a standard referral and thus completed the assessment within the seven-day time frame rather than within 24 hours. This issue was due to an error in the type of referral made, and was caught upon chart audit. Systemic issues such as this are addressed with a plan of correction by the Assistant Director of Dietetics, which is documented on the Nutrition Services Performance Improvement Indicators-Clinical database. Admission Nutrition Assessments with 24-hour high-risk referral continue to be audited for timeliness and content/quality each month. RD unit and audit work was redirected to essential food service operations during the power outage emergency 6/15-7/8. A June referral occurred during this time and the RD was delayed in responding. Training was given to this Dietitian to address critical 24-hour referrals even in emergency. The goal of 100% audit was not met for May data due to the power emergency.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.b	<p>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within three days of admission.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue to ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p>

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		<p>Findings: See D.5.a, Findings for Recommendation 1.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, two individuals had type b. assessments between April-September 2007, and two records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 100% of assessments were completed on time, 50% had complete subjective findings, 50% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 50% had appropriate recommendations.</p> <p>One record of the two individuals who received type b. assessments from April-September 2007 was available and review indicated that the assessment was completed on time, and had evidence of incomplete subjective findings, complete objective findings, correctly formulated nutrition diagnosis, individualized and measurable goals, and appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
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	Not applicable. ASH does not have a skilled nursing facility unit.

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	admission.	
D.5.d	<p>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Continue to ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.</p> <p>Findings: See D.5.a, Findings for Recommendation 1.</p> <p>Recommendation 2, April 2007: Evaluate discrepancies between departmental monthly report and compliance data.</p> <p>Findings: The RD monthly report captures timeliness for 100% of assessments due, whereas the compliance data is from a small sample size and is separated by assessment type. RD caseloads were reorganized on 9/1/07 to improve auditor availability in order to increase sample size and strengthen reliability. This is confirmed by review of the RD monthly report for September and accompanying Explanation of RD Monthly Report Data. According to the Explanation, the RD monthly report is no longer used for timeliness comparison to-six month compliance data, but is now used internally for caseload, productivity, and general tracking of timeliness.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, 104 individuals had type d. assessments between April-September 2007, and 57 records were audited using the</p>

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		<p>Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 81% of assessments were completed on time, 95% had complete subjective findings, 88% had complete objective findings, 90% had correctly formulated nutrition diagnosis, 88% had individualized and measurable goals, and 78% had appropriate recommendations.</p> <p>Record review of individuals receiving type d. assessments from April-September 2007 indicated that 71% of assessments were completed on time, 86% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 57% had individualized and measurable goals, and 57% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</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 1, April 2007: Same as D.5.a current recommendation 1.</p> <p>Findings: See D.5.a, Findings for Recommendation 1.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement.</p>

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		<p>Findings: According to facility report, 11 individuals had type e. assessments between April-September 2007 and nine records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 87% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 90% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 63% had appropriate recommendations.</p> <p>Record review of individuals receiving type e. assessments from April-September 2007 indicated that 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 100% had individualized and measurable goals, and 100% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, one individual had a type f. assessment between April-September 2007, and one record was audited using the Nutrition Care Monitoring Tool.</p>

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		<p>According to Nutrition Assessment audit data for April-September 2007, the assessment audited was not on time, and had evidence of complete subjective findings, complete objective findings, correctly formulated nutrition diagnosis, and individualized and measurable goals, but did not have appropriate recommendations.</p> <p>Record review of individual who received a type f. assessment from April-September 2007 indicated that the assessment was not completed on time, had complete subjective and objective findings, correctly formulated nutrition diagnosis and appropriate recommendations, but did not have individualized and measurable goals.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Same as D.5.a, Recommendation 1.</p> <p>Findings: See D.5.a, Findings for Recommendation 1.</p> <p>Recommendation 2, April 2007: Increase audited sample size.</p> <p>Findings: Admission Nutrition Assessments continue to be audited for timeliness and content/quality. The goal of a 100% sample has not been met due</p>

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		<p>to a shortage of audit resources. RD caseloads were reorganized on 9/1/07 to improve auditor availability. The goal starting 9/07 is to audit 100% on Program IV at a minimum and on other programs as audit resources permit.</p> <p>Recommendation 4, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, 265 individuals had type g. assessments between April-September 2007, and 46 records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 50% of assessments were completed on time, 99% had complete subjective findings, 85% had complete objective findings, 98% had correctly formulated nutrition diagnosis, 87% had individualized and measurable goals, and 71% had appropriate recommendations.</p> <p>Record review of individuals receiving type g. assessments from April-September 2007 indicated that 50% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 63% had correctly formulated nutrition diagnosis, 38% had individualized and measurable goals, and 75% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
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<p>D.5.h</p>	<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>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a protocol addressing the timeframe for assigning the NST. 2. Ensure that NSTs are assigned within specified timeframes. 3. Clarify compliance scoring on item 12 on the NCMT regarding timeliness of NST. <p>Findings: Nutrition Services Policy and Procedure 800 was revised to clarify protocol. Current practice is that NST must be assigned each for assessment, and "pending" status is no longer used. This is monitored with NCMT Instruction #12.</p> <p>Recommendation 4, April 2007: Continue to monitor this requirement.</p> <p>Findings: The facility database for all assessment types per month for April-September 2007 was reviewed. A weighted mean was calculated and revealed that 86% of assessments audited from April-September had evidence of a correctly assigned NST level.</p> <p>Upon record review of all assessment types (total of 52) from April-September, it is noted that that an average (weighted mean) of 85% of Nutrition Care assessments had evidence of a correctly assigned NST level.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendation: Continue current practice.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Report compliance data for all of the elements of this requirement.</p> <p>Findings: NCMT and instructions for items #1, 2, 3, 9, 10, 11, and 12 address all elements of this requirement and are reported separately below. The new statewide Nutrition Assessment Update form that includes all elements of this requirement was implemented in 6/07 and submitted for DMH approval on 8/14/07. Training on revisions was provided to all RDs on 6/12/07. This is verified by review of revisions and training sign-in sheets.</p> <p>Nutrition Assessment Updates have not been consistently monitored due to lack of auditor resources and focus on higher acuity levels (e.g. admissions, referrals, unit 1 transfers). RD caseloads were reorganized on 9/1/07 to improve auditor availability. RD vacancies and high caseloads appear to be factors that impact timeliness of updates. An average caseload per FTE is 4-6 units, which equals between 160-200 individuals per RD.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, 794 individuals had type i. assessments between April-September 2007, and 19 records were audited using the Nutrition Care Monitoring Tool.</p>

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		<p>According to Nutrition Assessment audit data for April-September 2007, 68% of assessments were completed on time, 94% had complete subjective findings, 60% had complete pertinent objective findings, 83% had correctly formulated nutrition diagnosis, 63% had individualized and measurable goals, and 73% had appropriate recommendations.</p> <p>Record review of individuals receiving type i. assessments from April-September 2007 indicated that 56% of assessments were completed on time, 100% had complete subjective findings, 89% had complete objective findings, 78% had correctly formulated nutrition diagnosis, 67% had individualized and measurable goals, and 67% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Report data regarding referrals (24-hour and seven-day) separately.</p> <p>Findings: Currently, all categories for change in condition are reported separately; this is verified by review of monitoring data tables for 7-day referrals, 24-hour referrals and non-administrative transfer to Unit 1.</p> <p>Recommendation 2, April 2007: Continue to provide training on components of an adequate assessment</p>

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		<p>for changes in conditions.</p> <p>Findings: Training specific to the new Nutrition Assessment Update form that is utilized for change in condition was provided to all RDs on 6/12/07; this was verified by review of Training sign-in sheets and corresponding competency-based "quizzes."</p> <p>Change in condition continues to be audited for timeliness and content/quality with the Nutrition Care Monitoring tool. Training/feedback from results of monitoring data is provided to Dietitians at group meetings and on an individual basis.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, four individuals had type j.i. 24 hour referral assessments between April-September 2007, and four records were audited using the Nutrition Care Monitoring Tool. A total of 177 individuals had type j.i. seven-day referral assessments between April-September 2007, and 20 records were audited using the Nutrition Care Monitoring Tool. It is reported that 35 individuals had type j.i. non-administrative transfer to unit 1 assessments between April-September 2007, and 25 records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, for j.i. 24-hour referrals, 100% of assessments were completed on time, 75% had complete subjective findings, 50% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 75% had individualized and measurable goals, and 50% had appropriate recommendations.</p>
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		<p>According to Nutrition Assessment audit data for April-September 2007, for j.i. seven-day referrals, 100% of assessments were completed on time, 93% had complete subjective findings, 29% had complete pertinent objective findings, 67% had correctly formulated nutrition diagnosis, 76% had individualized and measurable goals, and 59% had appropriate recommendations.</p> <p>According to Nutrition Assessment audit data for April-September 2007, for j.i. non-administrative transfer to unit 1, 100% of assessments were completed on time, 95% had complete subjective findings, 70% had complete pertinent objective findings, 94% had correctly formulated nutrition diagnosis, 79% had individualized and measurable goals, and 85% had appropriate recommendations.</p> <p>Record review of individuals receiving type j.i. assessments (weighted mean of sample of the three j.i. sub-types) from April-September 2007 indicated that 89% of assessments were completed on time, 89% had complete subjective findings, 100% had complete pertinent objective findings, 89% had correctly formulated nutrition diagnosis, 67% had individualized and measurable goals, and 78% had appropriate recommendations.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue current practice.</p>
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure accuracy of target population for compliance data.</p>

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		<p>Findings: Reporting for annual assessments due only includes those due in the current month and not carry-over assessments overdue from previous months. This change was implemented starting with 4/07 data and monthly report instructions were revised in 8/07.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to facility report, 370 individuals had type j.ii. assessments between April-September 2007, and 29 records were audited using the Nutrition Care Monitoring Tool.</p> <p>According to Nutrition Assessment audit data for April-September 2007, 49% of assessments were completed on time, 87% had complete subjective findings, 71% had complete pertinent objective findings, 90% had correctly formulated nutrition diagnosis, 56% had individualized and measurable goals, and 36% had appropriate recommendations.</p> <p>Record review of individuals receiving type j.ii. assessments from April-September 2007 indicated that 89% of assessments were completed on time, 78% had complete subjective findings, 89% had complete objective findings, 78% had correctly formulated nutrition diagnosis, 0% had individualized and measurable goals, and 45% had appropriate recommendations.</p> <p>Compliance: Partial.</p>
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		Current recommendation: Continue current practice.
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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. Janet Bouffard, LCSW, Acting Chief of Social Work 2. Richard Teubner, LCSW, Acting Clinical Supervisor <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 30 individuals (ADD, AH, BM, DB, DT, GR, JAB, JER, JFD, JJS, JKS, JR, JSR, LP, MAM, MBH, MK, MM, MN, MY, RC, RCT, RG, RJH, RM, RP, SS, SZ, TR, and TSK) 2. DMH Social Work Integrated Assessment 3. DMH 30-day Psychosocial Assessment 4. Social Work Training Documentation 5. Social Work EP Progress Report 6. Social Work Credentialing/Privileging Curriculum Vitae <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC for DAH, Program 1, Unit 11 2. WRPC for MC, Program 11, Unit 26 3. WRPC for AEC, Program 1, Unit 11
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement the five-day, 30-day, and annual social history reviews.</p> <p>Findings: ASH has revised the five-day Social History Assessment (Social Work Integrated Assessment) and the 30-day Psychosocial Assessment tools. These revised tools were implemented beginning August 31, 2007. ASH has discontinued the use of the Annual Social History tool as of</p>

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September 6, 2007.

This monitor reviewed 11 charts (RG, SS, MH, MY, MM, LP, AH, JR, JS, RC, and TR). Four of them were timely and comprehensive (LP, JS, RC, and TR). Seven of them (MY, MM, JR, SS, RG, MH, and AH) were not comprehensive, with failure to list all reporting sources, and sections of the evaluation were not completed without any explanation forwarded for the lack of data.

Recommendation 2, April 2007:

Include quality and accuracy indicators in the Social Work monitoring instruments.

Findings:

ASH used items #1, #2, and #3 from the Social Work Integrated Assessment as the quality and accuracy indicators, and audited 118 Social History Integrated Assessments, reporting 99%, 22%, and 5% compliance respectively. The table below with its monitoring indicators showing the number of Social History Integrated Assessments due per month (N), the number reviewed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#1: *Is current*

#2: *Is, to the reasonably possible, accurate*

#3: *Is comprehensive, includes or listed as not applicable*

	Jun	Jul	Aug	Mean
N	67	90	125	
n	2	36	80	
%S	3	40	64	
%C #1	100	100	96	99
%C #2	0	31	36	22
%C #3	0	3	11	5

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ASH audited the 30-day Psychosocial Assessments conducted in Program IV, using the same quality indicator items #1, #2, #3 (see listing above) from the Psychosocial Integrated Assessments, reporting 100%, 24%, and 12% compliance respectively.

	Apr	Jul	Aug	Mean
N	15	20	28	
n	12	2	10	
%S	80	10	36	
%C #1	100	100	100	100
%C #2	33	0	40	24
%C #3	17	0	20	12

As shown in both of the tables above, the timeliness of the assessments is high, but the quality of these assessments as measured by accuracy and comprehensiveness is low.

According to the Acting Chief of Social Work, Janet Bouffard, further training on the proper assessment and documentation of the Social Work Integrated Assessments is needed and inter-rater reliability needs to be established to improve compliance with the EP. Also, she noted that monitoring initiated in April was discontinued until July due to staffing and resource shortages.

This monitor reviewed 11 charts (RG, SS, MH, MY, MM, LP, AH, JR, JS, RC, and TR) to evaluate the quality of the Social Work Integrated Assessments. One of the assessments (LP) met the criteria, and the remaining ten (RG, SS, MH, MY, MM, AH, JR, JS, RC, and TR) failed to meet all the elements of the quality indicator.

Recommendation 3, April 2007:

Develop, finalize and implement the Statewide annual social history

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		<p>evaluation.</p> <p>Findings: ASH has discontinued the annual social history evaluation on the recommendation of its CRIPA consultant. This monitor is in agreement with the recommendation. The facility already conducts monthly WRP updates, which should provide timely information. ASH should ensure that the monthly WRPs are comprehensive, with updates from Social Work notes and other sources of information.</p> <p>Recommendation 4, April 2007: Align monitoring tools with the EP.</p> <p>Findings: According to the Acting Chief of Social Work, ASH has revised the monitoring tools to align with the EP and is awaiting approval from DMH.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments. 2. Align monitoring tools with the EP.
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 recommendations:</p> <p>Recommendation 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.

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		<p>Findings: ASH used item #4 from the 30-day Psychosocial Assessment monitoring tool to address this recommendation, reporting 3% compliance. The table below with this monitoring indicator showing the number of assessments due for the month (N), the number of assessments monitored (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <p><i>#4: Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies and explains the rationale for the resolution offered.</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Apr</th> <th>Jul</th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>15</td> <td>20</td> <td>28</td> <td></td> </tr> <tr> <td>n</td> <td>12</td> <td>2</td> <td>10</td> <td></td> </tr> <tr> <td>%S</td> <td>80</td> <td>10</td> <td>36</td> <td></td> </tr> <tr> <td>%C #4</td> <td>9</td> <td>0</td> <td>0</td> <td>3</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (RG, SS, MH, MY, MM, LP, AH, JR, JS, RC, and TR). One of the integrated assessments (RC) addressed the factual inconsistencies, and the remaining ten (RG, SS, MH, MY, MM, LP, AH, JR, JS, and TR) failed to address the issue of factual inconsistencies. In some cases (MM and SS) there were factual inconsistencies that the examiners had missed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to 		Apr	Jul	Aug	Mean	N	15	20	28		n	12	2	10		%S	80	10	36		%C #4	9	0	0	3
	Apr	Jul	Aug	Mean																							
N	15	20	28																								
n	12	2	10																								
%S	80	10	36																								
%C #4	9	0	0	3																							

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		correct the inconsistencies.																									
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30 th day of an individual's admission; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that all Social Work Integrated Assessments are completed and available to the WRPT before the seven-day WRPC.</p> <p>Findings: ASH used item #4 from the Social Work Integrated Assessment monitoring tool to address this recommendation, reporting 67% compliance. The table below with its monitoring indicator showing the number of assessments due per month (N), the number of assessments monitored (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <p><i>#4: Completed within the appropriate time frame</i></p> <table border="1" data-bbox="991 857 1862 1052"> <thead> <tr> <th></th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>67</td> <td>90</td> <td>125</td> <td></td> </tr> <tr> <td>n</td> <td>2</td> <td>36</td> <td>80</td> <td></td> </tr> <tr> <td>%S</td> <td>3</td> <td>40</td> <td>64</td> <td></td> </tr> <tr> <td>%C #4</td> <td>50</td> <td>72</td> <td>80</td> <td>67</td> </tr> </tbody> </table> <p>This monitor reviewed 27 charts (RG, ADD, GR, JER, JSR, MK, TSK, RM, MN, SZ, BM, MAM, RCT, DT, RJH, RP, JKS, SS, MBH, MY, MM, LP, AH, JR, JJS, RC, and TR). Nineteen of them were present and timely (RG, JER, TSK, RM, MN, BM, MAM, RCT, RJH, RP, JKS, SS, MBH, MY, MM, LP, AH, RC, and TR), and seven of them were untimely or not present in the chart (DT, JR, SZ, ADD, GR, JSR, and MK). As for JJS, the date of assessment was not recorded.</p>		Jun	Jul	Aug	Mean	N	67	90	125		n	2	36	80		%S	3	40	64		%C #4	50	72	80	67
	Jun	Jul	Aug	Mean																							
N	67	90	125																								
n	2	36	80																								
%S	3	40	64																								
%C #4	50	72	80	67																							

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		<p>Recommendation 2, April 2007: Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.</p> <p>Findings: ASH audited Program IV using item #6 from the 30-day Psychosocial Assessment, reporting 50% compliance. The table below with its monitoring indicator showing the number of assessments due per month (N), the number of assessments monitored (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <p><i>#6: Completed within the appropriate time frame</i></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Apr</th> <th>Jul</th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>15</td> <td>20</td> <td>28</td> <td></td> </tr> <tr> <td>n</td> <td>12</td> <td>2</td> <td>10</td> <td></td> </tr> <tr> <td>%S</td> <td>80</td> <td>10</td> <td>36</td> <td></td> </tr> <tr> <td>%C #6</td> <td>50</td> <td>50</td> <td>50</td> <td>50</td> </tr> </tbody> </table> <p>This monitor reviewed nine charts (RG, SS, MY, LP, AH, JR, JS, RC, and TR). Six of them (RG, SS, LP, AH, JR, and JS) did not have the 30-day Psychosocial Assessments. Two of them (MY and RC) were present and timely, and one of them (TR) was present but untimely.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission. 		Apr	Jul	Aug	Mean	N	15	20	28		n	12	2	10		%S	80	10	36		%C #6	50	50	50	50
	Apr	Jul	Aug	Mean																							
N	15	20	28																								
n	12	2	10																								
%S	80	10	36																								
%C #6	50	50	50	50																							

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<p>D.6.d</p>	<p>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.</p> <p>Findings: ASH audited Program IV using item #5 from the 30-day Psychosocial Assessment, reporting 6% compliance. The table below with its monitoring indicator showing the number of assessments due per month (N), the number of assessments monitored (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <p><i>#5: The assessment contributes to clinical decision making, discharge planning and aftercare services.</i></p> <table border="1" data-bbox="991 820 1858 1015"> <thead> <tr> <th></th> <th>Apr</th> <th>Jul</th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>15</td> <td>20</td> <td>28</td> <td></td> </tr> <tr> <td>N</td> <td>12</td> <td>2</td> <td>10</td> <td></td> </tr> <tr> <td>%S</td> <td>80</td> <td>10</td> <td>36</td> <td></td> </tr> <tr> <td>%C #5</td> <td>8</td> <td>0</td> <td>10</td> <td>6</td> </tr> </tbody> </table> <p>This monitor reviewed 11 charts (RG, SS, MH, MY, MM, LP, AH, JR, JS, RC, and TR). Two of the psychosocial assessments in them (MM, RC) addressed the individual's social factors and educational status to reliably inform the individual's WRPT. The remaining nine (RG, SS, MH, MY, LP, AH, JR, JS, and TR) assessments did not include sufficient information, offer an explanation for data that was not available, or suggest a plan for getting the missing data.</p> <p>Compliance: Partial.</p>		Apr	Jul	Aug	Mean	N	15	20	28		N	12	2	10		%S	80	10	36		%C #5	8	0	10	6
	Apr	Jul	Aug	Mean																							
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%C #5	8	0	10	6																							

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		<p>Current recommendations: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.</p>
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7. Court Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. David Fennel, MD, Chair, FRP 2. Robert Napp, MD, Medical Director 3. Jennifer Brush, Case Record Manager <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of six individuals admitted under PC 1026 (FL, JPS, MR, RA, TG and TR) 2. Charts of six individuals admitted under PC 1370 (DAA, ER, EWK, LS, NSB, and RH) 3. AD #516.9, Penal Code Sections 1026.2, 1026.5 and 1026(f) Report Content, October 2, 2007 4. AD # 516.8, Penal Code Section 1370 Report Content, October 2, 2007 5. AD 222.40, Forensic Review Panel (FRP), October 2, 2007 6. Memorandum from Chair of FRP to all WRPT Member Psychologists and Psychiatrists (September 24, 2007) re 1026 and 1370 reports 7. Memorandum from Chair of FRP to all Psychologists and Psychiatrists (October 11, 2007) re 1026(f) reports 8. ASH Court Report PC 1026 Monitoring Form 9. Court Report PC 1026 Monitoring summary data (May and September 2007) 10. ASH Court Report PC 1370 Monitoring Form 11. Court Report PC 1370 Monitoring summary data (May to September 2007) 12. Minutes of the FRP (May, June, July, September and October 2007)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an	<p>Compliance: Partial.</p>

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	<p>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:</p>	
D.7.a.i	<p>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);</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions.</p> <p>Findings: ASH has implemented this recommendation. AD #516.9, Penal Code Sections 1026.2, 1026.5 and 1026(f), effective August 21, 2007, contains expectations regarding the format of 1026 court submissions that are consistent with EP requirements.</p> <p>Recommendation 2, April 2007: Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRPTs to achieve compliance.</p> <p>Findings: ASH has implemented this recommendation. The facility developed and implemented AD #222.40, Forensic Review Panel (FRP). This AD includes the requirement that the FRP reviews all Section 1026 reports. Since September 2007, the facility has required that all WRPTs implement the recommendations of the FRP prior to sending the reports to the courts. In addition, the facility has developed a mechanism to ensure oversight by the Medical Director's office regarding implementation of these recommendations.</p>

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		<p>Recommendation 3, April 2007: Monitor this requirement and ensure adequate monitoring sample in the self-assessment data.</p> <p>Findings: ASH used the Court Report PC 1026 Monitoring Form to assess compliance with requirements in D.7.a.1 through D.7.a.ix. The FRP reviewed all PC 1026 reports in September 2007 and reported 100% compliance with this requirement.</p> <p>Recommendation 4, April 2007: Improve compliance with this requirement.</p> <p>Findings: ASH reported 100% compliance. However, there continues to be discrepancy between the facility's data and findings by this monitor (see Other findings).</p> <p>Other findings: This monitor reviewed the charts of six individuals admitted under PC 1026 (FL, JPS, MR, RA, TG, and TR). Dr. Fennel, the chair of the FRP, attended this review. The monitor found non-compliance in five charts and partial compliance in one (TG). The main reason for the low compliance is that the reports often did not outline the symptoms that contributed to the instant offense or the clinical progress regarding those symptoms.</p> <p>Current recommendation: Continue to monitor 100% of PC 1026 reports and address any significant discrepancy between the facility's data and findings by this monitor.</p>
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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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 100%.</p> <p>Other findings: This monitor's reviews revealed compliance in five charts and non-compliance in one (MR).</p> <p>Current recommendation: Same as above.</p>
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 25%.</p> <p>Other findings: This monitor's reviews showed partial compliance in three charts (FL, TR and TG) and non-compliance in three (MR, GPS and RA).</p> <p>Current recommendation: Same as above.</p>
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	<p>Current findings on previous recommendation:</p>

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	<p>treatment;</p>	<p>Recommendation, April 2007: Same as above.</p> <p>Findings: The following is an outline of the indicators relevant to this requirement and corresponding compliance rates:</p> <table border="1" data-bbox="993 451 1881 568"> <tr> <td>1.</td> <td><i>Individual's acceptance of mental illness</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Individual's adherence to treatment</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Individual's understanding of the need for treatment</i></td> <td>100%</td> </tr> </table> <p>Other findings: This monitor's reviews revealed compliance in two charts (FL and TR), partial compliance in two (TG and RA) and non-compliance in two (JPS and MR).</p> <p>Current recommendation: Same as above.</p>	1.	<i>Individual's acceptance of mental illness</i>	100%	2.	<i>Individual's adherence to treatment</i>	100%	3.	<i>Individual's understanding of the need for treatment</i>	100%
1.	<i>Individual's acceptance of mental illness</i>	100%									
2.	<i>Individual's adherence to treatment</i>	100%									
3.	<i>Individual's understanding of the need for treatment</i>	100%									
D.7.a.v	<p>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;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: The following is an outline of the indicators relevant to this requirement and corresponding compliance rates.</p> <table border="1" data-bbox="993 1230 1881 1385"> <tr> <td>1.</td> <td><i>Individual's development of relapse prevention plan for mental illness symptoms</i></td> <td>75%</td> </tr> <tr> <td>2.</td> <td><i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i></td> <td>25%</td> </tr> </table>	1.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	75%	2.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	25%			
1.	<i>Individual's development of relapse prevention plan for mental illness symptoms</i>	75%									
2.	<i>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</i>	25%									

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		<p>Other findings: This monitor found partial compliance in four charts (FL, JPS, TG and RA), compliance in one (TR) and non-compliance in one (MR).</p> <p>Current recommendation: Same as above.</p>
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 75%.</p> <p>Other findings: This monitor found non-compliance in five charts and compliance in one (TR).</p> <p>Current recommendation: Same as above.</p>
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 50%.</p> <p>Other findings: This monitor found compliance in one (FL) and non-compliance in one (MR). This requirement did not apply to the charts of JPS, TR, TG and</p>

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		<p>RA.</p> <p>Current recommendation: Same as above.</p>
D.7.a.viii	<p>social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 25%.</p> <p>Other findings: This monitor's reviews showed non-compliance in all cases.</p> <p>Current recommendation: Same as above.</p>
D.7.a.ix	<p>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.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a compliance rate of 50%.</p> <p>Other findings: This monitor found non-compliance in four charts (FL, MR, JPS and RA) and partial compliance in two (TR and TG).</p> <p>Current recommendation: Same as above.</p>

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<p>D.7.b</p>	<p>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:</p>	<p>Compliance: Substantial.</p>
<p>D.7.b.i</p>	<p>relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as D.7.a.i (as applicable to PC 1370).</p> <p>Findings: ASH used the Court Report PC 1370 Monitoring Form to assess compliance with requirements in D.7.b.i through D.7.b.iv (May to September 2007). The mean compliance rate for this requirement was 77%.</p> <p>Other findings: This monitor reviewed charts of six individuals admitted under PC 1370 (DAA, EWK, ER, NSB, RH and LS). The chair of the FRP (Dr. Fennel) attended this review. The monitor found general evidence of improvement in the format and quality of these reports since the last</p>

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		<p>review. Regarding this requirement, the reviews showed compliance in five charts and partial compliance in one (ER).</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor 100% of PC 1370 reports. 2. Continue current progress in the format and quality of PC 1370 reports. 						
D.7.b.ii	<p>clinical description of the individual at the time of admission to the hospital;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a mean compliance rate of 88%.</p> <p>Other findings: This monitor found compliance in all charts.</p> <p>Current recommendation: Same as above.</p>						
D.7.b.iii	<p>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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: The following is an outline of the indicators relevant to this requirement and corresponding compliance rates:</p> <table border="1" data-bbox="989 1339 1879 1416"> <tr> <td data-bbox="989 1339 1050 1377">1.</td> <td data-bbox="1050 1339 1774 1377"><i>Description of any progress or lack of progress</i></td> <td data-bbox="1774 1339 1879 1377">92%</td> </tr> <tr> <td data-bbox="989 1377 1050 1416">2.</td> <td data-bbox="1050 1377 1774 1416"><i>Individual's response to treatment</i></td> <td data-bbox="1774 1377 1879 1416">93%</td> </tr> </table>	1.	<i>Description of any progress or lack of progress</i>	92%	2.	<i>Individual's response to treatment</i>	93%
1.	<i>Description of any progress or lack of progress</i>	92%						
2.	<i>Individual's response to treatment</i>	93%						

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		<table border="1"> <tr> <td data-bbox="989 191 1050 228">3.</td> <td data-bbox="1050 191 1776 228"><i>Current relevant mental status</i></td> <td data-bbox="1776 191 1879 228">94%</td> </tr> <tr> <td data-bbox="989 228 1050 380">4.</td> <td data-bbox="1050 228 1776 380"><i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i></td> <td data-bbox="1776 228 1879 380">82%</td> </tr> </table>	3.	<i>Current relevant mental status</i>	94%	4.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	82%
3.	<i>Current relevant mental status</i>	94%						
4.	<i>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</i>	82%						
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.	<p>Other findings: Reviews by this monitor showed compliance in all charts.</p> <p>Current recommendation: Same as above.</p> <p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: ASH reported a mean compliance rate of 79%.</p> <p>Other findings: This monitor found compliance in four charts (DAA, EWK, NSB and RH) and partial compliance in two (ER and LS).</p> <p>Current recommendations: Same as above.</p>						
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Develop and implement a procedure that specifies membership, duties and responsibilities of an FRP.</p>						

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	<p>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>	<p>Findings: AD #222.40, Forensic Review Panel (FRP) outlines the membership, duties and responsibilities of the FRP as required by the EP.</p> <p>Recommendation 2, April 2007: Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under PCs 1026 and 1370. The panel must provide feedback to WRPTs to ensure compliance with all above requirements.</p> <p>Findings: ASH has implemented this recommendation. The facility reports that the FRP currently reviews all reports for individuals admitted under PCs 1026 and 1370. The reviews are performed on a monthly basis or more frequently if clinically indicated (as per the chair of the FRP). These proceedings are memorialized in the minutes of each FRP meeting. As mentioned earlier, the facility has developed a mechanism to ensure oversight by the Medical Director's office regarding implementation by the WRPTs of FRP recommendations for corrective action.</p> <p>Recommendation 3, April 2007: In order to rapidly meet the requirements of the EP, the DMH may want to consider having the Chair of the Forensic Review panel and the Forensic Psychiatry Consultant to PSH provide training and consultation. It is critical that all state hospitals use a standard format for court reports and for monitoring these reports.</p> <p>Findings: The DMH is currently in the process of developing a manual that standardizes the process of monitoring the reports.</p>
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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice regarding reviews by the FRP and oversight by the Medical Director. 2. Standardize monitoring indicators (PCs 1026 and 1370) for use across all four facilities and develop instructions for each indicator.
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>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure compliance with EP requirements regarding membership of the FRP and qualifications of the Chair.</p> <p>Findings: ASH has implemented this recommendation. In May 2007, ASH revised the membership of the FRP. The present membership consists of: Chief of Psychology designee, Medical Director Designee, Chief of Social Services designee, Chief of Nursing Services designee, and Chief of Rehabilitation Services. The Chair of the Forensic Review Committee is a psychiatrist with certification in general psychiatry and sub-specialty certification in forensic psychiatry.</p> <p>Recommendation 2, April 2007: Develop and implement a mechanism to ensure that all members of the FRP have completed adequate training in forensic procedures.</p> <p>Findings: ASH is in the process of implementing this recommendation. At this time, only psychology and psychiatry representatives are privileged for forensic report writing. The chair of the FRP provides on-going in-service training to panel members who have no forensic training</p>

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		<p>background. This training is provided as part of regularly scheduled forensic seminars on a weekly basis.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all members of the FRP, including psychiatry and psychology, have completed adequate training in forensic procedures.</p>
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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. A Family Therapy Needs Assessment Tool has been developed and implemented. 2. Tracking and monitoring of individuals referred for discharge has improved.
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. Janet Bouffard, LCSW, Acting Chief of Social Work 2. Richard M. Teubner, LCSW, Acting Clinical Supervisor. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 20 individuals (DAH, DB, DL, DNM, DR, FF, JAB, JFD, JJS, JVW, KS, KZ, MAB, MBH, MR, RB, RG, RJ, RR, and WT). 2. List of Individuals Referred for Discharge Still in Hospital. 3. Discharge Planning and Community Integration Tool. 4. DMH WRP Discharge Planning and Community Integration Auditing Form. 5. DMH WRP Discharge Planning and Community Integration Auditing Form Instructions. 6. ASH Training Sign-In List. 7. List of individuals who are interested in Family Therapy. <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Three WRPCs (DAH, Program 1, Unit 11; MC, Program 11, Unit 26; and AEC, Program 1, Unit 11). 2. Four Mall Groups (Medication Management 1, WRAP, Medication Management II, Medication Management III, and Anger Management).

Section E: Discharge Planning and Community Integration

<p>E.1</p>	<p>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:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process.</p> <p>Findings: ASH has provided training to its Social Work staff to treat discharge as a continuous process from the individual's admission to discharge, what is involved and how to achieve continuity. Training was conducted from September 18 to 20, 2007, with 71% of the participants achieving a score of 85% or better on the post-test dealing with the alignment between the EP and Wellness and Recovery Planning.</p> <p>An overview of the data obtained from sections C2, D2, E, and F2 of this report shows that the performance of the various departments and areas within these departments including WRPs, WRPTs, PSR services, and the discharge process itself, are in need of better collaboration to improve the quality of services and to fulfill the goal of achieving a continuous discharge process.</p> <p>Recommendation 2, April 2007: Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR small groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu.</p> <p>Findings: This monitor reviewed eight charts (KZ, RG, RR, DL, RB, DR, RJ, and MR). None of the WRPs in the charts had documentation to indicate that the individual was involved in the discussion of the discharge process, and how the individual was assisted to take advantage of the</p>
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Section E: Discharge Planning and Community Integration

		<p>available services in ASH. This situation was the same at the WRPCs this monitor attended (DAH, MC, and AEC). The individuals in these conferences, even those who were psychiatrically stable, were not fully engaged in the discussion on the discharge process.</p> <p>Recommendation 3, April 2007: Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual.</p> <p>Findings: This monitor reviewed eight charts (KZ, RG, RR, DL, RB, DR, RJ, and MR). One of them (RG) had documented evidence to show that discharge status of the individual was discussed at the WRPT, and the remaining seven did not have such evidence. This was also the case in the WRPCs for DAH and MC attended by this monitor.</p> <p>Recommendation 4, April 2007: Ensure that staff conducting assessment is aware of, trained in and track this requirement.</p> <p>Findings: According to the Acting Chief of Social Work, the Social Work staff has received training and is aware of this requirement. Staff training was conducted from September 18-20, 2007, with 71% of the Social Work staff receiving 85% or better scores on the post-test.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Involve the individual in the discharge process through discussion
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Section E: Discharge Planning and Community Integration

		<p>of discharge criteria and how to meet them by attending relevant PSR mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu.</p> <ol style="list-style-type: none"> 3. Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. 4. Continue to train staff on this requirement.
E.1.a	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria.</p> <p>Findings: This monitor reviewed eleven charts (KZ, RG, JJS, MBH, RR, DL, RB, DR, KS, RJ, and MR). Two of them (MR and DR) had fairly well-developed interventions, utilizing the individuals' strengths and preferences, and linked to the individuals' discharge goals. Nine of them (KZ, RG, JJS, MBH, RR, KS, DL, RB, and RJ) did not have the individuals' discharge goals addressed through proper interventions. For example, JJS and MBH do not have interventions addressing some of their discharge goals. The discharge criteria for RG were not well framed. In some cases the discharge goals were not written in a meaningful/measurable manner. For example, one of KS's discharge goals was written as "Evaluation, medication, psycho education, and stabilization to return to CDC". RJ's last WRP in the chart was dated April 2007.</p> <p>Recommendation 2, April 2007: The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.</p>

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		<p>Findings: This monitor reviewed seven (KZ, RG, RR, DL, RB, DR, and MR) charts. Two of the WRPs in them (DR and MR) had the individual's life goals linked to one or more foci of hospitalization with associated objectives and interventions. Five of them (KZ, RG, RR, DL, and RB) did not utilize the individual's life goals in a meaningful way, even when the individual's life goals were appropriate.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the care formulation section of the WRP.</p> <p>Findings: ASH used item #2 from the WRP Discharge Planning Monitoring Tool (<i>The individual's level of psychosocial functioning</i>) to address this recommendation, reporting 32% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the Percentage compliance obtained (%C) is a summary of the facility's data.</p>

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		<table border="1" data-bbox="991 228 1791 423"> <thead> <tr> <th></th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>N</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38</td> <td></td> </tr> <tr> <td>%C #2</td> <td>32</td> <td>32</td> </tr> </tbody> </table> <p data-bbox="991 464 1881 789">This monitor reviewed nine charts (KZ, JAB, DAH, RG, RR, DL, RB, DR, and MR). Three of the WRPs in them (DR, DL, and RB) had information on the individual's functional status, describing the progress the individual has made on assigned groups/therapies in the Present Status section of the individual's WRP. Six of them (KZ, RG, DAH, JAB, MR, and RR) failed to fully address the individuals' functional status. In many cases, the only information on the individual's status is that the individual is/is not "participating", "attending" groups (for example, DAH).</p> <p data-bbox="991 833 1881 938">Recommendation 2, April 2007: Use the DMH WRP Manual in developing and updating the case formulation.</p> <p data-bbox="991 982 1881 1417">Findings: This monitor reviewed nine charts (KZ, RG, JFD, JVW, DAH, JFD, RR, DL, and RB). Two of the WRPs in the charts presented an acceptable quality of case formulation (DK and RB). Seven of them (RG, RR, KZ, JVW, JFD, DAH, and JAB) were incomplete, non-comprehensive, and/or lacked continuity. For example, in JVW's WRP, pages 3 and 4 were the same, and the same information was repeated on pages 3 and 5. One of the discharge criteria read, "Ability to admit and understand the nature of his mental disorder and need for psychiatric medication." Some of the objectives and interventions were more than three months old, there has been no change in the stages or status, yet the objectives and interventions were not modified/revised. More</p>		Aug	Mean	N	139		N	53		%S	38		%C #2	32	32
	Aug	Mean															
N	139																
N	53																
%S	38																
%C #2	32	32															

		<p>importantly, there was no information on how the team planned to address the issues. For DAH, the Predisposing Factors section read, "Mr. H denied a familial history of mental illness, criminality, or alcoholism." The section under the 'Previous Treatment and Response' the information entered for DAH was the number of suicidal attempts and hospitalization, and for JFD the address of the hospital.</p> <p>Recommendation 3, April 2007: Ensure that team members are aware of and trained in elements to consider in updating GAF scores.</p> <p>Findings: According to the Acting Chief of Social Work, ASH conducted training on October 4, 2007 to social workers regarding WRP elements, including GAF scores.</p> <p>This monitor reviewed five charts (DL, DR, MR, JVW, and RB). GAF scores were changed in four of them (DR, RB, JVW, and MR). However, the score changes were not reflected with the information in the Present Status sections of the individuals' WRPs (for example, MR and RB). This monitor is unable to ascertain if the teams were inattentive or uninformed on the elements to consider in updating the GAF scores.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the care formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation. 3. Ensure that team members are aware of and trained in elements to
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		consider in updating GAF scores.															
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 recommendations:</p> <p>Recommendation 1, April 2007: Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.</p> <p>Findings: ASH used item #3 from the WRP Discharge Planning Monitoring Tool (<i>Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements</i>) to address this recommendation, reporting 9% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the Percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 894 1814 1088"> <thead> <tr> <th></th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>n</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38.1</td> <td></td> </tr> <tr> <td>%C #3</td> <td>9</td> <td>9</td> </tr> </tbody> </table> <p>This monitor reviewed seven charts (KZ, RG, RR, DL, RB, DR, and MR). One of the WRPs in the chart (MR) showed evidence that discharge barriers were discussed with the individual at the WPRC. The other six (KZ, RG, RR, DL, RB, and DR) did not show evidence that the discharge barriers were discussed with the individual.</p> <p>Recommendations 2-3, April 2007: 2. Include all skills training and supports in the WRP so that the</p>		Aug	Mean	N	139		n	53		%S	38.1		%C #3	9	9
	Aug	Mean															
N	139																
n	53																
%S	38.1																
%C #3	9	9															

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		<p>individual can overcome barriers and meet discharge criteria.</p> <p>3. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.</p> <p>Findings: ASH used item #4 from the WRP Discharge Planning Monitoring Tool (<i>The skills and supports necessary to live in the setting in which the individual will be placed, or the setting that the individual chooses for post discharge residence.</i>) to address this recommendation, reporting 15% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the Percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 711 1860 902"> <thead> <tr> <th></th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>n</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38</td> <td></td> </tr> <tr> <td>%C #4</td> <td>15</td> <td>15</td> </tr> </tbody> </table> <p>This monitor reviewed seven charts (KZ, RG, RR, RB, DL, DR, and MR). Two of them (DL and MR) had information on the individuals needed skills and supports to overcome discharge barriers. The remaining five of them (KZ, RG, RR, RB, and DR) did not address the skills and supports the individual needs to overcome the discharge barriers. In some cases the Social Work notes contained the information, but the information was not integrated into the individual's WRP. Similarly, the individuals' progress in overcoming the barriers or lack thereof was not updated in the WRPs.</p> <p>Compliance: Partial.</p>		Sep	Mean	N	139		n	53		%S	38		%C #4	15	15
	Sep	Mean															
N	139																
n	53																
%S	38																
%C #4	15	15															

Section E: Discharge Planning and Community Integration

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 3. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary. <p>Findings:</p> <p>This monitor reviewed seven charts (KZ, RG, RR, DL, RB, DR, and MR). Two of them (DL and MR) had assessed the skills and supports needed for the individual to be successful in the next placement, and the other five (KZ, RG, RR, RB, and DR) did not have documentation to indicate that any assessments of the skills and supports were conducted. Team members should not only assess the skills and supports but also include an objective and intervention for each identified skill or support deficit that is needed for the new placement.</p> <p>ASH had conducted training for social workers on this and other elements, from September 18-20, 2007. According to the Acting Chief of Social Work, the monitoring tool to track this recommendation was implemented in Program IV on August 7, 2007.</p>

Section E: Discharge Planning and Community Integration

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary. 																				
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 recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. <p>Findings: ASH used item #12 from the DMH WRP Team Observation Tool (<i>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</i>) to address this recommendation, reporting 1% compliance. The table below with its monitoring indicator showing the number of WRPTs due per month (N) in program IV, the number of WRPT's observed (n), and the Percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1190 1780 1385"> <thead> <tr> <th></th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>236</td> <td>260</td> <td></td> </tr> <tr> <td>n</td> <td>17</td> <td>131</td> <td></td> </tr> <tr> <td>%S</td> <td>7</td> <td>50</td> <td></td> </tr> <tr> <td>%C#12</td> <td>0</td> <td>2</td> <td>1</td> </tr> </tbody> </table>		Aug	Sep	Mean	N	236	260		n	17	131		%S	7	50		%C#12	0	2	1
	Aug	Sep	Mean																			
N	236	260																				
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%C#12	0	2	1																			

Section E: Discharge Planning and Community Integration

		<p>This monitor reviewed ten charts (KZ, RG, RR, DL, RB, DR, MR, WT, MAB, and DAH). The WRP in one of them (DR) had information on the individual's input into the discharge planning process. The remaining nine (KZ, RG, RR, DL, RB, MR, WT, MAB, and DAH) had no documented evidence indicating that the individual was an active participant in the discharge process. MAB was diagnosed as functioning at the Borderline Intellectual level which could impact his ability to provide input, but this was not addressed in the Present Status section nor was how the team planned to address this limitation.</p> <p>Recommendation 3, April 2007: Prioritize objectives and interventions related to the discharge processes.</p> <p>Findings: This monitor reviewed eight charts (KZ, RG, RR, MAB, DL, RB, DR, and MR). Two of them (RR and DL) had prioritized objectives and interventions related to the discharge. The other six (MAB, KZ, RG, RB, DR, and MR) failed to develop objectives and interventions for some of the discharge goals. For example, MAB's discharge criteria indicated the need for "remission" of verbal altercations and understanding of what each medication was for. However, there were no specific objectives or interventions for these learning outcomes.</p> <p>Recommendation 4, April 2007: Ensure that the individual understands all of the discharge requirements before leaving the WRPC.</p> <p>Findings: This monitor reviewed seven charts (KZ, RG, RR, DL, RB, DR, and MR). One of them (MR) had some documentation to show the individual understood the discharge requirements before leaving the WRPC, and the other six (KZ, RG, RR, DL, RB, and DR) did not.</p>
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Section E: Discharge Planning and Community Integration

		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.
E.3	<p>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:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.</p> <p>Findings: A review of the data obtained from Sections C2, D2, D6, E, and F2 showed that many elements related to discharge in WRPs, WRPC's, and PSR Mall services are weak, including writing measurable discharge criteria, prioritizing discharge goals with appropriate objectives and interventions, updating the individual's progress in the Present Status section, involving the individual fully in the discharge process, assigning individuals to groups according to their intellectual functioning, reviewing the individual's progress regularly and modifying their goals/objectives/interventions in a timely manner, and assessing the skills and supports needed for the next placement. Much of the monitor's review data are supported by ASH's progress report/self-</p>

Section E: Discharge Planning and Community Integration

		<p>assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.</p>															
E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p> <p>Findings: ASH used item #7a from the WRP Discharge Planning Monitoring Tool (<i>Measurable interventions regarding these discharge considerations</i>) to address this recommendation, reporting 43% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the Percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1190 1766 1385"> <thead> <tr> <th></th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>n</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38</td> <td></td> </tr> <tr> <td>%C #7a</td> <td>43</td> <td>43</td> </tr> </tbody> </table>		Aug	Mean	N	139		n	53		%S	38		%C #7a	43	43
	Aug	Mean															
N	139																
n	53																
%S	38																
%C #7a	43	43															

Section E: Discharge Planning and Community Integration

		<p>This monitor reviewed ten charts (KZ, RR, RG, DL, JJS, RB, DR, MR, MBH, and JVW). Two of them (DR and MR) included interventions that were written in observable/measurable terms. The other eight (KZ, RR, RG, DL, JJS, RB, MBH, and JVW) had written numerous interventions and/or discharge criteria that were not observable/measurable. For example, one of JVW's discharge criteria read, "Compliance with all psychiatric medications and be stable for an extended time." Stable from what and how long is "an extended time"? One of JJS's intervention read, "Staff will observe signs/symptoms of mental illness and will use his strength his desire for discharge." Observation is not an intervention.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.</p> <p>Findings: ASH used item #7b from the WRP Discharge Planning Monitoring Tool to address this recommendation, reporting 49% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p>

Section E: Discharge Planning and Community Integration

		<p><i>The staff responsible for implementing the interventions is identified.</i></p> <table border="1" data-bbox="991 302 1717 496"> <thead> <tr> <th></th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>n</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38</td> <td></td> </tr> <tr> <td>%C #7b</td> <td>49</td> <td>49</td> </tr> </tbody> </table> <p>This monitor reviewed nine charts (KZ, RG, RR, DL, RB, DR, JFD, MR, and DB). The interventions in six of the WRPs (KZ, RG, RR, DL, RB, and MR) had identified the staff responsible for implementing the interventions. Three of them (DR, JFD, and DB) had one or more interventions that failed to identify the staff responsible for the interventions. For example, two of DR's interventions simply read, "Symptom management group" and "Mental illness awareness group", and one of JFD's interventions read, " The WRT will enroll Mr. D. into a Anger Management treatment group...".</p> <p>Recommendation 2, April 2007: Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.</p> <p>Findings: This monitor reviewed five charts (DAH, MC, WT, DM, and MAB). The staff listed in the WRPs as providing the services were verified to be the ones providing the service through Mall group observations and by checking the PSR Mall schedules.</p> <p>Compliance: Partial.</p>		Aug	Mean	N	139		n	53		%S	38		%C #7b	49	49
	Aug	Mean															
N	139																
n	53																
%S	38																
%C #7b	49	49															

Section E: Discharge Planning and Community Integration

		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 															
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.</p> <p>Findings: ASH used item #7c from the WRP Discharge Planning Monitoring Tool (<i>The time frames for completion of the interventions</i>) to address this recommendation, reporting 40% compliance. The table below with its monitoring indicator showing the number of WRPs due per month (N) in program IV, the number of WRPs reviewed (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 971 1694 1161"> <thead> <tr> <th></th> <th>Aug</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>139</td> <td></td> </tr> <tr> <td>n</td> <td>53</td> <td></td> </tr> <tr> <td>%S</td> <td>38</td> <td></td> </tr> <tr> <td>%C #7c</td> <td>40</td> <td>40</td> </tr> </tbody> </table> <p>This monitor reviewed ten charts (KZ, RG, RR, DL, RB, DR, MR, MBH, DAH, and MAB). The interventions in seven of them (KZ, RG, RR, DL, RB, DR, and MR) had the time frame for review of the interventions identified. Three of them (MBH, DAH, and MAB) had the time frame identified; however, the time frames did not fit the individual's next scheduled WRPC. For example, MBH's WRPC (7-day initial conference)</p>		Aug	Mean	N	139		n	53		%S	38		%C #7c	40	40
	Aug	Mean															
N	139																
n	53																
%S	38																
%C #7c	40	40															

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		<p>was on September 20, 2007, and the time frames for some of the interventions were dated September 21, 2007, and December 29, 2007.</p> <p>Monitors/auditors of this recommendation should be attentive to recommendations/objectives marked as inactive, to ensure that they do not get counted and attenuate the compliance percentage.</p> <p>Compliance: Partial.</p> <p>Current recommendation: For each intervention in the Mall or for individual therapy, clearly state the time frame for the next schedule review. This review should be the same as the individual's scheduled WRPC.</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: Partial.</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 recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. <p>Findings: ASH audited individuals who were referred for discharge but remained in the facility. The table below showing the number of individuals</p>

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		<p>discharged but still in the hospital, and the number of days since the referral for discharge is a summary of the facility's data.</p> <table border="1" data-bbox="991 302 1740 453"> <thead> <tr> <th>CONREP referrals pending d/c</th> <th>Under 60 days</th> <th>60 - 120 days</th> <th>120 - 180 days</th> <th>180 - 240 days</th> <th>Over 240 days</th> </tr> </thead> <tbody> <tr> <td>15</td> <td>7</td> <td>1</td> <td>5</td> <td>1</td> <td>1</td> </tr> </tbody> </table> <p>As the table above shows, 30 individuals are still in the facility following referral for discharge, and the number of days their discharge has been delayed ranges up to more than 240 days.</p> <p>This monitor reviewed the list of individuals under CONREP referrals. The reasons identified for the delay of discharge were many, including waiting for a bed (RJ), disagreement by the agencies that the individual was ready for discharge (SR and JR), and waiting to be placed (EN).</p> <p>This monitor interviewed Janet Bouffard, the Acting Chief of Social Work. It was obvious that she has given much thought to discharge planning and community integration matters. She was well informed on the issues facing the individuals referred for discharge and the problems posed by the external agencies, as well as the in-house problems causing the delay. She identified the following as external factors: lack of placement, delay in court orders, the individual's legal status (e.g. 290), and the types of supports the individual needs that may not be readily available in a community placement. She also identified internal factors that included: WRPT process and paperwork, and difficulty with tracking referrals. It appears that the lack of secretarial/clerical support to assist in a number of tasks related to referral and discharge contributes to the delay (for example, communication with external agencies/professionals, copying, etc.).</p>	CONREP referrals pending d/c	Under 60 days	60 - 120 days	120 - 180 days	180 - 240 days	Over 240 days	15	7	1	5	1	1
CONREP referrals pending d/c	Under 60 days	60 - 120 days	120 - 180 days	180 - 240 days	Over 240 days									
15	7	1	5	1	1									

Section E: Discharge Planning and Community Integration

		<p>Recommendation 4, April 2007: Ensure that reasons for admission, previous admissions, and potential discharge settings are taken into account when setting discharge criteria.</p> <p>Findings: This monitor reviewed five charts (KZ, RG, RR, DL, and RB). Two of them (DL and RB) contained discharge criteria that was relevant to the individuals' potential placement, previous placement(s) and reasons for hospitalization.</p> <p>Recommendation 5, April 2007: Write all discharge criteria in behavioral terms.</p> <p>Findings: This monitor reviewed eleven charts (KZ, RG, JAB, DNM, WT, JFD, RR, DL, RB, DR, and MR). Three of them (DL, DNM, and WT) contained discharge criteria written in behavioral terms, and eight of them (KZ, RG, RR, JFD, JAB, RB, DR, and MR) contained one or more discharge criteria that was not written in behavioral terms. For example, one of JFD's discharge criteria read, "remain treatment and medication adherent," and JAB's read, "Demonstrate insight into as well as personal responsibility and appropriate remorse for the instant offense and criminal behavior."</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. 4. Ensure that reasons for admission, previous admissions, and
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Section E: Discharge Planning and Community Integration

		<p>potential discharge settings are taken into account when setting discharge criteria.</p> <p>5. Write all discharge criteria in behavioral terms.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting. 3. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual. <p>Findings:</p> <p>According to the Acting Chief of Social Work, a monitoring tool was implemented on August 2007, in Program IV. However, this tool does not specifically track the elements of this recommendation. ASH is planning on using the Statewide monitoring tool when approved to address this criterion. This recommendation calls for ASH to identify the individual's needs that relate to transition/adjustment to a new setting, and when possible and appropriate assist the individual in addressing the needs prior to being transitioned to the new setting. ASH is not required to assist the individual once discharged from the facility.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual

Section E: Discharge Planning and Community Integration

		and/or appropriate others when the individual is transitioned to a new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to ASH because it does not serve children or adolescents.
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:</p> <ol style="list-style-type: none"> 1. ASH has maintained some reduction in the unjustified use of certain high-risk medications (benzodiazepines and anticholinergics) since the baseline assessment. 2. ASH has initiated a monitoring system, and provided data, based on adequate indicators, regarding the use of benzodiazepines, anticholinergics and polypharmacy. 3. ASH has provided monitoring data regarding the screening of individuals suffering from Tardive Dyskinesia. 4. ASH has developed a draft of an adequate policy and procedure, including a new data collection tool, regarding adverse drug reaction (ADR) reporting. 5. ASH has adopted a new data collection tool regarding medication variance reporting and implemented a new adequate system for reporting in Program IV. <p>Summary of Progress on Psychological Services:</p> <ol style="list-style-type: none"> 1. Overall there is improvement in many areas of Psychological Services since the coming on board of the ED. His mandates and directives have had a positive effect in the culture and character of the staff as a whole towards the implementation of EP. However, the overall data does not reflect the improvement at this time as it is negatively skewed by the inclusion of five months of data prior to his coming on board. In addition, a number of areas can only be improved with additional staffing. 2. The relationship between the Senior Psychology staff and the senior staff/leadership from other disciplines is very positive, resulting in a productive working relationship as evidenced by many collaborative meetings, tool development, and decision-making aligned with EP (for example, individuals with learned maladaptive behaviors are now referred using the PBS-BCC pathway, PBS and

Section F: Specific Therapeutic and Rehabilitation Services

	<p>BY CHOICE program are under the supervision of the Chief of Psychology, and the Clinical Administrator and the Mall Director have a good working relationship).</p> <ol style="list-style-type: none">3. Individuals with maladaptive behaviors are now referred through the PBS-BCC pathway.4. The PBS team works with unit staff at the behavioral guideline level instead of waiting for a PBS referral for assessment and intervention. However, with only one full PBS team ASH is unable to provide the service to all and in a timely manner.5. The PBS team members attend WRPCs to assist the WRPTs in identifying and referring for services individuals with significant learned maladaptive behaviors.6. BCC meetings were held twice a month and were held consistently. However, attendance at these meetings by the committee members could be improved.7. There is a full DCAT team that is actively working with the PBS team and the Mall Curriculum sub-committee to identify and evaluated individuals with cognitive deficits.8. Medication Education groups are now facilitated by the Department of Medicine staff for individuals on their caseloads.9. ASH now has three Central Mall Campuses.10. The BY CHOICE program now provides WRPTs with additional information including graphs, percentages, and individuals' status in particular areas.11. ASH has implemented the Mall progress notes facility-wide.12. ASH has increased the number and variety of Mall groups offered. <p>Summary of Progress on Nursing Services:</p> <ol style="list-style-type: none">1. Several Nursing Policies have been revised in alignment with the EP.2. A number of adequate monitoring instruments have been developed and implemented.3. The Nursing Department at ASH has adopted the Wellness and Recovery Model to guide its nursing practices.
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	<p>Summary of Progress on Rehabilitation Therapy Services:</p> <ol style="list-style-type: none">1. Rehabilitation disciplines are yet to be integrated into a cohesive Rehabilitation Services Department.2. Rehabilitation therapy services have yet to be fully incorporated into the WRP process. Therapists have yet to receive WRP training and their findings on individuals' progress toward objectives are not consistently documented and/or provided to the WRPTs. <p>Summary of Progress on Nutrition Services:</p> <ol style="list-style-type: none">1. A statewide training policy has been developed regarding incorporation of dietary and nutritional issues into the WRP. All new nursing hires are receiving this training, which is also offered monthly to existing staff.2. The Meal Accuracy Report was implemented in September 2007 and will formalize the tracking of diet order implementation. <p>Summary of Progress on Pharmacy Services:</p> <ol style="list-style-type: none">1. ASH has developed a policy and procedure that outlines the process by which pharmacists screen medication orders, communicate information and recommendations to prescribing physicians, and document the recommendations. <p>Summary of Progress on General Medical Services:</p> <ol style="list-style-type: none">1. ASH has, in general, maintained the provision of adequate medical care and a range of specialty services to meet the needs of its individuals.2. ASH has improved the timeliness of consultation/specialty clinic services.3. ASH has improved the timeliness of receiving outside hospital records upon individuals' return from hospitalization.
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Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. Several monitoring instruments have been developed and implemented to demonstrate compliance with the requirements of the EP.2. Through this process the Infection Control Department has become better integrated into the WRPT. <p>Summary of Progress on Dental Services</p> <ol style="list-style-type: none">1. A Dental software package has been selected and purchased.2. Two additional fulltime dentists have been hired to provide dental services to the individuals at ASH.
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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. Robert Knapp, MD, Medical Director 2. Jean Dansereau, MD, Acting Senior Psychiatrist 3. Sherry Heber, Standards Compliance Department 4. John Coyle, Chairman, Pharmacy and Therapeutics Director 5. Ronald O'Brien, PharmD, Acting Pharmacy Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 37 individuals (AA, AWS, BJT, BO, CG, CW, DMB, DR, DS, DXL, EA, ED, GCC, GEO, HMR, JE, JEP, JJG, JJP, JLF, JWB, KAW, KLC, LCR, MB, MDG, MLD, MWM, MWN, NBM, OAA, RLJ, RPR, SO, SSM, TG, and TSM) 2. DMH Psychopharmacology Guidelines (June 13, 2007) 3. ASH Department of Psychiatry Manual 4. Monthly Progress Notes Monitoring (Psychiatry) Form 5. Monthly Progress Notes Monitoring (Psychiatry) summary data (September 2007) 6. ASH Benzodiazepine Data Collection Sheet 7. Benzodiazepine Monitoring summary data (July to September 2007) 8. ASH Anticholinergic Data Collection Sheet 9. Anticholinergic Monitoring summary data (July to September 2007) 10. ASH Polypharmacy Monitoring Form 11. Polypharmacy Monitoring summary data (April to September 2007) 12. ASH draft Antipsychotic PRN Data Collection Sheet 13. ASH draft Stat/Emergency Medication Data Collection Sheet 14. ASH New Generation Antipsychotic Monitoring Form 15. New Generation Antipsychotic Monitoring summary data (May to September 2007) 16. ASH current database regarding individuals diagnosed with Tardive Dyskinesia

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		<ol style="list-style-type: none"> 17. ASH Tardive Dyskinesia Monitoring Form 18. Tardive Dyskinesia Monitoring summary data (April to September 2007) 19. ASH AD#516.7, Screening for Possible Movement Disorders Related to Neuroleptic Medication 20. Minutes of the Medication Review Committee (MRC) meeting (July 24, 2007) 21. Minutes of the Pharmacy and Therapeutics (P&T) Committee meeting (August 22, 2007) 22. ASH Draft Adverse Drug Reaction (ADR) Policy and Procedure. 23. ASH ADR Report (April 1 to September 30, 2007) 24. ASH Annual ADR Report (January 1 to September 21, 2007) 25. ASH report of all ADRs that resulted in transfer to an acute care setting (April 1, 2006 to March 6, 2007) 26. Last ten completed ADR reports 27. ASH Department of Psychiatry/Pharmacy DUE Calendar 28. ASH Nursing Policy and Procedure #310.1, September 12, 2007 29. ASH Medication Variances Reports (Program IV Pilot), July to September 2007 30. ASH Medication Variance Database Rollout Plan (September 10, 2007) 31. ASH report of serious medication variances reported April to September 2007 32. ASH Unit Medication Room Staff Training Report, Insulin Administration Training
F.1.a	<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</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation s 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Finalize and implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the

Section F: Specific Therapeutic and Rehabilitation Services

	<p>psychotropic medications to ensure that they are:</p>	<p>formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.</p> <ol style="list-style-type: none"> 2. Ensure adequate input from the medical staff in the process of finalization of the medication guidelines. <p>Findings: A statewide psychopharmacology committee has implemented this recommendation. In June 2007, the committee finalized guidelines for use across state facilities. The guidelines involved the use of new-generation antipsychotic medications, some mood stabilizers (divalproex and lamotrigine) and some antidepressant medications (serotonin-specific reuptake inhibitors). ASH has adopted the guidelines. Since the initial version of the guidelines was issued in March 2007, the statewide committee has implemented updates of these guidelines that involved the following areas:</p> <ol style="list-style-type: none"> 1. Laboratory monitoring requirements regarding the use of clozapine, olanzapine, risperidone, ziprasidone and divalproex; 2. Clinical monitoring requirements regarding the use of lamotrigine; 3. Precautions/contraindications regarding the use of olanzapine and divalproex; and 4. Therapeutic Review Committee oversight regarding upper dose limits for combinations of oral and depot formulations of the same medications. <p>The guidelines have yet to include the use of other mood stabilizers (e.g. lithium, carbamazepine and oxcarbazepine) and antidepressants (e.g. bupropion, venlafaxine, and mirtazapine).</p> <p>Recommendation 3, April 2007: Implement recommendations listed in D.1.c, D.1.d, D.1.e and F.1.g.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>Findings: Same as in D.1.c, D.1.d, D.1.e and F.1.g.</p> <p>Recommendation 4, April 2007: Monitor this requirement based on a 20% sample.</p> <p>Findings: See F.1.a.i through F.1.a.viii.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Continue to monitor this requirement and ensure that all indicators are specifically matched to the requirement. 									
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<p>ASH used the Monthly Progress Notes Monitoring (Psychiatry) Form to assess compliance. The facility reviewed a sample of 3% of all individuals who have been hospitalized for 90 days or longer (September 2007). The following is a summary of the relevant indicators and corresponding compliance rates:</p> <table border="1" data-bbox="991 1227 1879 1382"> <tr> <td>1.</td> <td><i>Rationale for current psychopharmacology plan</i></td> <td>20%</td> </tr> <tr> <td>2.</td> <td><i>Response to pharmacologic treatments</i></td> <td>8%</td> </tr> <tr> <td>3.</td> <td><i>Rationale for continuation of medications or proposed plans</i></td> <td>8%</td> </tr> </table>	1.	<i>Rationale for current psychopharmacology plan</i>	20%	2.	<i>Response to pharmacologic treatments</i>	8%	3.	<i>Rationale for continuation of medications or proposed plans</i>	8%
1.	<i>Rationale for current psychopharmacology plan</i>	20%									
2.	<i>Response to pharmacologic treatments</i>	8%									
3.	<i>Rationale for continuation of medications or proposed plans</i>	8%									

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		<p>ASH also used the Benzodiazepine and Anticholinergic Data Collection Tools to assess compliance regarding the use of these specific classes of medications (August and September 2007). The data collection was based on a manual review of medical records, and no data were available as to the total number of individuals who were receiving the agents during the review period. The facility reports that beginning in October 2007, a listing of all individuals currently receiving each agent will be provided by the Pharmacy Department and samples will be selected at random from that list. The average sample sizes varied from 3% to 19% depending on the month of monitoring and the indicator selected for review. The following is a summary of the relevant indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 672 1873 1273"> <tr> <td data-bbox="991 672 1058 748">1.</td> <td data-bbox="1058 672 1789 748"><i>Verification in a clinically justifiable manner to support the continued routine use of benzodiazepines</i></td> <td data-bbox="1789 672 1873 748">14%</td> </tr> <tr> <td data-bbox="991 748 1058 824">2.</td> <td data-bbox="1058 748 1789 824"><i>Verification in a clinically justifiable manner to support the to support the PRN use of a benzodiazepine</i></td> <td data-bbox="1789 748 1873 824">5%</td> </tr> <tr> <td data-bbox="991 824 1058 901">3.</td> <td data-bbox="1058 824 1789 901"><i>Verification in a clinically justifiable manner to support the continued, routine use of anticholinergics</i></td> <td data-bbox="1789 824 1873 901">16%</td> </tr> <tr> <td data-bbox="991 901 1058 977">4.</td> <td data-bbox="1058 901 1789 977"><i>Verification in a clinically justifiable manner to support the PRN use of anticholinergics</i></td> <td data-bbox="1789 901 1873 977">8%</td> </tr> <tr> <td data-bbox="991 977 1058 1118">5.</td> <td data-bbox="1058 977 1789 1118"><i>Verification in a clinically justifiable manner for routine usage (of anticholinergics) that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner</i></td> <td data-bbox="1789 977 1873 1118">9%</td> </tr> <tr> <td data-bbox="991 1118 1058 1273">6.</td> <td data-bbox="1058 1118 1789 1273"><i>Verification in a clinically justifiable manner for PRN usage (of anticholinergics) that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner</i></td> <td data-bbox="1789 1118 1873 1273">6%</td> </tr> </table>	1.	<i>Verification in a clinically justifiable manner to support the continued routine use of benzodiazepines</i>	14%	2.	<i>Verification in a clinically justifiable manner to support the to support the PRN use of a benzodiazepine</i>	5%	3.	<i>Verification in a clinically justifiable manner to support the continued, routine use of anticholinergics</i>	16%	4.	<i>Verification in a clinically justifiable manner to support the PRN use of anticholinergics</i>	8%	5.	<i>Verification in a clinically justifiable manner for routine usage (of anticholinergics) that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner</i>	9%	6.	<i>Verification in a clinically justifiable manner for PRN usage (of anticholinergics) that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner</i>	6%
1.	<i>Verification in a clinically justifiable manner to support the continued routine use of benzodiazepines</i>	14%																		
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6.	<i>Verification in a clinically justifiable manner for PRN usage (of anticholinergics) that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner</i>	6%																		
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	Using the above-mentioned psychiatric progress notes monitoring process, the facility assessed compliance with this requirement (September 2007). However, the indicators used were not matched to																		

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		the requirement. ASH used the same process to assess compliance with F.1.a.iii through F.1.a.viii. The relevant indicators and corresponding compliance rates are listed for each sub-cell below.															
F.1.a.iii	tailored to each individual's symptoms;	<table border="1"> <tr> <td>1.</td> <td><i>Subjective complaints</i></td> <td>65%</td> </tr> <tr> <td>2.</td> <td><i>Identified target symptoms</i></td> <td>15%</td> </tr> </table>	1.	<i>Subjective complaints</i>	65%	2.	<i>Identified target symptoms</i>	15%									
1.	<i>Subjective complaints</i>	65%															
2.	<i>Identified target symptoms</i>	15%															
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1"> <tr> <td>1.</td> <td><i>Response to pharmacological treatments</i></td> <td>8%</td> </tr> <tr> <td>2.</td> <td><i>Rationale for continuation of treatment or proposed plans</i></td> <td>8%</td> </tr> </table>	1.	<i>Response to pharmacological treatments</i>	8%	2.	<i>Rationale for continuation of treatment or proposed plans</i>	8%									
1.	<i>Response to pharmacological treatments</i>	8%															
2.	<i>Rationale for continuation of treatment or proposed plans</i>	8%															
F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <td></td> <td><i>Monitoring of side effects, including sedation</i></td> <td>42%</td> </tr> </table>		<i>Monitoring of side effects, including sedation</i>	42%												
	<i>Monitoring of side effects, including sedation</i>	42%															
F.1.a.vi	modified based on clinical rationales;	<table border="1"> <tr> <td>1.</td> <td><i>Rationale for current psychopharmacology plan</i></td> <td>20%</td> </tr> <tr> <td>2.</td> <td><i>Benefits and risks of current psychopharmacology treatment, including benzodiazepines, anticholinergics and polypharmacy</i></td> <td>8%</td> </tr> <tr> <td>3.</td> <td><i>Response to pharmacological treatment</i></td> <td>8%</td> </tr> <tr> <td>4.</td> <td><i>Monitoring of side effects, including sedation</i></td> <td>42%</td> </tr> <tr> <td>5.</td> <td><i>Rationale for continuation of medications or proposed plans</i></td> <td>8%</td> </tr> </table> <p>However, the indicators did not address the requirement regarding actual modification of treatment.</p>	1.	<i>Rationale for current psychopharmacology plan</i>	20%	2.	<i>Benefits and risks of current psychopharmacology treatment, including benzodiazepines, anticholinergics and polypharmacy</i>	8%	3.	<i>Response to pharmacological treatment</i>	8%	4.	<i>Monitoring of side effects, including sedation</i>	42%	5.	<i>Rationale for continuation of medications or proposed plans</i>	8%
1.	<i>Rationale for current psychopharmacology plan</i>	20%															
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4.	<i>Monitoring of side effects, including sedation</i>	42%															
5.	<i>Rationale for continuation of medications or proposed plans</i>	8%															

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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"> <tr> <td data-bbox="987 228 1060 269">1.</td> <td data-bbox="1060 228 1787 269"><i>Monitoring of side effects, including sedation</i></td> <td data-bbox="1787 228 1879 269">42%</td> </tr> <tr> <td data-bbox="987 269 1060 342">2.</td> <td data-bbox="1060 269 1787 342"><i>Response to non-pharmacologic treatments, including PBS, if applicable</i></td> <td data-bbox="1787 269 1879 342">13%</td> </tr> </table>	1.	<i>Monitoring of side effects, including sedation</i>	42%	2.	<i>Response to non-pharmacologic treatments, including PBS, if applicable</i>	13%
1.	<i>Monitoring of side effects, including sedation</i>	42%						
2.	<i>Response to non-pharmacologic treatments, including PBS, if applicable</i>	13%						
F.1.a.viii	Properly documented.	The data provided by the facility did not include an average of the above sub-cells, as it should have.						
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Update the Department of Psychiatry manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications.</p> <p>Findings: The revised ASH Department of Psychiatry Manual (Section XI-110-1.4.2.5 and XI-110-1.4.2.6) includes these requirements.</p> <p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Monitor the use of PRN and Stat medications to ensure correction of the above deficiencies. 3. Ensure monitoring of a sample of 20% of the target population. <p>Findings: ASH used the Monthly Progress Notes Monitoring (Psychiatry) Form to assess compliance. As mentioned earlier, the data are based on a review of a sample of 3% of all individuals who have been hospitalized for 90 days or longer (September 2007). The facility used a variety of indicators, but only one indicator regarding the documentation of the rationale for PRN medications and the rationale for ongoing PRN/Stat medications use addressed this requirement. The compliance rate was</p>						

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		<p>17%.</p> <p>Recommendation 4, April 2007: Consolidate the monitoring processes for PRN and/or Stat medications and for psychiatric reassessments (progress notes).</p> <p>Findings: The DMH is in the process of developing and finalizing a monitoring instrument that addresses the use of PRN/Stat medications. ASH developed a draft form that includes specific precautions regarding the use of injections of the new-generation antipsychotic agents ziprasidone, olanzapine and aripiprazole, and the concomitant use of haloperidol and ziprasidone .</p> <p>Other findings: See D.1.f.i for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor showed that ASH has yet to make progress in correcting the deficiencies outlined in the baseline assessment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements regarding each of the following:<ol style="list-style-type: none">a. Psychiatric documentation of PRN medication use;b. Psychiatric documentation of Stat medication use;c. Nursing documentation of PRN medication use; andd. Nursing documentation of Stat medication use.2. Monitor the use of PRN and Stat medications based on at least 20% sample.
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		<ol style="list-style-type: none"> 3. Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of the deficiencies noted by this monitor. 4. Implement a procedure to ensure that all PRN orders for psychotropic medications are limited to no more than 14 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use.
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Update the Department of Psychiatry manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy.</p> <p>Findings: ASH has implemented this recommendation (Section XI-110-1.4.2.6).</p> <p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on a 20% sample. 3. Ensure that the justification of use is consistent with current generally accepted standards. <p>Findings: ASH used the Psychopharmacology Data Collection Sheets regarding the use of benzodiazepines, anticholinergics and polypharmacy to assess compliance with this requirement. The facility refined the indicators to provide information regarding the routine and PRN use of benzodiazepines and anticholinergics. The average sample size and months of monitoring varied for each monitoring process. The following is a summary of the facility's monitoring data, including months of monitoring, average sample, indicators and mean corresponding compliance rates.</p>

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		<p>Benzodiazepines, Routine August and September 2007 Average sample: 14%</p> <table border="1"> <tr> <td data-bbox="989 342 1058 415">1.</td> <td data-bbox="1058 342 1766 415"><i>Verification that the individual has DSM-IV diagnosis of Anxiety Disorder</i></td> <td data-bbox="1766 342 1866 415">7%</td> </tr> <tr> <td data-bbox="989 415 1058 529">2.</td> <td data-bbox="1058 415 1766 529"><i>Verification in a clinically justifiable manner to support the continued routine use of a benzodiazepine, with appropriate analysis of the risks and benefits</i></td> <td data-bbox="1766 415 1866 529">16%</td> </tr> <tr> <td data-bbox="989 529 1058 643">3.</td> <td data-bbox="1058 529 1766 643"><i>Verification that benzodiazepines were not used in at-risk individuals, including, but not limited to, those with cognitive impairment and brain injury</i></td> <td data-bbox="1766 529 1866 643">55%</td> </tr> <tr> <td data-bbox="989 643 1058 756">4.</td> <td data-bbox="1058 643 1766 756"><i>Verification that benzodiazepines were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i></td> <td data-bbox="1766 643 1866 756">86%</td> </tr> <tr> <td data-bbox="989 756 1058 870">5.</td> <td data-bbox="1058 756 1766 870"><i>Verification that benzodiazepines were not used in at-risk individuals, with a history of alcohol abuse/dependence and/or drug abuse/dependence</i></td> <td data-bbox="1766 756 1866 870">16%</td> </tr> <tr> <td data-bbox="989 870 1058 1016">6.</td> <td data-bbox="1058 870 1766 1016"><i>Verification in a clinically justifiable manner that modifications of other psychiatric treatments are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i></td> <td data-bbox="1766 870 1866 1016">3%</td> </tr> <tr> <td data-bbox="989 1016 1058 1162">7.</td> <td data-bbox="1058 1016 1766 1162"><i>Verification in a clinically justifiable manner that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i></td> <td data-bbox="1766 1016 1866 1162">3%</td> </tr> <tr> <td data-bbox="989 1162 1058 1308">8.</td> <td data-bbox="1058 1162 1766 1308"><i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated: increased cognitive impairment (requires MMSE every three months)</i></td> <td data-bbox="1766 1162 1866 1308">11%</td> </tr> <tr> <td data-bbox="989 1308 1058 1422">9.</td> <td data-bbox="1058 1308 1766 1422"><i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated psychomotor impairment/falls</i></td> <td data-bbox="1766 1308 1866 1422">11%</td> </tr> </table>	1.	<i>Verification that the individual has DSM-IV diagnosis of Anxiety Disorder</i>	7%	2.	<i>Verification in a clinically justifiable manner to support the continued routine use of a benzodiazepine, with appropriate analysis of the risks and benefits</i>	16%	3.	<i>Verification that benzodiazepines were not used in at-risk individuals, including, but not limited to, those with cognitive impairment and brain injury</i>	55%	4.	<i>Verification that benzodiazepines were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i>	86%	5.	<i>Verification that benzodiazepines were not used in at-risk individuals, with a history of alcohol abuse/dependence and/or drug abuse/dependence</i>	16%	6.	<i>Verification in a clinically justifiable manner that modifications of other psychiatric treatments are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	3%	7.	<i>Verification in a clinically justifiable manner that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	3%	8.	<i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated: increased cognitive impairment (requires MMSE every three months)</i>	11%	9.	<i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated psychomotor impairment/falls</i>	11%
1.	<i>Verification that the individual has DSM-IV diagnosis of Anxiety Disorder</i>	7%																											
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		10.	<i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated sedation</i>	15%
		11.	<i>Verification that, in the continued use of benzodiazepines, the individual has not demonstrated drug seeking/dependence</i>	13%
		12.	<i>Verification that the dosage is within accepted hospital guidelines</i>	97%
		13.	<i>Verification to support the involuntary order/use of benzodiazepine</i>	36%
<p>Benzodiazepines, PRN July to September 2007 Average sample: 7%</p>				
		1.	<i>Verification in a clinically justifiable manner to support the PRN use of a benzodiazepine, with appropriate analysis of the risks and benefits</i>	2%
		2.	<i>Verification that benzodiazepines were not used in at-risk individuals, including but not limited to those with cognitive impairment and brain injury</i>	35%
		3.	<i>Verification that benzodiazepines were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i>	82%
		4.	<i>Verification that benzodiazepines were not used in at-risk individuals, with a history of alcohol abuse/dependence and/or drug abuse/dependence</i>	13%
		5.	<i>Verification in a clinically justifiable manner that modifications of other psychiatric treatments are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	6%
		6.	<i>Verification in a clinically justifiable manner that modifications of the psychiatric diagnosis are</i>	1%

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			<i>considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	
		7.	<i>Verification for PRN usage that the order contains the specific circumstances/behaviors/indications that allow use</i>	20%
		8.	<i>Verification that the dosage is within accepted hospital guidelines</i>	98%
		9.	<i>Verification to support the involuntary order/use of benzodiazepine</i>	60%
<p>Benzodiazepines, Stat August and September 2007 Average sample: 64%</p>				
		1.	<i>Verification in a clinically justifiable manner to support the Stat/emergency use of a benzodiazepine, with appropriate analysis of the risks and benefits</i>	67%
		2.	<i>Verification in a clinically justifiable manner that modifications of other psychiatric treatments are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	33%
		3.	<i>Verification in a clinically justifiable manner that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	22%
		4.	<i>Verification that the dosage is within accepted hospital guidelines</i>	100%
		5.	<i>Verification to support the involuntary order/use of benzodiazepine</i>	44%
		6.	<i>Verification that the individual was seen face-to-face within 24 hours</i>	89%
		7.	<i>Verification of the individual's response to Stat/emergency medication</i>	33%

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		<p>8. <i>Verification that benzodiazepine was not part of intra-class polypharmacy</i></p>	<p>84%</p>
<p>Anticholinergics, Routine July to September 2007 Average sample: 14%</p>			
<p>1.</p>		<p><i>Verification in a clinically justifiable manner to support the continued routine use of an anticholinergic</i></p>	<p>14%</p>
<p>2.</p>		<p><i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i></p>	<p>16%</p>
<p>3.</p>		<p><i>Verification that anticholinergics were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i></p>	<p>87%</p>
<p>4.</p>		<p><i>Verification in a clinically justifiable manner that modifications of other psychiatric treatments are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i></p>	<p>10%</p>
<p>5.</p>		<p><i>Verification in a clinically justifiable manner that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i></p>	<p>4%</p>
<p>6.</p>		<p><i>Verification that, in the continued use of anticholinergics, the individual has not demonstrated: increased cognitive impairment, psychomotor impairment/falls, sedation, anticholinergic side effects, drug seeking</i></p>	<p>5%</p>
<p>7.</p>		<p><i>Verification that the dosage is within accepted hospital guidelines</i></p>	<p>100%</p>
<p>8.</p>		<p><i>Verification to support the involuntary order/use of benzodiazepine</i></p>	<p>37%</p>

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		<table border="1"> <tr> <td colspan="3" data-bbox="989 228 1864 337"> Anticholinergics, PRN July to September 2007 Average sample: 9% </td> </tr> <tr> <td data-bbox="989 337 1060 415">1.</td> <td data-bbox="1060 337 1766 415"><i>Verification in a clinically justifiable manner to support the PRN use of an anticholinergic</i></td> <td data-bbox="1766 337 1864 415">5%</td> </tr> <tr> <td data-bbox="989 415 1060 526">2.</td> <td data-bbox="1060 415 1766 526"><i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i></td> <td data-bbox="1766 415 1864 526">58%</td> </tr> <tr> <td data-bbox="989 526 1060 636">3.</td> <td data-bbox="1060 526 1766 636"><i>Verification that anticholinergics were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i></td> <td data-bbox="1766 526 1864 636">84%</td> </tr> <tr> <td data-bbox="989 636 1060 787">4.</td> <td data-bbox="1060 636 1766 787"><i>Verification in a clinically justifiable manner for PRN usage that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i></td> <td data-bbox="1766 636 1864 787">3%</td> </tr> <tr> <td data-bbox="989 787 1060 898">5.</td> <td data-bbox="1060 787 1766 898"><i>Verification for PRN usage that the order contains the specific circumstances/behaviors/indications that allow use</i></td> <td data-bbox="1766 787 1864 898">54%</td> </tr> <tr> <td data-bbox="989 898 1060 976">6.</td> <td data-bbox="1060 898 1766 976"><i>Verification that the dosage is within accepted hospital guidelines</i></td> <td data-bbox="1766 898 1864 976">99%</td> </tr> <tr> <td data-bbox="989 976 1060 1053">7.</td> <td data-bbox="1060 976 1766 1053"><i>Verification to support the involuntary order/use of anticholinergic</i></td> <td data-bbox="1766 976 1864 1053">57%</td> </tr> <tr> <td colspan="3" data-bbox="989 1127 1864 1235"> Anticholinergics, Stat August and September 2007 Average sample: 100% </td> </tr> <tr> <td data-bbox="989 1235 1060 1313">1.</td> <td data-bbox="1060 1235 1766 1313"><i>Verification in a clinically justifiable manner to support the Stat/emergency use of an anticholinergic</i></td> <td data-bbox="1766 1235 1864 1313">75%</td> </tr> <tr> <td data-bbox="989 1313 1060 1425">2.</td> <td data-bbox="1060 1313 1766 1425"><i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i></td> <td data-bbox="1766 1313 1864 1425">50%</td> </tr> </table>	Anticholinergics, PRN July to September 2007 Average sample: 9%			1.	<i>Verification in a clinically justifiable manner to support the PRN use of an anticholinergic</i>	5%	2.	<i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i>	58%	3.	<i>Verification that anticholinergics were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i>	84%	4.	<i>Verification in a clinically justifiable manner for PRN usage that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	3%	5.	<i>Verification for PRN usage that the order contains the specific circumstances/behaviors/indications that allow use</i>	54%	6.	<i>Verification that the dosage is within accepted hospital guidelines</i>	99%	7.	<i>Verification to support the involuntary order/use of anticholinergic</i>	57%	Anticholinergics, Stat August and September 2007 Average sample: 100%			1.	<i>Verification in a clinically justifiable manner to support the Stat/emergency use of an anticholinergic</i>	75%	2.	<i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i>	50%
Anticholinergics, PRN July to September 2007 Average sample: 9%																																			
1.	<i>Verification in a clinically justifiable manner to support the PRN use of an anticholinergic</i>	5%																																	
2.	<i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i>	58%																																	
3.	<i>Verification that anticholinergics were not used in at-risk individuals, age 65 or older or with significantly relevant medical conditions</i>	84%																																	
4.	<i>Verification in a clinically justifiable manner for PRN usage that modifications of the psychiatric diagnosis are considered in an appropriate and timely manner to ensure proper indications and minimize risk</i>	3%																																	
5.	<i>Verification for PRN usage that the order contains the specific circumstances/behaviors/indications that allow use</i>	54%																																	
6.	<i>Verification that the dosage is within accepted hospital guidelines</i>	99%																																	
7.	<i>Verification to support the involuntary order/use of anticholinergic</i>	57%																																	
Anticholinergics, Stat August and September 2007 Average sample: 100%																																			
1.	<i>Verification in a clinically justifiable manner to support the Stat/emergency use of an anticholinergic</i>	75%																																	
2.	<i>Verification that anticholinergics were not used in at-risk individuals, including, but not limited to those with cognitive impairment and brain injury</i>	50%																																	

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		<p>Polypharmacy April to September 2007 Average sample: no data</p>																						
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		<p>Recommendations 4-5, April 2007: 4. Consolidate the process of monitoring of all individual medications</p>																						

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		<p>within the Drug Utilization Evaluation (DUE) Process.</p> <p>5. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.</p> <p>Findings: ASH has yet to implement these recommendations.</p> <p>Other findings: Chart reviews by this monitor revealed that several individuals are receiving long-term treatment with benzodiazepines (lorazepam or clonazepam) without documented justification or appropriate analysis of risks and benefits of treatment. The following table includes examples of this practice in the presence of diagnoses that increase the risks of treatment:</p> <table border="1" data-bbox="991 743 1879 1422"> <thead> <tr> <th>Individual</th> <th>Medication</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>MLD</td> <td>Diazepam (and benztropine)</td> <td>Dementia NOS</td> </tr> <tr> <td>DS</td> <td>Lorazepam</td> <td>Dementia due to head trauma with behavioral disturbance, and polysubstance dependence</td> </tr> <tr> <td>CG</td> <td>Lorazepam</td> <td>Amphetamine abuse, drug-induced mood disorder and cannabis abuse</td> </tr> <tr> <td>CW</td> <td>Lorazepam</td> <td>Polysubstance dependence</td> </tr> <tr> <td>AA</td> <td>Lorazepam</td> <td>Polysubstance dependence</td> </tr> <tr> <td>MWM</td> <td>Clonazepam</td> <td>Dementia and polysubstance dependence</td> </tr> <tr> <td>SO</td> <td>Clonazepam</td> <td>Cognitive disorder, NOS and polysubstance dependence</td> </tr> <tr> <td>KAW</td> <td>Clonazepam</td> <td>Cognitive disorder, NOS and polysubstance dependence</td> </tr> <tr> <td>BO</td> <td>Clonazepam</td> <td>Polysubstance dependence</td> </tr> </tbody> </table>	Individual	Medication	Diagnosis	MLD	Diazepam (and benztropine)	Dementia NOS	DS	Lorazepam	Dementia due to head trauma with behavioral disturbance, and polysubstance dependence	CG	Lorazepam	Amphetamine abuse, drug-induced mood disorder and cannabis abuse	CW	Lorazepam	Polysubstance dependence	AA	Lorazepam	Polysubstance dependence	MWM	Clonazepam	Dementia and polysubstance dependence	SO	Clonazepam	Cognitive disorder, NOS and polysubstance dependence	KAW	Clonazepam	Cognitive disorder, NOS and polysubstance dependence	BO	Clonazepam	Polysubstance dependence
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		SSM	Clonazepam	Polysubstance dependence
		NBM	Clonazepam	Borderline Intellectual Functioning
		GCC	Clonazepam (and Lorazepam PRN)	Alcohol Abuse
<p>Examples of unjustified long-term use of anticholinergic medications were found in several charts as illustrated in the following table:</p>				
		Individual	Medication	Diagnosis
		MLD	Benztrapine (and diazepam)	Tardive dyskinesia and dementia
		TSM	Benztrapine	Mild Mental Retardation
		GEO	Benztrapine	Mild Mental Retardation
		AWS	Benztrapine	Mild Mental Retardation
		JEP	Benztrapine	Borderline Intellectual Functioning
		NBM	Benztrapine	Borderline Intellectual Functioning
		HMR	Benztrapine	Borderline Intellectual Functioning
		JEP	Benztrapine and diphenhydramine	Borderline Intellectual Functioning
		LCR	Diphenhydramine	Dementia, NOS
<p>ASH has a database regarding the use of antipsychotic polypharmacy that includes, by error, many individuals receiving therapy with only one agent either in a divided dose regular regimen or as regular and PRN regimen. Review by this monitor of the charts of individuals receiving various forms of polypharmacy revealed the following examples of inadequate documentation of the rationale for polypharmacy and of associated risks.</p>				

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		Individual	Medications	Diagnosis
		DMB	Chlorpromazine, risperidone, divalproex, lithium, topiramate, loxapine PRN, lorazepam PRN and diphenhydramine PRN	Schizoaffective disorder and polysubstance dependence
		BO	Chlorpromazine, risperidone, clonazepam, divalproex, lithium, benztropine, benztropine PRN and zolpidem PRN	Schizoaffective disorder and polysubstance dependence
		EA	Clozapine, risperidone, lithium, fluvoxamine, lorazepam PRN and zolpidem PRN	Schizophrenia, undifferentiated type, attention deficit hyperactivity disorder, by history, polysubstance abuse and social phobia,
		MB	Ziprasidone, haloperidol, trazadone, ziprasidone PRN and benztropine PRN	Schizophrenia, undifferentiated, other unkown substance dependence, mental disorder NOS due to history of head injury and mental retardation, severity unspecified
		JWB	Fluphenazine, risperidone, divalproex, benztropine, chlorpromazine, lorazepam PRN and zolpidem PRN	Major depression, recurrent with psychotic features, polysubstance dependence
		KLC	Risperidone, fluphenazine, lithium, clonazepam,	Schizoaffective disorder, bipolar type and

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			benztropine, lorazepam PRN, chlorpromazine PRN, zoplidem PRN and benztropine PRN	polysubstance dependence
		<p>An example of adequately documented justification for the use of polypharmacy (olanzapine, quetiapine and PRN clonazepam) is found in the chart of RA.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Standardize monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy for use across facilities and ensure that these instruments are aligned with the DMH medication guidelines. 2. Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample. 3. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct deficiencies outlined by this monitor above. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. 		
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 recommendations:</p> <p>Recommendation 1, April 2007: Same as in F.1.a.</p> <p>Findings: Same as in F.1.a.</p>		

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		<p>Recommendation 2, April 2007: Same as in F.1.g.</p> <p>Findings: Same as in F.1.g.</p> <p>Recommendation 3, April 2007: Monitor this requirement and ensure a 20% sample.</p> <p>Findings: The facility used the ASH New Generation Antipsychotic Monitoring Form to assess compliance with this requirement (May to September 2007). The number of charts reviewed varied from 61 (May) to 119 (September), but the sample size was not reliable because the total target population was not properly identified. ASH has an adequate plan to address limitations in sampling methodology. The following is a summary of the facility's data, with relevant indicators and mean corresponding compliance rates identified:</p> <table border="1" data-bbox="991 894 1873 1424"> <tr> <td>1.</td> <td><i>Documentation of benefits and tolerability</i></td> <td>66%</td> </tr> <tr> <td>2.</td> <td><i>Justification in PPN with diagnosis of dyslipidemia</i></td> <td>27%</td> </tr> <tr> <td>3.</td> <td><i>Justification in PPN with diagnosis of diabetes</i></td> <td>49%</td> </tr> <tr> <td>4.</td> <td><i>Justification in PPN with diagnosis of obesity</i></td> <td>32%</td> </tr> <tr> <td>5.</td> <td><i>Justification in PPN with diagnosis of hyperprolactinemia</i></td> <td>16%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate baseline and periodic monitoring of family/personal risk factors</i></td> <td>39%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate baseline and periodic monitoring of BMI</i></td> <td>60%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate baseline and periodic monitoring of waist circumference</i></td> <td>27%</td> </tr> <tr> <td>9.</td> <td><i>Appropriate baseline and periodic monitoring of triglycerides</i></td> <td>81%</td> </tr> <tr> <td>10.</td> <td><i>Appropriate baseline and periodic monitoring of</i></td> <td>81%</td> </tr> </table>	1.	<i>Documentation of benefits and tolerability</i>	66%	2.	<i>Justification in PPN with diagnosis of dyslipidemia</i>	27%	3.	<i>Justification in PPN with diagnosis of diabetes</i>	49%	4.	<i>Justification in PPN with diagnosis of obesity</i>	32%	5.	<i>Justification in PPN with diagnosis of hyperprolactinemia</i>	16%	6.	<i>Appropriate baseline and periodic monitoring of family/personal risk factors</i>	39%	7.	<i>Appropriate baseline and periodic monitoring of BMI</i>	60%	8.	<i>Appropriate baseline and periodic monitoring of waist circumference</i>	27%	9.	<i>Appropriate baseline and periodic monitoring of triglycerides</i>	81%	10.	<i>Appropriate baseline and periodic monitoring of</i>	81%
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			<i>cholesterol</i>																									
		11.	<i>Appropriate baseline and periodic monitoring of fasting blood glucose</i>	82%																								
		12.	<i>Appropriate baseline and periodic monitoring of Glycosylated HgBA1C levels</i>	85%																								
		13.	<i>Appropriate baseline and periodic monitoring of EKG for individuals receiving ziprasidone</i>	83%																								
		14.	<i>Appropriate baseline and periodic monitoring of EKG for other new generation antipsychotics</i>	65%																								
		15.	<i>Appropriate baseline and periodic monitoring of blood counts (WBC/ANC) for individuals receiving clozapine</i>	89%																								
		16.	<i>PPN documentation of potential and actual risks for each medication used</i>	29%																								
		17.	<i>Treatment modified in an appropriate and timely manner to address identified risks</i>	68%																								
		<p>Other findings: This monitor reviewed the charts of nine individuals who are receiving new-generation antipsychotic agents and many of whom are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the documented metabolic disorder(s):</p>																										
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		DR	Clozapine	Hyperlipidemia
		TG	Clozapine	BMI=34.2
<p>This review showed that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies exist in the following areas:</p> <ol style="list-style-type: none"> 1. Frequency of laboratory monitoring of cholesterol and triglycerides in individuals who are overweight (TG) and/or suffering from diabetes mellitus (OAA and JJP); 2. WRP documentation of dyslipidemia as a diagnosis or a focus despite supporting laboratory findings (DXL); 3. WRP documentation of obesity as a diagnosis or a focus despite supporting findings (MDG and TG); 4. WRP documentation of hyperlipidemia as a diagnosis or a focus despite supporting laboratory findings and other documentation in the chart (DR); 5. WRP documentation of diabetes mellitus as a diagnosis or a focus despite supporting laboratory findings (and other documentation) in the chart (JJP). 6. Laboratory monitoring of prolactin levels (OAA and KLC); 7. Physician documentation of interventions to address recent significant weight gain in an individual suffering from diabetes mellitus (KLC); 8. Physician documentation of adequate interventions to address persistent significant dyslipidemia in an individual suffering from diabetes mellitus (DXL); 9. Physician documentation of risks and benefits of use and of attempts to use safer treatment alternatives (in most charts); and 10. WRP documentation of interventions for individuals who repeatedly refused laboratory testing (MEB). 				

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Standardize the monitoring instruments relevant to this requirement for use across facilities and ensure that the indicators address vital signs monitoring for individuals receiving clozapine. 2. Monitor this requirement based on a 20% sample of the appropriate total target population. 3. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined by this monitor above.
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the Department of Psychiatry manual includes requirements regarding monitoring of individuals with TD.</p> <p>Findings: ASH has implemented this recommendation (Department of Psychiatry Manual Sections XI-110-1.3.1.4, XI-110-1.6.1 and XI-110-1.7.1).</p> <p>Recommendations 2-4, April 2007:</p> <ol style="list-style-type: none"> 2. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. 4. Address and correct factors related to non-compliance. <p>Findings: ASH has yet to implement these recommendations. ASH reports that</p>

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		<p>the facility currently requires staff psychiatrists to complete a revised diagnosis form at the time of the WRPC if TD is added or deleted in the diagnostic scheme. The facility is in the process of discussions with the one neurologist employed at ASH. A proposal will be developed for the addition of a TD clinic to the Medical/Surgical area, involving the participation of a neurologist, to provide specialized care to all individuals diagnosed with TD. The facility has yet to develop and implement a policy and procedure that includes adequate operational criteria regarding the screening, periodic monitoring and ongoing care of individuals with current diagnosis or history of TD.</p> <p>Recommendation 5, April 2007: Monitor this requirement in all cases.</p> <p>Findings: ASH used the Tardive Dyskinesia Monitoring form to assess compliance (April to September 2007). The data were based on a review of an average sample of 64% of individuals who have been admitted or had an anniversary of admission, during the reporting month. Although the data are meaningful, this method does not ensure that all individuals with a diagnosis with TD are being monitored. The following outlines the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="989 1040 1871 1414"> <tr> <td>1.</td> <td><i>Does the individual have TD?</i></td> <td>2%</td> </tr> <tr> <td>2.</td> <td><i>Do monthly progress notes (PPNs) for past three months regarding prescribed antipsychotic medications discuss documented benefits?</i></td> <td>72%</td> </tr> <tr> <td>3.</td> <td><i>Do PPNs for past three months regarding prescribed antipsychotic medications discuss tolerability of the medication?</i></td> <td>41%</td> </tr> <tr> <td>4.</td> <td><i>If a conventional antipsychotic is used, is there evidence in the PPN of justification of using the older generation medication?</i></td> <td>6%</td> </tr> </table>	1.	<i>Does the individual have TD?</i>	2%	2.	<i>Do monthly progress notes (PPNs) for past three months regarding prescribed antipsychotic medications discuss documented benefits?</i>	72%	3.	<i>Do PPNs for past three months regarding prescribed antipsychotic medications discuss tolerability of the medication?</i>	41%	4.	<i>If a conventional antipsychotic is used, is there evidence in the PPN of justification of using the older generation medication?</i>	6%
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4.	<i>If a conventional antipsychotic is used, is there evidence in the PPN of justification of using the older generation medication?</i>	6%												

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		<table border="1"> <tr> <td data-bbox="991 198 1060 230">5.</td> <td data-bbox="1060 198 1768 230"><i>Was an AIMS exam done on admission?</i></td> <td data-bbox="1768 198 1873 230">71%</td> </tr> <tr> <td data-bbox="991 230 1060 305">6.</td> <td data-bbox="1060 230 1768 305"><i>Was an annual exam done at time of last annual physical exam?</i></td> <td data-bbox="1768 230 1873 305">46%</td> </tr> <tr> <td data-bbox="991 305 1060 380">7.</td> <td data-bbox="1060 305 1768 380"><i>If this individual has TD, was a new AIMS exam done every three months?</i></td> <td data-bbox="1768 305 1873 380">26%</td> </tr> <tr> <td data-bbox="991 380 1060 454">8.</td> <td data-bbox="1060 380 1768 454"><i>If this individual has a history of TD, was an AIMS exam done every three months?</i></td> <td data-bbox="1768 380 1873 454">58%</td> </tr> <tr> <td data-bbox="991 454 1060 600">9.</td> <td data-bbox="1060 454 1768 600"><i>Do PPNs for past three months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD or a positive AIMS test to reduce risk?</i></td> <td data-bbox="1768 454 1873 600">18%</td> </tr> </table>	5.	<i>Was an AIMS exam done on admission?</i>	71%	6.	<i>Was an annual exam done at time of last annual physical exam?</i>	46%	7.	<i>If this individual has TD, was a new AIMS exam done every three months?</i>	26%	8.	<i>If this individual has a history of TD, was an AIMS exam done every three months?</i>	58%	9.	<i>Do PPNs for past three months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD or a positive AIMS test to reduce risk?</i>	18%	<p>Other findings: This monitor reviewed the charts of all six individuals (PRP, RLJ, MLD BJT, MWN and ED) who were identified in the facility's current database as having a diagnosis of tardive dyskinesia. The reviews showed the following pattern of deficiencies:</p> <ol style="list-style-type: none"> 1. The WRP does not include a diagnosis of TD despite documentation in the corresponding psychiatric progress notes and AIMS of abnormal involuntary movements consistent with TD (MLD); 2. The WRP does not identify TD as a diagnosis, but it includes the condition as a focus. The psychiatric interventions do not address any attempts to utilize safer antipsychotic treatment alternatives and the psychiatric reassessments prove a careless review of the movement disorder (ED); 3. The WRP identified the movement disorder as a diagnosis and a focus but did not include corresponding objectives/interventions (PRP); 4. The WRP states that tardive dyskinesia has resolved, but the corresponding AIMS and psychiatric progress note indicate otherwise (RLJ). This WRP does not include the abnormal involuntary movements as a focus or provide any objectives and/or
5.	<i>Was an AIMS exam done on admission?</i>	71%																
6.	<i>Was an annual exam done at time of last annual physical exam?</i>	46%																
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		<p>interventions to address this condition;</p> <ol style="list-style-type: none"> 5. Regular treatment with benztropine was initiated in one case (RLJ) and continued for at least the past year in another case (MLD) without justification or consideration of the risk of this treatment in individuals suffering from documented abnormal movement disorder. 6. AIMS was not conducted on a quarterly basis as required for individuals suffering from TD (PRP and MLD); 7. There is no documentation of a psychiatric reassessment of the involuntary movement disorder for the past four months (MLD); and 8. The TD database includes a current diagnosis of TD for an individual whose movement disorder was ruled out as per WRP documentation (BJT). <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Monitor this requirement in all individuals who are diagnosed with abnormal movement disorder or have history of this disorder. 2. Develop and implement a policy and procedure to ensure that: <ol style="list-style-type: none"> a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Increase reporting of ADRs and provide instruction to all clinicians</p>

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		<p>regarding significance and proper methods in reporting ADRs.</p> <p>Findings: ASH has yet to implement this recommendation. ASH acknowledges that underreporting of ADRs continues to be a problem. The facility has yet to develop guidelines for clinicians regarding proper methods of reporting.</p> <p>Recommendation 2, April 2007: Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has developed a draft policy, which contains the required components. When properly implemented, these components can correct the deficiencies that were previously outlined in the monitor's reports. The facility has yet to finalize and implement this policy.</p> <p>Recommendation 3, April 2007: Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs.</p> <p>Findings: ASH has yet to implement this recommendation. The facility has yet to ensure that ADR reports are communicated in a timely manner to appropriate medical staff committees or departments and that annual reports and intensive case analyses (as indicated), are performed in a timely manner. The facility has a plan to address this issue and ensure appropriate and timely tracking, aggregation and analysis of data, identification of trends/patterns and implementation of follow up corrective actions.</p>
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		<p>Recommendation 4, April 2007: Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations.</p> <p>Findings: ASH has yet to implement this recommendation. This monitor reviewed ASH reports of ADRs that met severity thresholds for an intensive analysis during the period of April 1, 2006 to March 6, 2007. This review showed that the facility did not perform the required analysis in any of these cases and that as a result of this omission, corrective/educational actions were not performed as needed in at least two instances.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide instruction to all clinicians regarding significance and proper methods of reporting ADRs. 2. Increase reporting of ADRs and provide data regarding ADRs reported during each review period, compared with the previous two periods. 3. Finalize and implement the draft policy and procedure regarding ADRs. 4. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 5. Provide information for each review period regarding each ADR that required additional medication to treat and/or resulted in increased length of hospitalization, transfer to acute care setting, serious morbidity or death, including any intensive case analysis done and any follow-up corrective/educational actions.
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<p>F.1.g</p>	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Same as Recommendation #1 in F.1.a.</p> <p>Findings: Same as in F.1.a.</p> <p>Recommendations 2-4, April 2007:</p> <ol style="list-style-type: none"> 2. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines. 3. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. <p>Findings: ASH has yet to implement these recommendations. The statewide Psychopharmacology Advisory Committee has developed adequate DUE monitoring instruments that accompanied the individualized medication guidelines. ASH developed a calendar for DUEs that are to be completed during the period of October 2007 to July 2008. However, the facility has yet to develop a policy and procedure to codify its DUE system and include requirements regarding systematic review of all medications, with priority given to high-risk, high-volume uses, sample size and acceptable thresholds for compliance.</p> <p>Recommendation 5, April 2007: Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends.</p>
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		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 6, April 2007: Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.</p> <p>Findings: As mentioned in F.1.a., the DMH Statewide Psychopharmacology Committee has updated the guidelines. The facility has yet to conduct any DUEs that can be used to inform further updates.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a DUE policy and procedure, based on the individualized medication guidelines, to ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 2. Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. 3. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 4. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial	Current findings on previous recommendations:

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	<p>action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Recommendation 1, April 2007: Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances.</p> <p>Findings: ASH has adopted a new Medication Variance Reporting and Monitoring Form that, when properly implemented, can correct the process deficiencies that were outlined in the monitor's previous reports. The tool was used as the basis for revising the facility's policy and procedure regarding Medication Variances. The new data collection tool is being piloted on Program IV, with the plan to roll it out hospital-wide. The facility has data based on this pilot showing that 214 potential and 26 actual variances were reported (July to September 2007). This indicates that the identification and reporting of potential variances have improved as result of implementing the tool.</p> <p>Recommendation 2, April 2007: Provide instruction to all clinicians regarding the significance of and proper methods in MVR.</p> <p>Findings: ASH has yet to develop and implement written instructions that can adequately assist staff in the reporting of variances.</p> <p>Recommendation 3, April 2007: Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above.</p> <p>Findings: As mentioned earlier, using the newly adopted data collection tool, the facility revised its policy and procedure regarding Medication Variances. The new policy (Nursing Procedure Manual #310.1) contains</p>
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		<p>elements that, when properly implemented, are adequate to correct the deficiencies. ASH has yet to implement this policy facility-wide.</p> <p>Recommendation 4, April 2007: Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances.</p> <p>Findings: ASH has yet to implement this recommendation hospital-wide. The facility presented data based on the Program IV pilot that includes the following:</p> <ol style="list-style-type: none">1. The number of potential and actual variances;2. The number of variances in each outcome category;3. The number of variances by unit;4. The number of variances in each breakdown point (prescribing, transcribing, ordering/procurement, dispensing/storage, administration, documentation and drug security); and5. The number of times a particular staff member is involved in a medication variance. <p>These data represent an adequate basis for improved tracking and analysis of variances at ASH.</p> <p>Recommendation 5, April 2007: Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations.</p> <p>Findings: ASH has yet to implement this recommendation. This monitor reviewed</p>
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		<p>ASH reports of all variances (#18) that were classified as serious and reported from April to September 2007. Only a few variances reportedly had adverse effects on the individual. All such effects were reportedly temporary in nature. The facility implemented corrective actions in those situations that appeared to require such action. However, the facility's assessment of contributing factors and needed corrections were not based on an adequate intensive case analysis in any of these cases.</p> <p>Recommendation 6, April 2007: Ensure that MVR is a non-punitive process.</p> <p>Findings: The facility's policy #310.1 contains instruction to that effect.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Implement the new policy and procedure regarding medication variances and ensure that this policy applies to all involved disciplines (medicine, psychiatry, nursing and pharmacy).2. Provide written instructions to all clinicians regarding the significance and proper methods of MVR.3. Develop and implement adequate tracking log and data analysis systems and identify patterns and trends related to medication variances facility-wide.4. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
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<p>F.1.i</p>	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: 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>Recommendation 2, April 2007: Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.</p> <p>Findings: ASH is in the process of improving access by pharmacy staff to the new database for medication variances as well as modifying the current database that accumulates drug prescribing information to produce the monthly reports necessary for benzodiazepine, anticholinergic, and polypharmacy monitoring</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use
<p>F.1.j</p>	<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, April 2007: Same as in F.1.b and F.1.i.</p>

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		<p>Findings: Same as in F.1.b and F.1.i.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.b and F.1.i.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: Same as above.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as above.</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 1, April 2007: Development and implement a physician's performance quality profile and ensure that the indicators address and integrate all the medication management requirements outlined in section F.</p> <p>Findings: Same as in D.1.b.ii</p>

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		<p>Recommendation 2, April 2007: Ensure that the Department of Psychiatry manual includes clear expectations regarding medication management that are aligned with all the requirements in section F.</p> <p>Findings: The manual (Section VI. 16) currently contains the DMH drug protocols and corresponding DUEs. It is being updated to include all required monitoring in Sections D and F.</p> <p>Recommendation 3, April 2007: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Findings: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in D.1.b, D.1.c, D.1.f.viii 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:	Please see sub-cells for compliance findings.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Same as in F.1.c.</p> <p>Findings: Same as in F.1.c.</p>

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		<p>Recommendation 2, April 2007: Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Same as F.1.e. 2. Ensure the proper identification and management of TD as well as

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		<p>proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience.</p> <p>3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.</p> <p>Findings: Same as F.1.e.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: 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>Compliance: Partial.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in C.2.o and F.1.c.</p>

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

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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. Five individuals (BH, WM, ES, AS, and MB) 2. Diane Imrem, PsyD, Chief of Psychology 3. Teresa George, PhD, Supervising Psychologist 4. Christine Mathiesen, PhD, Director, C-PAS 5. Charles Broderick, PhD, Acting Senior Supervising Psychologist 6. Matt Hennessy, PsyD, Mall Director 7. Jeffrey Tueber, PhD, PBS Team Leader 8. Donna Nelson, Director, Standards Compliance 9. Karen Dubiel, Assistant to Clinical Coordinator 10. Charlie Joslin, Clinical Administrator. 11. Leslie Bolin, PhD, Neuropsychologist 12. Cheryl Smith, Ph.D, Clinical Neuropsychologist, DCAT Leader 13. John Myers, SPT, Data Analyst <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Charts of 24 individuals (AS, CW, DSR, DW, EPN, ER, GR, HCG, HL, IAP, JAB, JD, JF, JS, JW, LH, MAM, MB, MM, OR, RCD, RJM, TK, and ZS) 2. SO #131.00 3. AD #416 and #417 4. BY CHOICE Chart Audit Data 5. Mall Progress Notes 6. List of Individuals Needing Behavioral Interventions 7. List of individuals by BMI 8. Completed PBS-BCC Checklists 9. PSR Mall Manual 10. PSR Mall Schedule 11. PSR Mall Curricula 12. PSR Mall Hours by Discipline

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		<ol style="list-style-type: none"> 13. PSR Mall Hours by Administrative Support Staff 14. List of Trigger Items 15. Standard Psychological Assessment Protocols 16. Membership List of BCC 17. BCC Attendance Summary 18. Individuals Not Making Progress on PBS Plans 19. List of Individuals Referred to BCC 20. List of Individuals Needing Neuropsychological Services 21. Individuals on PBS Plans 22. List of Individuals Whose PBS Plans Are Implemented 23. PBS Plans That Need Updating 24. Individuals in Need of PBS Plans 25. Structural Assessments 26. Functional Assessments 27. Behavioral Guidelines 28. Psychosocial Active Treatment List 29. Psychosocial Enrichment Activity List 30. PSR Mall Activity List of Individuals Scheduled Vs Attended 31. List of Individuals receiving DCAT Services 32. DCAT Team Monitoring form <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Four Mall Groups (Medication Management 1, WRAP, Medication Management II, Medication Management III, and Anger Management). 2. Three WRP Conferences (DAH, Program 1, Unit 11; MC, Program 11, Unit 26, and AEC, Program 1, Unit 11).
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is

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	<p>specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>responsible for making the referral and what is expected once a referral is made, timelines).</p> <ol style="list-style-type: none"> 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment. <p>Findings: According to the Chief of Psychology, the PBS manual has been revised. The revised version has been put into practice since July 25, 2007.</p> <p>This monitor reviewed the PBS Manual. The Manual includes guidelines on conducting structural and functional assessments. The Manual also includes evidence-based tools to use for the structural and functional assessments.</p> <p>Recommendation 4, April 2007: Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as Stated in the EP.</p> <p>Findings: ASH has not filled all the vacant positions to meet the 1:300 ratio as stated in the EP. ASH has one full PBS team. ASH needs at least four PBS teams to meet this ratio. ASH is actively recruiting to fill the vacant positions.</p> <p>Recommendation 5, April 2007: Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.</p> <p>Findings: ASH is continuing the training of its direct care staff. New staff is trained through the New Employee Orientation sessions. This monitor</p>
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		<p>learned from the Chief of Psychology that ASH is considering a two-hour training module on PBS with the direct care staff. Two hours of training is woefully inadequate for direct care staff to know, understand, comprehend, analyze, and apply PBS principles and procedures, especially when it comes to generalization and application of PBS principles to individuals and situations different from the training samples. ASH should consider using the eight-hour module to empower the staff in acquiring sufficient knowledge and skills in PBS especially in the area of data collection, treatment integrity, antecedent manipulation, and structural assessment,</p> <p>Recommendation 6, April 2007: Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in ASH.</p> <p>Findings: According to Diane Imrem, Chief of Psychology, and Teresa George, PBS team coordinator, they have the necessary clinical authority to carry out their tasks to supervise the psychology staff and oversee the services in order to improve the quality of life of individuals served in ASH. The Chief of Psychology now has the administrative and clinical authority over PBS/DCAT and the BY CHOICE programs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as Stated in the EP. 2. Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.
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<p>F.2.a.i</p>	<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 recommendations:</p> <p>Recommendation 1, April 2007: Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.</p> <p>Findings: ASH has offered numerous training sessions to its PBS staff using both internal and external resources, including a four-hour training on August 9, 2007 by their consultant, Angela Adkins; a one-day training session by Susan Velasquez, PBS team leader from Patton State Hospital; and a two-and-a-half-day training session by Jeffrey Teuber, ASHs PBS team leader.</p> <p>This monitor reviewed the training documentation and participant sign-in sheets and confirmed ASHs report.</p> <p>Recommendation 2, April 2007: Conduct treatment implementation fidelity checks regularly. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes.</p> <p>Findings: According to Jeffrey Teuber, PBS teams regularly conduct fidelity checks. ASH had conducted two fidelity checks on the active PBS plans as of August, 2007. According to the PBS team members, shortage of staffing and lack of a data analyst through July 2007 reduced the number of fidelity checks conducted.</p> <p>ASH used item #2 from the DMH Psychology Services Monitoring Form (<i>The development of PBS plans, including methods of monitoring</i></p>
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program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program) to address this recommendation, reporting 75% compliance. The table below with its monitoring indicator showing the number of fidelity checks by month (N), the number of fidelity checks monitored (n), and the compliance obtained (%C) is a summary of the facility's data.

	May	Jun	Mean
N	1	1	
n	1	1	
%S	100	100	
%C# 2	50	100	75

This monitor reviewed the fidelity data, PBS plans, and staff training data. This monitor's findings are in agreement with the facility's data.

Recommendations 3-4, April 2007:

3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual.
4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation.

Findings:

According to the Chief of Psychology, Diane Imrem, and PBS Coordinator, Theresa George, plans were not reviewed in a timely manner from April through August 2007, due to lack of a Data Analyst.

This monitor reviewed the WRPs of AS and MB, who had active PBS

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		<p>plans. PBS plans were documented in the Present Status sections of the WRPs. However, there were no clear statements as to the level of progress or quantitative data to show trends in target behaviors. Both plans had been revised on October 5, 2007. Outcome data showed that the individuals have shown some progress since the implementation of the PBS plans. Structural and Functional Assessments had been conducted. The staff had discussed multi-modal therapy including medication as evidenced by the Psychiatric Nurse notes (Inter-Disciplinary Notes: May 24, 2006 for AS and April 13, 2007 for MB).</p> <p>Recommendation 5, April 2007: The PBS teams, WRPTs and the BCC require further training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC.</p> <p>Findings: According to Teresa George, PBS teams have received training on how they are connected with the PBS-BCC process and pathway. Senior Psychology staff members are part of the BCC committee. ASH has established semi-annual training sessions for PBS, WRP, and BCC in order to maintain the quality of services.</p> <p>Recommendation 6, April 2007: Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans.</p> <p>Findings: ASH has continued to provide ongoing training to its PBS team members by using both external and in-house resources, including their consultant Angela Adkins, their PBS team leader Jeffery Teuber, and Susan Velasquez, PBS team leader from Patton State Hospital.</p>
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		<p>Recommendation 7, April 2007: Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).</p> <p>Findings: ASH has chosen to use the AAMR module for PBS training. Mary Garrett, Nurse Practitioner and PBS team member, is providing two hours of training monthly on PBS to new employees in ASH. According to Teresa George, PBS team members now participate in all WRPTs in Program IV. As of August 2007, 80% of the staff in ASH who required training has been trained in PBS policies and principles.</p> <p>Recommendation 8, April 2007: Integrate a response to triggers in the referral process.</p> <p>Findings: ASH is developing a protocol to align with this recommendation with support from their CRIPA consultant, Nirbhay Singh. The senior psychologist supervisor attends such meetings on Program IV only and directs the necessary information to the PBS teams as needed.</p> <p>This monitor reviewed six charts of individuals with high triggers (CW, JAB, ZS, JW, OR, and RJM). Three of these individuals had been picked up by the PBS team for evaluation (CW, JW, and RJM) and three of them (JAB, ZS, and OR) were not picked up by PBS. ASH should continue to refine the response to triggers to ensure that individuals with severe maladaptive behaviors and high triggers are brought to the attention of the PBS teams.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. 3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. 4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. 5. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure all staff correctly implements the BY CHOICE program. 2. Implement the program as per the manual. <p>Findings:</p> <p>ASH has not implemented this requirement. According to the BY CHOICE coordinator, ASH will be monitoring the implementation of the BY CHOICE program beginning in November 2007, using the BY CHOICE Competency and Fidelity Score Sheet (staff).</p> <p>ASH has implemented the BY CHOICE program to all individuals in the facility following the guidelines in the Manual, except for those in the 6600 commitment code. These individuals were waiting to be</p>

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		<p>transferred to Coalinga State Hospital.</p> <p>This monitor's review of documentations/communications between the ASH psychology staff showed that they were concerned that introducing the individuals with commitment code 6600 to the BY CHOICE program might confuse them in the event Coalinga State Hospital came up with a slightly different process in its BY CHOICE program. It is this monitor's view that individuals at ASH at this time should be offered the BY CHOICE program unless a transfer date has been set and is imminent, first because there is no telling when the transfer to Coalinga State Hospital will occur and second because the individuals may have maladaptive behaviors that could be improved through proper point allocation along with other behavioral interventions in place.</p> <p>Recommendation 3, April 2007: Ensure that the program has additional staff members, computers and software.</p> <p>Findings: The BY CHOICE program at ASH now is under the clinical and administrative supervision of the Chief of Psychology. The BY CHOICE coordinator now has four additional staff to support the operation and evaluation of the BY CHOICE program. The BY CHOICE program has the necessary computer hardware and the coordinator is now working on fixing the software system to improve the online communication and sharing of information, including the monthly report with percentages and graphs to the WRPTs.</p> <p>Recommendations 4-5, April 2007:</p> <ol style="list-style-type: none"> 4. BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff. 5. Report BY CHOICE point allocation in the Present Status section of
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		<p>the individual's case formation and update at every scheduled WRPC.</p> <p>Findings: ASH has developed and implemented a BY CHOICE Monitoring Form. This form is a working draft yet to be approved. ASH used item #1 from the BY CHOICE Monitoring Form (draft version) (<i>Individual has input into the reallocation of points as evidenced by documentation in the WRP</i>) to address this recommendation, reporting 12% compliance. The table below with its monitoring indicator showing the number of individuals , admitted at least for 90 days (N), the number of individuals audited (two chosen from each unit and all of them from Program IV (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 743 1866 938"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1051</td> <td>1096</td> <td>1096</td> <td>1052</td> <td>1012</td> <td>969</td> <td></td> </tr> <tr> <td>n</td> <td>56</td> <td>75</td> <td>78</td> <td>73</td> <td>176</td> <td>100</td> <td></td> </tr> <tr> <td>%S</td> <td>5</td> <td>7</td> <td>7</td> <td>7</td> <td>17</td> <td>10</td> <td></td> </tr> <tr> <td>%C #1</td> <td>14</td> <td>7</td> <td>9</td> <td>15</td> <td>16</td> <td>7</td> <td>12</td> </tr> </tbody> </table> <p>ASH also reviewed 558 charts using item #2 (<i>Progress of BY CHOICE status from month to month is discussed as evidenced by documentation in the Present Status Section of the WRP</i>) from the BY CHOICE Monitoring form, reporting 29% compliance.</p> <p>This monitor reviewed 13 charts (RCD, JD, HCG, DW, EPN, MAM, ER, JS, GR, TK, HL, LH, and MM). Ten of the WRPs in the charts (RCD, JD, HCG, DW, EPN, MAM, ER, JS, GR, and TK) had documentation on the individuals BY CHOICE program. Only two of them (DW and GR) had some meaningful information regarding the individual's BY CHOICE participation and points. The entries on the remaining eight (RCD, JD, HCG, EPN, MAM, ER, JS, and TK) were inadequate. For example, TK's</p>		Apr	May	Jun	Jul	Aug	Sep	Mean	N	1051	1096	1096	1052	1012	969		n	56	75	78	73	176	100		%S	5	7	7	7	17	10		%C #1	14	7	9	15	16	7	12
	Apr	May	Jun	Jul	Aug	Sep	Mean																																			
N	1051	1096	1096	1052	1012	969																																				
n	56	75	78	73	176	100																																				
%S	5	7	7	7	17	10																																				
%C #1	14	7	9	15	16	7	12																																			

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		<p>read "occasionally using BY CHOICE," and ER's read, "BY CHOICE point allocation has been reviewed." Two of them (LH and MM) did not have any information on their BY CHOICE program. LH was not participating in the BY CHOICE program and the team did not provide any reasons for the individual's decision or how the team was planning to motivate the individual to participate in the program.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure all staff correctly implements the BY CHOICE program. 2. Implement the program as per the manual. 3. BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff. 4. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.
F.2.b	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Use the Special Order as the ASH AD. 2. Implement the AD. 3. Follow the requirements of the EP. <p>Findings: According to the Chief of Psychology, ASH revised ADs 416 and 417 on September 6, 2007 to align with DMH Special Orders for PBS and BY CHOICE, and implemented the changes on September 8, 2007. The Chief of Psychology now has the clinical and administrative responsibility for both the PBS and BY CHOICE programs.</p>

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		<p>This monitor reviewed the ADs 416 and 417, PBS Manual, and the BY CHOICE Manual. This monitor's findings are in agreement with the facility's data.</p> <p>Compliance: Full compliance.</p> <p>Current recommendation: Continue with current regulations.</p>
F.2.c	Each State Hospital shall ensure that:	<p>Compliance: Partial.</p>
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation.</p> <p>Findings: ASH has continued to provide competency-based training to its DCAT and PBS team members. The trainings were conducted by consultant Angela Adkins; Susan Velasquez, the PBS team leader from Patton State Hospital; and Jeffery Teuber, the PBS team leader from ASH. This monitor's findings from review of the training documents are in agreement with ASH's data.</p> <p>Recommendation 2, April 2007: Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions.</p> <p>Findings: According to the Chief of Psychology, ASH is working to address this</p>

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		<p>recommendation via the WRP Task Tracking Form. When completed, these forms are to be sent to Standards Compliance for entry into the database, which will then be used by the PBS teams to identify individuals who are in need of behavioral interventions. This monitor's review of documentation showed that the current list was derived from a survey conducted by Theresa George asking unit psychologists to identify individuals in their units who would benefit from behavioral interventions.</p> <p>Recommendation 3, April 2007: Use the PBS-BCC pathway for all consultations.</p> <p>Findings: According to the Chief of Psychology, all referrals are channeled through the PBS-BCC pathway. ASH has had two referrals during this reporting period (AS and MB) and both were referred through the PBS-BCC pathway.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.</p>

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Findings:

ASH used item #6 from the DMH Psychology Services Monitoring Form (*The hypotheses of the maladaptive behavior are based on structural and functional assessments*) to address this recommendation, reporting 50%. The table below with its monitoring indicator showing the number of PBS plans completed by month (N), the number of plans audited (n), and the percentage compliance obtained (%C) is a summary of the facility's data.

	May	Jun	Mean
N	1	1	
n	1	1	
%S	100	100	
%C #6	100	0	50

This monitor reviewed two PBS plans (MB and AS). Structural and Functional Assessments were conducted prior to developing the plans. The hypotheses derived from these assessments were discussed in both plans, under Statement of Functional Hypothesis for MB, and under Functional Hypothesis for AS.

According to the Chief of Psychology, PBS team leaders are to present weekly reports to the Senior Psychologists on referrals received and on active PBS plans. The Senior Psychologists are to assist the team with challenges/barriers, if any, to implementation of the plans according to EP requirements.

Current recommendation:

Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

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<p>F.2.c.iii</p>	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions. <p>Findings:</p> <p>ASH used item #7 from the DMH Psychology Services Monitoring Form (<i>There is documentation of previous behavioral interventions and their effects</i>) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator showing the number of PBS plans completed by month (N), the number of PBS plans audited (n), and the percentage compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 743 1625 938"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #7</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>According to Theresa George and Diane Imrem, these recommendations were not audited since June 2007. They expect proper auditing with the new rule requiring PBS team leaders to submit weekly reports to the Senior Psychologists.</p> <p>This monitor reviewed two active PBS plans (AS and MB). The plans were dated October 5, 2007. Both plans addressed the issue of previous interventions. There was documentation/discussion of previous interventions and their effectiveness for AS. As for MB, there was documentation stating that "there was no apparent documentation of previous behavioral interventions by others outside the PBS team, and none was provided."</p>		May	Jun	Mean	N	1	1		n	1	1		%S	100	100		%C #7	0	0	0
	May	Jun	Mean																			
N	1	1																				
n	1	1																				
%S	100	100																				
%C #7	0	0	0																			

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions. 																				
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, April 2007: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Findings: ASH used item #8 from the DMH Psychology Services Monitoring Form (<i>Behavioral interventions, which include PBS plans, are based on a PBS model and do not include the use of aversive or punishment contingencies</i>) to address this recommendation, reporting 100% compliance. The table below showing the number of PBS plans completed by month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1003 1535 1198"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #8</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table> <p>This monitor reviewed two active PBS Plans (AS and MB). Both plans were formulated using positive strategies. According to Jeffrey Teuber, PBS team leader and the other PBS team members, they have never used aversive/punishment strategies as part of their PBS plans. This monitor discussed with the PBS team the issue of having crisis</p>		May	Jun	Mean	N	1	1		n	1	1		%S	100	100		%C #8	100	100	100
	May	Jun	Mean																			
N	1	1																				
n	1	1																				
%S	100	100																				
%C #8	100	100	100																			

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		<p>plans, which generally include aversive interventions, as attachments to PBS plans.</p> <p>Current recommendations: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p>																				
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training.</p> <p>Findings: ASH used item #9 from the DMH Psychology Services Monitoring Form (<i>Behavioral interventions are consistently implemented across all settings</i>) to address this recommendation, reporting 50% compliance. The table below showing the number of PBS plans completed by month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1005 1564 1198"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #9</td> <td>100</td> <td>0</td> <td>50</td> </tr> </tbody> </table> <p>The two active PBS plans (AS and MB) reviewed by this monitor did not have data to support that the plans were being implemented consistently with integrity across settings.</p>		May	Jun	Mean	N	1	1		n	1	1		%S	100	100		%C #9	100	0	50
	May	Jun	Mean																			
N	1	1																				
n	1	1																				
%S	100	100																				
%C #9	100	0	50																			

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		<p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings. 3. Conduct regular fidelity checks. <p>Findings: According to the Chief of Psychology and the PBS team leader, staff training across settings is inconsistent.</p> <p>This monitor reviewed two active PBS Plans (AS and MB). There was no documentation or data in the Present Status sections of the individuals WRPs that the plans were being implemented consistently across settings. Furthermore, there was no documentation to verify that staff training was conducted across settings.</p> <p>This monitor's review of information/documents shows that the situation with fidelity checks is the same. Fidelity checks were not conducted regularly, especially across settings.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Continue to refine the trigger system.</p>

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		<p>Findings: According to the Chief of Psychology and the Clinical Administrator, a number of data collection mechanisms that enable the PBS teams to report data on all triggers activated have been introduced in Program IV to meet compliance with the EP. Accuracy of the data is checked by Standards Compliance.</p> <p>Recommendation 2, April 2007: Ensure that staff is aware of the PBS-BCC pathway.</p> <p>Findings: ASH has continued to train its WRPTs on the referral process using the PBS-BCC pathways. Cheryll Smith, DCAT leader, explained the referral process and procedures.</p> <p>This monitor's review of the recent referrals showed that the referrals were made following the established pathway, using the PBS-BCC checklist.</p> <p>Recommendation 3, April 2007: Using the PCMC in place of the BCC is a violation of the EP.</p> <p>Findings: ASH has revised AD #518 and # 523 to align with EP and the Medical Staff Bylaws for PCMC. These changes reflect the changes made to the referral pathway for individuals with maladaptive behaviors.</p> <p>This monitor's review of referrals made to both the PCMC and BCC showed that in September 2007, all referrals were made to PBS and none to PCMC. Furthermore, PCMC meeting minutes indicate that as of August, all individuals under PCMC service were discharged and many of them were taken up by the PBS team.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to refine the trigger system. 2. Ensure that staff is aware of the PBS-BCC pathway.
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 1, April 2007: Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options.</p> <p>Findings: This monitor reviewed the two active PBS Plans (AS and MB). Both plans were developed following structural and functional assessments to derive a data-based hypothesis to guide treatment options. However, the structural and functional assessments need to be thorough and across all settings where the behaviors are exhibited and all variables that are suspected to influence the target behaviors.</p> <p>Recommendation 2, April 2007: Integrate all behavioral interventions with other treatment modalities including drug therapy.</p> <p>Findings: ASH used item #11 from the DMH Psychology Services Monitoring Form (<i>PBS teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy</i>) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator showing the number of PBS plans completed during the month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p>

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		<table border="1" data-bbox="991 228 1614 423"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>N</td> <td>1</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #11</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p data-bbox="991 464 1885 862">This monitor reviewed the two active PBS plans (AS and MB). These plans were implemented on October 5, 2007. Both plans had evaluated the influence of the individuals' mental illnesses, medical conditions, and their impact on the individuals' maladaptive behaviors, as evidenced by the Inter-Disciplinary Notes by the Psychiatric Nurse, Mary Garrett (April 13, 2007). The IDN indicated that PBS should not use food as an incentive as it might affect one individual's diabetes, and to ensure environmental safety due to MB's seizures. The note went on to add that MB will benefit from his PBS plan due to improvement in his moods as a result of his medication changes. Notation to this effect was also found under Data Sources in MB's PBS Plan.</p> <p data-bbox="991 911 1325 935">Current recommendations:</p> <ol data-bbox="991 946 1839 1122" style="list-style-type: none"> 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Integrate all behavioral interventions with other treatment modalities including drug therapy. 		May	Jun	Mean	N	1	1		N	1	1		%S	100	100		%C #11	0	0	0
	May	Jun	Mean																			
N	1	1																				
N	1	1																				
%S	100	100																				
%C #11	0	0	0																			
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	<p data-bbox="991 1170 1577 1195">Current findings on previous recommendation:</p> <p data-bbox="991 1243 1444 1268">Recommendations 1-2, April 2007:</p> <ol data-bbox="991 1279 1850 1414" style="list-style-type: none"> 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. 2. Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done. 																				

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Findings:

ASH used item #12 from the DMH Psychology Services Monitoring Form (*All PBS plans are specified in the objectives and interventions section of the WRP*) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator showing the number of PBS plans completed during the month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	May	Jun	Mean
N	1	1	
N	1	1	
%S	100	100	
%C #12	0	0	0

This monitor reviewed the WRPs for the two active PBS plans (AS and MB). Both WRPs did not have proper entries in the objectiveS and intervention sections. For example, the entry in AS's objectives section read, "T. will do various jobs as outlined in his PBS plan AEB point report;" this statement does not clarify what percentAGE of the jobs and/or how many points have to be accrued to meet criteria. The entry in the interventions section read, "PBS has outlined a simple grid for T. to keep track of his job, how well it is done and his pay." This entry failed to reference the implementation of the PBS plan to the therapeutic milieu.

This monitor met with the Senior Psychology staff and the DCAT and PBS team members. Information gathered from this meeting showed that WRPT members are or should be aware of the WRP Manual from the training sessions conducted with the WRPTs. However, the documentation in the WRPs does not conform to the rules and examples given in the WRP Manual.

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done. 																				
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>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the present status section of the individual's case formulation. Identify ways to improve collaboration among all parties that participate in/support PBS plans. <p>Findings:</p> <p>ASH used item #13 from the DMH Psychology Services Monitoring Form (<i>All PBS 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 WRP</i>) to address this recommendation, reporting 0% compliance. The table below with its monitoring indicator showing the number of PBS plan completed by month (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.</p> <table border="1" data-bbox="991 1149 1562 1344"> <thead> <tr> <th></th> <th>May</th> <th>Jun</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1</td> <td>0</td> <td></td> </tr> <tr> <td>n</td> <td>1</td> <td>0</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #13</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>According to Theresa George, Acting Senior Supervising Psychologist</p>		May	Jun	Mean	N	1	0		n	1	0		%S	100	100		%C #13	0	0	0
	May	Jun	Mean																			
N	1	0																				
n	1	0																				
%S	100	100																				
%C #13	0	0	0																			

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		<p>and PBS coordinator, the PBS teams had failed to submit their plans and the data to the WRPTs, causing the lack of data in the Present Status sections of the individuals' WRPS.</p> <p>According to Diane Imrem and Theresa George, ASH has made a number of changes to ensure better collaboration between the PBS teams and the WRPTs, including monthly monitoring of the plans, weekly reporting of the barriers and challenges to implementing the plan to the Senior Psychologist, participation of PBS team members in WRPCs, and the implementation of the statewide system-level PBS protocol.</p> <p>This monitor's review of the two WRPs for individuals with active PBS plans (AS and MB) and findings thereof are in agreement with the facility's findings. The Present Status sections of these individuals' WRPs did not include sufficient information to be informative as to the improvement in their maladaptive behaviors and PBS interventions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation. 2. Implement the steps that will improve collaboration among all parties that participate in/support PBS plans.
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, April 2007: Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</p>

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		<p>Findings: ASH did not provide competency-based training to the staff responsible for implementing the behavioral interventions. Staff responsible for implementing the interventions was not certified as to their competency. Furthermore, there was lack of monthly fidelity data on the implementation of the PBS plans.</p> <p>Current recommendation: Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.</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>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS team members provide PBS services full-time until the needs of all individuals requiring behavioral interventions is met. 2. Hire additional staff to add PBS teams to meet the 1:300 ratio. 3. Hire PBS support staff for tasks including data management and graphing. <p>Findings: PBS staff in ASH has as their primary responsibility the provision of PBS duties to individuals requiring behavioral interventions. However, due to the shortage of PBS teams, the goal of serving all individuals needing behavioral interventions in a timely manner is not met. ASH only has one full PBS team at this time.</p> <p>With the current staffing, ASH does not meet the 1:300 ratio. However, ASH has increased its PBS staffing since the last review with an additional Psychiatric Technician and a Data Analyst. ASH is</p>

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		<p>actively recruiting to fill the remaining vacant positions.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all PBS team members provide PBS services full-time until the needs of all individuals requiring behavioral interventions is met. 2. Hire additional staff to add PBS teams to meet the 1:300 ratio. 3. Hire PBS support staff for tasks including data management and graphing.
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement BY CHOICE system-wide.</p> <p>Findings: ASH has rolled out the BY CHOICE program to all individuals in the facility except those individuals under commitment code 6600. Reportedly, these individuals are to be transferred to the Coalinga State Hospital and the staff at ASH is concerned that Coalinga State Hospital may be introducing a different format of the BY CHOICE program, which could "confuse" the individuals.</p> <p>This monitor's view is that ASH should introduce the BY CHOICE plan to these individuals. It is not certain when these individuals will be transferred. Besides, these individuals need the incentive to function appropriately, and the staff needs to have the BY CHOICE system as a means to motivate these individuals for various activities/behaviors (unless the date of transfer is established and is imminent).</p> <p>Recommendation 2, April 2007: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>

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Findings:

ASH used items #3, #4, #5, and #6 (see below) from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 14%, 9%, 8%, and 2% compliance respectively. The table below with its monitoring indicator showing the number of individuals in the facility for longer than 90 days (N), the number of charts (two from each unit, and all of them from Program IV) audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#3: Whether the individual is on a baseline card or reallocated card is documented in the WRP.

#4: The WRPT reallocated BY CHOICE points during the WRPC as evidenced by documentation in the WRP.

#5: A rationale for BY CHOICE point reallocation is documented in the WRP.

#6: The BY CHOICE point allocation is updated monthly in the individual's WRP.

	Apr	May	Jun	Jul	Aug	Sep	Mean
N	1051	1096	1096	1052	1012	969	
n	56	75	78	73	176	100	
%S	5	7	7	7	17	10	
%C #3	14	7	22	2	14	23	14
%C #4	16	7	3	7	12	9	9
%C #5	4	4	6	6	12	7	8
%C #6	0	3	0	0	5	0	2

As the table above shows, BY CHOICE documentation in the Present

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		<p>Status sections of the individuals' WRPs is very poor. Senior psychology staff was unsure as to the reasons for such poor documentation. According to the Chief of Psychology, the ED has mandated that team psychologists be responsible for the monitoring and documentation of the BY CHOICE program for the WRPT. However, as of this review, there were as many as 15 teams without a psychologist.</p> <p>This monitor reviewed 11 charts (GR, MM, JD, RCD, JF, HCG, HL, EPN, IAP, JS, and TK). One of them (GR) had ample discussion of the individual's BY CHOICE status. The remaining ten of them (MM, JD, RCD, JF, HCG, HL, EPN, IAP, JS, and TK) did not have their BY CHOICE mentioned (MM) or the documentation was overly brief and not informative. For example, for IAP the statement was "BY CHOICE point allocation has been reviewed," and for TK the statement was "Occasionally using BY CHOICE program."</p> <p>Recommendation 3, April 2007: Revise the BY CHOICE point allocation database to make it more user-friendly.</p> <p>Findings: ASH has improved upon the BY CHOICE database. The database now includes a more detailed monthly report indicating the individual's status in specific areas of the BY CHOICE program, and includes information in the form of graph and percentages.</p> <p>This monitor's findings through observation of the computer at work in one of the BY CHOICE incentive stores, and review of a printout of the data base was in agreement with the facility's report.</p> <p>Current recommendations: 1. Implement BY CHOICE system-wide.</p>
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		<p>2. Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>
<p>F.2.d</p>	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure there is a DCAT team. 2. Ensure that DCAT team members' primary responsibility is consistent with the EP. <p>Findings: ASH has a full DCAT, with Cheryll Smith as its team leader. A review of the DCAT manual and interview with the DCAT members showed that the DCAT team members' primary responsibility is consistent with EP requirements. The DCAT members were able to explain to this monitor their role and functions.</p> <p>Recommendation 3, April 2007: Ensure that all DCAT team members receive appropriate training.</p> <p>Findings: This monitor's review of the training documentation (sign-in sheets, training schedules, and training curriculum) and information from Cheryll Smith, DCAT leader showed that the DCAT members have participated in all training sessions presented to and attended by the PBS teams, including the neuropsychology seminar. In addition, DCAT members have participated in a two-day training with the facility's CRIPA consultant, Nirbhay Singh, a one-day training under their consultant Angela Adkins, a one-day training from their PBS team leader Jeffrey Teuber and their DCAT team leader Cheryll Smith, and a one-day training from Susan Velasquez, PBS team leader from the Patton State Hospital.</p>

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		<p>The DCAT members informed this monitor that they would like training on dual diagnosis. They are of the opinion that information on dual diagnosis will assist them in the identification and assessment of individuals with dual diagnosis, which is a frequent diagnosis in ASH.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that all DCAT team members receive appropriate training.</p>
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the BCC functions as intended and expressed by the EP as outlined in special Order 129 and AD 416.</p> <p>Findings: According to the Chief of Psychology, the BCC functions are aligned with EP requirements and comply with SO #129 and AD #416. The BCC chair is the Chief of Psychology, with the Co-chair being the Assistant Medical Director, Jean Garcia, M.D. The BCC meets twice a month. Referrals and case reviews are conducted and barriers to program implementation are addressed at the meetings.</p> <p>This monitor reviewed ASH's BCC Meeting Attendance Record. ASH has had two meetings per month (May through September 2007). Attendance at these meetings ranged from 22% to 78%.</p> <p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none"> 2. Establish proper guidelines for referral to the BCC. 3. Ensure that staff is informed on the sequence of steps for referrals to the BCC.

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		<p>Findings: According to the Chief of Psychology, staff is aware of the process for referring cases to the BCC. ASH has provided training to staff on the PBS-BCC procedures. ASH uses the PBS-BCC checklist as its pathway to the referral. Furthermore, PBS team members attend WRPCs and representatives from the PBS team and WRPT attend BCC meetings when a case is up for review.</p> <p>Recommendation 4, April 2007: Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly.</p> <p>Findings: The BCC meetings are held twice a month. According to the Chief of Psychology, the Executive Director has designated 13 members as "required" members of the BCC. Attendance of these members at the meetings is around 50%. For example, the attendance in August and September, 2007, was 58% and 46% respectively.</p> <p>Recommendation 5, April 2007: Include PBS team members and WRPT members at BCC team meetings to problem-solve as to why plans are not fully implemented.</p> <p>Findings: All BCC meetings include PBS team members and WRPT members responsible for implementing the plan. These members provide the BCC with contextual information for the committee to better understand the challenges and barriers in implementing the PBS/BCC plans and to find solutions to those challenges and barriers.</p> <p>Recommendation 6, April 2007: Set up a system of accountability to ensure that BCC plans are properly</p>
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		<p>implemented when indicated.</p> <p>Findings: The BCC had one referral since April 2007. While there is a system established to collect fidelity data primarily through the PBS teams, the data is not consistently collected. According to ASH's data, intervention plans are consistently implemented only 50% of the time.</p> <p>ASH is addressing this deficit through database to follow up with timely fidelity checks. In addition, PBS team members will present the Senior Psychologist overseeing EP Section F2 (Psychological Services) with weekly progress reports.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 2. Include PBS team members and WRPT members at BCC team meetings to problem-solve as to why plans are not fully implemented. 3. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments.</p> <p>Findings: ASH used item #19 from the DMH Psychology Services Monitoring</p>

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Form (*Sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness*) to address this recommendation, showing that appropriate referrals were made 100% of the time, and reporting 22% providing appropriate assessment/services in a timely manner. The table below with its monitoring indicator showing the number of individuals requiring neuropsychological services by month (N), the number of individuals referred for neuropsychological Services per month, and the percentage compliance obtained (%C) is a summary of the facility's data.

	Apr	May	Jun	Jul	Aug	Sep	Mean
N	17	7	9	11	13	11	
n	17	7	9	11	13	11	
%S	100	100	100	100	100	100	
%C #19	29	43	33	9	23	0	22

The table above shows that individuals needing neuropsychological assessments were being referred appropriately, in this case 100% of the time. However, the timely assessment of and services to the individuals was not forthcoming, as only 22% of them were assessed/served in a timely manner on average.

According to Christine Mathiesen, neuropsychologists and the C-PAS director, neuropsychologists have attended unit supervisors meeting, conducted training with psychologists, and are waiting to meet with psychiatrists to do the same. Neuropsychologists had conducted a 30-minute in-service to Unit Supervisors on August 15, 2007.

Recommendation 2, April 2007:

Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.

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		<p>Findings: According to Christine Mathiesen, ASH had requested that its neuropsychologists provide general Mall group services, so the neuropsychologists are facilitating the Emotion Management, Foundations of Treatment, Symptom Management, and the Anger Management groups on Program IV. Nevertheless, the neuropsychologists will provide Cognitive Remediation groups when they are released from these other group duties and can devote time to cognitive rehabilitation groups.</p> <p>Recommendation 3, April 2007: Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p> <p>Findings: ASH now has four full-time neuropsychologists on its service, but only three are functioning as neuropsychologists. One of them, Charles Broderick, is functioning as an Acting Supervising Psychology Monitor responsible for Section D2 (Psychological Assessments) of the EP.</p> <p>According to Christine Mathiesen, the Neuropsychology section requires between five and seven neuropsychologists to provide all the necessary services in the facility. However, it appears additional office space and resources including computer supports will also become necessary when hiring of new staff take place.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Make referrals, when appropriate, for neuropsychological assessments.2. Ensure that neuropsychologists provide cognitive remediation and
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		<p>cognitive retraining groups in the PSR Mall.</p> <p>3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.</p>
<p>F.2.g</p>	<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>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that psychologists have the authority to write order as specified in the EP. 2. Ensure that this authority is fully approved and implemented. <p>Findings: Psychologists in ASH now have the authority to write orders. AD #416 addresses this requirement. This directive has been incorporated in the Psychology Manual. According to the Chief of Psychology, the department of psychology has revised the rules and regulations that include the privileging criteria. This document is to be forwarded to the Medical Executive Committee for approval, prior to implementation of the authority to write orders for PBS plans.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Ensure that this authority is fully approved and implemented.</p>

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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Vickie Vinke, HSS 2. Al Joachim, Acting Nurse Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH's progress report and data 2. Nursing Administration of PRN/Stat Medication monitoring tool and instructions 3. Nursing Policy 307.0.1, Documentation of Medication and Treatments dated 9/19/07 4. Nursing Policy 311.0, Medication Administration Orientation/Competency Validation dated 10/3/07 and 11/1/07 5. Medication Administration Competency Validation Monitoring tool (Draft) dated 9/22/07 6. Nursing Policy 340.0, Night Audits (draft) dated 3/8/07 7. Nursing Policy 310.0, Medication Variances (draft) dated 9/12/07 8. Nursing Policy 202.0, Developing a Nursing Wellness and Recovery Plan dated 4/19/07 9. Nursing Interventions Monitoring Form and instructions dated 7/01/07 10. WRP training roster for Program IV 11. WRP Knowledge Assessment training post-test 12. Nursing Policy 218.0, Shift Change (Draft) dated 11/1/07 13. DMH Nursing Service Shift Change Monitoring Form (draft) 14. Change in Status form dated May 2007 and instructions 15. Nursing Policy 303.0, Daily Care of the Bed-Bound Individual dated 9/20/07 16. Nursing Services Bed-Bound Individual Monitoring Form (draft) 17. Therapeutic Milieu Observation Monitor form and instructions 18. Reviewed medical records for the following individuals: SD, RM, AS,

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		<p>SRB, RE, AS, AC, OA, FA, DB, SM, PP, AD, JM, DN, LV, AG, AHL, JR, MA, MR, AF, MW, NN, DM, DB, RC, CN, OM, RH, GP, SS, LJ, YM, TN, NS, RA, DC, EH, HL, RS, FN, CW, MM, GH, AH, VM, JF, RW, WST, JER, BG, EAJ, EDM, TJC, CRD, DJ, COH</p> <p><u>Observed:</u></p> <p>1. Shift report on Program IV</p>
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p>Compliance:</p> <p>Partial.</p>
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications.</p> <p>Findings: Appropriate revisions were made to Nursing Policy 307.0 Administration of Medication and Treatments, Nursing Policy 307.01 Documentation of Medication and Treatments, and Nursing Policy 311.0 Medication Administration Orientation/Competency Validation addressing this recommendation.</p> <p>Recommendation 2, April 2007: Implement the monitoring of the administration and documentation of medication administration, including PRN and Stat medication.</p>

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		<p>Findings: ASH implemented monitoring regarding medication administration and documentation, including PRN and Stat medications limited to Program IV 8/01/07. In November, a system will be implemented to ensure continuing competency regarding medication administration for nursing staff on Program IV. The facility needs to continue to increase its monitoring of this requirement to other units in the facility.</p> <p>Recommendation 3, April 2007: Report PRN medication data and Stat medication data separately.</p> <p>Findings: Data provided by ASH for Program IV reported PRN and Stat data separately. The following tables summarize ASH's data regarding PRN and Stat medications for Program IV. No data was collected for April-July 2007.</p> <table border="1" data-bbox="991 820 1812 1421"> <thead> <tr> <th colspan="4">Nursing Administration of PRN Medication Form</th> </tr> <tr> <th>2007</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>328</td> <td>329</td> <td></td> </tr> <tr> <td>n</td> <td>280</td> <td>263</td> <td></td> </tr> <tr> <td>%S</td> <td>85</td> <td>80</td> <td></td> </tr> <tr> <td>%C #1 <i>Nursing staff document the circumstances necessitating PRN administration</i> <i>F.3.a.iiI</i></td> <td>62</td> <td>73</td> <td>67</td> </tr> <tr> <td>%C #2 <i>Does the documentation include interventions that were attempted prior to the administration of PRN medication</i> <i>F.3.ai</i></td> <td>22</td> <td>19</td> <td>21</td> </tr> </tbody> </table>	Nursing Administration of PRN Medication Form				2007	Aug	Sep	Mean	N	328	329		n	280	263		%S	85	80		%C #1 <i>Nursing staff document the circumstances necessitating PRN administration</i> <i>F.3.a.iiI</i>	62	73	67	%C #2 <i>Does the documentation include interventions that were attempted prior to the administration of PRN medication</i> <i>F.3.ai</i>	22	19	21
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		<p>%C #3 <i>Nursing staff assessed the individual within one hour of administration of the psychiatric PRN medication</i> <i>H.6.d</i></p>	83	92	87																								
		<p>%C# 4 <i>Nursing staff documents the individual's response to the PRN medication</i> <i>F.3.iii</i></p>	81	87	84																								
		<p>N = # of PRNs administered each month on Program IV n = # of audits completed on Program IV</p>																											
		<p>From my review of 18 individuals (from a number of units) who received a number of PRN medications (SD, RM, AS, SRB, RE, AS, AC, OA, FA, DB, SM, PP, AD, JM, DN, LV, AG, AHL) I found that only four (FA, AHL, DB, OA) had the appropriate documentation. In 14 cases, the documentation was incomplete and/or inadequate regarding the PRN medication. In several cases the name of the medication, the time it was given, the route, and the location if given by injection was not documented in the progress notes. Consequently, it was impossible to determine if the individual was assessed within one hour of administration. In most cases, no alternative interventions were documented.</p>																											
		<table border="1"> <thead> <tr> <th colspan="4">Nursing Administration of Stat Medication Form</th> </tr> <tr> <th>2007</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>7</td> <td>11</td> <td></td> </tr> <tr> <td>n</td> <td>7</td> <td>7</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>64</td> <td></td> </tr> <tr> <td>%C #1 <i>Nursing staff document the</i></td> <td>71</td> <td>57</td> <td>64</td> </tr> </tbody> </table>				Nursing Administration of Stat Medication Form				2007	Aug	Sep	Mean	N	7	11		n	7	7		%S	100	64		%C #1 <i>Nursing staff document the</i>	71	57	64
Nursing Administration of Stat Medication Form																													
2007	Aug	Sep	Mean																										
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%S	100	64																											
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		<i>circumstances necessitating Stat administration</i> <i>F.3.a.iiI</i>			
		%C #2 <i>Does the documentation include interventions that were attempted prior to the administration of Stat medication</i> <i>F.3.ai</i>	43	14	29
		%C #3 <i>Nursing staff assessed the individual within one hour of administration of the psychiatric Stat medication</i> <i>H.6.d</i>	71	86	79
		%C #4 <i>Nursing staff documents the individuals response to the Stat medication</i> <i>F.3.iii</i>	29	86	56
<p>N = # of Stats administered each month on Program IV n = # of audits completed on Program IV</p> <p>From my review of nine individuals (from a number of units) who received Stat medications (JR, FA, MA, JM, MR, AF, MW, RE, LV), I found that all nine had documentation regarding the circumstances for the Stat medication. Only one individual (FA) had documentation regarding alternative interventions and seven were assessed within one hour of administration of the medication and included the individual's response.</p> <p>Recommendation 4, April 2007: Implement a system to ensure staff competency regarding deficiencies</p>					

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		<p>and appropriate procedures for safe administration of PRN medications and Stat medications.</p> <p>Findings: ASH indicated that data regarding PRN and Stat medications from Standards Compliance will be reviewed during the HSS meetings. In addition, training curriculum for medication and restraint classes indicated that they will include the process for documenting alternatives to PRN or restraint and seclusion, circumstances requiring these interventions and response to these interventions.</p> <p>Recommendation 5, April 2007: Implement Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately.</p> <p>Findings: The data provided by ASH indicated that PRN and Stat data is separated.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. Implement monitoring on additional units.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure that all monitoring forms reflect PRN and Stat data separately.</p> <p>Findings: See F3.a.i under Findings for Recommendation #5.</p> <p>Recommendation 2, April 2007: Continue to revise policies and procedures to reflect this requirement.</p>

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		<p>Findings: ASH's progress report indicated that policies and procedures reflected that PRN and Stat data was to be separated. However, data regarding this requirement (documentation of circumstances requiring PRN/Stat medication) was not addressed.</p> <p>Recommendation 3, April 2007: Provide staff training on policy and procedure revisions.</p> <p>Findings: ASH indicated that hard copies of policies and procedures with revisions were read and signed by all staff on the unit. However, the "read and sign" method of training regarding PRN and Stat medication administration is not adequate in reviewing ASH's data. Interactive training would be more effective.</p> <p>Other findings: See data tables in F.3.a.i addressing this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide interactive training regarding policies and procedures relating to PRN and Stat medications. 2. Provide data regarding policy and procedure revisions reflecting this requirement. 3. Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications.</p>

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		<p>Findings: See F.3.a.i under Findings for Recommendation #4.</p> <p>Recommendation 2, April 2007: Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data.</p> <p>Findings: Nursing Policy 307.0.1, Documentation of Medications and Treatments and Nursing Policy 311.0, Medication Administration Orientation/Competency Validation adequately addresses this recommendation.</p> <p>Recommendation 3, April 2007: Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications.</p> <p>Findings: See F.3.a.i under Findings for Recommendation #4.</p> <p>Other findings: See data tables in F.3.a.i addressing this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Implement monitoring tools to include this requirement.</p>

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	<p>follow-up occurs to prevent recurrence of such variances.</p>	<p>Findings: The 24 Hour Medication Audit was implemented on Program IV in September 2007 addressing this recommendation. However, the data collected by ASH did not indicate that medication variance forms were completed for each failure to sign the MTR and/or the controlled medication log.</p> <p>Recommendation 2, April 2007: Revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as reportable medication variances.</p> <p>Findings: ASH's Nursing Policy 310.0, Medication Variances (draft) dated 9/12/07 adequately addresses this recommendation.</p> <p>Recommendation 3, April 2007: Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances.</p> <p>Findings: At the time of this review, data regarding this requirement was only being collected on Program IV. From my interview with Nursing, the plan to address this recommendation includes having Program IV HSSs review the medication variance data that is submitted to Standards Compliance. A report will be generated for Central Nursing Services to review and develop strategies for prevention. In addition, medication system failures will be reviewed by the program and at the Medication Steering Committee. No data was available regarding this recommendation during this review.</p>
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		<p>Recommendation 4, April 2007: Provide training to staff regarding the above.</p> <p>Findings: Thus far, only Program IV HSSs and staff have been trained.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data reflecting this requirement. 2. Continue to expand monitoring of this requirement to additional units. 3. Continue to monitor this requirement.
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Revise policies and procedures to reflect this requirement.</p> <p>Findings: Nursing Policy 202.0, Developing a Nursing Wellness and Recovery Plan adequately addresses this requirement.</p> <p>Recommendation 2, April 2007: Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model.</p> <p>Findings: Although no data was provided, ASH reported that initial WRP training is being provided for level of care staff that includes a post-test requiring a 95% score for passing. Data needs to be provided regarding this recommendation.</p>

		<p>Recommendation 3, April 2007: Ensure that interventions are written in observable, behavioral, and/or measurable terms.</p> <p>Findings: Data collected from Program IV in August and September indicated that the mean compliance for interventions written in observable, behavioral, and/or measurable terms was 7%.</p> <p>From my review of 34 individuals' WRPs,(NN, DM, DB, JR, RM, RC, CN, OM, RH, GP, SS, LJ, YM, MW, TN, NS, RA, DC, EH, HL, RS, MW, FN, AS, CW, MM, GH, AH, JM, VM, JF, RW, RH, AG), I found that only four had interventions written in observable, behavioral, and/or measurable terms. In addition, I did not find evidence from the progress notes that interventions were actually implemented.</p> <p>Recommendation 4, April 2007: Develop and implement proactive interventions related to the individual's needs.</p> <p>Findings: ASH's progress report indicated that the HSS group is in the process of developing a packet of proactive interventions/identification of risk factors related to the individual's needs. Training will be developed and provided to level of care staff. ASH reported that monitoring for this recommendation will be implemented in November 2007.</p> <p>Recommendation 5, April 2007: Develop and implement a monitoring instrument and tracking system addressing this requirement.</p>
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		<p>Findings: This recommendation has not been addressed as of yet. ASH indicated that training regarding care planning, writing objectives and interventions will begin December 1</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding competency related to WRP and the Recovery Model. 2. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 3. Develop and implement a system to monitor and track the implementation of interventions. 4. Continue to develop and implement proactive interventions related to individuals' needs. 5. Develop and implement a monitoring instrument and tracking system addressing this requirement.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Implement a statewide monitoring instrument and tracking system addressing this requirement.</p> <p>Findings: ASH is currently using the Nursing Knowledge of Individuals' Goals, Objectives and Interventions Monitoring Form only on Program IV thus far.</p> <p>Other findings: The table below summarizes ASH's data for Program IV regarding</p>

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		<p>staff's familiarity with individuals' goals, objectives and interventions.</p> <table border="1" data-bbox="993 266 1837 885"> <thead> <tr> <th colspan="4" style="text-align: center;">Nursing Knowledgeable of Individual's Goals, Objectives and Interventions Monitoring Form Program IV</th> </tr> <tr> <th style="text-align: center;">2007</th> <th style="text-align: center;">Aug</th> <th style="text-align: center;">Sep</th> <th style="text-align: center;">Mean</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">N</td> <td style="text-align: center;">170</td> <td style="text-align: center;">188</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td style="text-align: center;">n</td> <td style="text-align: center;">20</td> <td style="text-align: center;">26</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td style="text-align: center;">%S</td> <td style="text-align: center;">12</td> <td style="text-align: center;">14</td> <td style="background-color: #cccccc;"></td> </tr> <tr> <td style="text-align: center;">%C #1 <i>Nursing staff working with the individual is able to verbalize individual's goals</i></td> <td style="text-align: center;">25</td> <td style="text-align: center;">31</td> <td style="text-align: center;">28</td> </tr> <tr> <td style="text-align: center;">%C #2 <i>Nursing staff is able to state one objective for selected focus</i></td> <td style="text-align: center;">15</td> <td style="text-align: center;">31</td> <td style="text-align: center;">24</td> </tr> <tr> <td style="text-align: center;">%C #3 <i>Nursing staff is able to state therapeutic intervention(s) for this objective</i></td> <td style="text-align: center;">27</td> <td style="text-align: center;">32</td> <td style="text-align: center;">30</td> </tr> <tr> <td style="text-align: center;">%C #4 <i>Is nursing staff able to state therapeutic intervention(s) for this objective?</i></td> <td style="text-align: center;">18</td> <td style="text-align: center;">28</td> <td style="text-align: center;">24</td> </tr> </tbody> </table> <p>N = # of individuals on Program IV n = # of audits completed for Program IV</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expand monitoring to additional units. 2. Continue to monitor this requirement. 	Nursing Knowledgeable of Individual's Goals, Objectives and Interventions Monitoring Form Program IV				2007	Aug	Sep	Mean	N	170	188		n	20	26		%S	12	14		%C #1 <i>Nursing staff working with the individual is able to verbalize individual's goals</i>	25	31	28	%C #2 <i>Nursing staff is able to state one objective for selected focus</i>	15	31	24	%C #3 <i>Nursing staff is able to state therapeutic intervention(s) for this objective</i>	27	32	30	%C #4 <i>Is nursing staff able to state therapeutic intervention(s) for this objective?</i>	18	28	24
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F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Ensure that all elements of this requirement are being monitored and</p>																																				

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	<p>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>tracked for compliance.</p> <p>Findings: At the time of this review, there was no system in place monitoring individuals who had a medical change in status. From my discussion with Nursing, it was agreed that individuals who warranted hospitalizations and/or transfer to the medical unit needed to be reviewed regarding the elements of this requirement and data reported. ASH has a Change in Status monitoring form with instructions. However, the data that were provided by ASH could not be interpreted. In addition, the monitoring form needs to be enhanced to provide more meaningful data regarding changes in status and appropriate standards of nursing practice.</p> <p>ASH has developed a draft policy addressing shift change, Nursing Policy 218.0, Shift Change. However, there is no mention of any WRP information such as individualized interventions to be passed on to the oncoming shift. In addition, a DMH Nursing Service Shift Change Monitoring tool had been developed but has not yet been implemented.</p> <p>Recommendation 2, April 2007: Develop and implement policies and procedures addressing criteria for shift change reports.</p> <p>Findings: ASH reported that the State nursing group is meeting October 30 to finalize the new shift change process and tools. As noted above, the current policy draft Nursing Policy 218.0 does not address any connection with the individuals' WRPs. Training and implementation of the new shift change tool and process is to begin in November 2007. Data provided by ASH could not be interpreted.</p>
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		<p>Other findings:</p> <p>From my review of 10 individuals (WST, JER, BG, EAJ, EDM, TJC, CRD, DJ, COH, RH) who required emergency medical care, I found significant issues with the documentation from Nursing and Psych Techs. Below is a summary of my findings:</p> <ol style="list-style-type: none">1. WST was sent to the Twin Cities Community Hospital (TCCH) Emergency Room (ER) to rule out Deep Vein Thrombosis on 5/14/07. Issues included:<ol style="list-style-type: none">a. Nursing not notified by Psych Tech of a temperature of 102.2.b. No documentation of a complete set of vital signs or accompanying symptoms.c. No complete assessment by nursing documented.d. A number of progress notes indicating that WST slept in his wheelchair during the day and during the night. There was no evidence indicating that staff tried to assist him to his bed to sleep. There was no assessment documented regarding circulation issues and his current positioning.e. No complete assessment of WST's status prior to being sent to the ER for an ultrasound of his right lower leg.f. No documentation of his status upon return from the ER except for a set of vital signs.g. No nursing summary of ER visit.h. No evidence of regular monitoring and tracking of symptoms in the progress notes before and after ER evaluation.i. Legibility of progress notes is poor and titles of staff are very difficult to read.2. DJ was sent to the TCCH ER on 6/9/07 to rule out drug overdose. Issues included:<ol style="list-style-type: none">a. No progress note from Unit 24 staff regarding change in status.b. Incomplete assessment prior to being sent to TCCH ER and
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		<p>upon return.</p> <ul style="list-style-type: none"> c. Late entries by staff not noted as such. d. No documentation that nursing was notified of change in status. e. Daily Benadryl PRN use for anxiety not addressed by WRPT. f. DJ's access to the medication room keys and missing Ativan. g. Vital sign values not included in the progress notes. h. No follow-up addressing possible overdose. i. No nursing summary of ER visit. <p>3. COH was sent to the TCCH ER on 4/26/07 for tachycardia. Issues included:</p> <ul style="list-style-type: none"> a. Several progress notes report vital signs "WNL" (within normal limits) rather than documenting the actual values for comparison. b. No progress note written on the day he was sent to TCCH ER for tachycardia. c. No nursing assessment documented prior to being sent to TCCH ER or upon return. d. No nursing summary of ER visit. e. Several late entries not noted as such in the progress notes. f. Several progress notes reported that "tachycardia was not observed." <p>4. RH was sent to TCCH ER on 4/23/07 for Congestive Heart Failure. Issues included:</p> <ul style="list-style-type: none"> a. No documentation indicating why RH was sent and admitted to TCCH. b. No status updates documented from 4/23/07 when admitted to the hospital to 5/2/07 when returned. c. No nursing assessment and summary of hospitalization documented upon return from hospitalization. d. Prior EKG not found in chart for comparison with current EKG. e. No consistent assessment documented regarding pitting edema
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		<p>to determine status changes.</p> <p>f. Complaints of chest pain (a score of 10 out of 10 on the pain scale) on 5/8/07. No documentation found that the physician was notified. On 5/9/07 RH was found unresponsive and no pulse. Code Blue called and RH was sent to the hospital.</p> <p>5. CRD was sent to the TCCH ER on 4/7/07 to rule out acute pancreatitis. Issues included:</p> <ul style="list-style-type: none">a. Incomplete nursing assessment in response to complaints of upper left quadrant pain.b. Progress note stated that CRD is "starting to have a temperature." No documentation of temperature included in note.c. No nursing assessment prior to being sent to TCCH by ambulance or upon return to the facility.d. No nursing summary of hospitalization.e. One progress note refers to gallstones. No indication from the documentation that this was an issue. <p>6. TJC was sent to the TCCH ER on 5/11/07 to rule out a stroke. Issues included:</p> <ul style="list-style-type: none">a. No nursing assessment upon return from ER.b. No nursing summary of ER visit.c. No assessment of initial signs and symptoms after return from ER.d. No assessment of cognitive skills included in notes for stroke-like symptoms. <p>7. EDM was sent to the TCCH ER on 8/7/07 to rule out a head injury. Issues included:</p> <ul style="list-style-type: none">a. Incomplete nursing assessment prior to being sent to TCCH ER.b. No nursing assessment upon return from hospital.c. No nursing summary of ER visit.
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		<ul style="list-style-type: none">d. Several notes indicated that vital signs and neuro checks were "WNL" rather than documenting actual findings for comparison.e. No cognitive assessment documented from nursing in assessing for a head injury.f. Documentation does not support EDM being kept in wrist restraints or seclusion. <p>8. EAJ was sent to the TCCH ER on 8/19/07 for evaluation of urinary retention. Issues included:</p> <ul style="list-style-type: none">a. Incomplete nursing assessments in response to complaints of feeling ill.b. No documentation of physician notification for significant change in status (sweating profusely, increase in temperature and pulse).c. No documentation of intake and output for symptoms of urinary retention. <p>9. BG was seen on 8/10/07 at TCCH ER to rule out a Bowel Obstruction. Issues included:</p> <ul style="list-style-type: none">a. No documentation that nursing was notified that BG complained of not having a bowel movement for three days on 8/8/07.b. No nursing assessment of bowel sounds in response to complaints of no bowel movement for three days beginning on 8/8/07. <p>10. JER was seen on 4/6/07 at the ER for chest pain. Issues included:</p> <ul style="list-style-type: none">a. No follow-up documentation regarding complaints of weakness and morning dose of insulin held.b. No documentation of nursing assessment prior to being sent to ER.c. No note indicating when JER was sent to the ER.d. No staff progress notes on 4/8/07 or from 4/9/07-4/17/07 regarding follow-up from symptoms reported on 4/6/07.
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		<p>Clearly, ASH needs to implement a system to monitor acute changes in status.</p> <p>In addition, I observed a shift report on Unit 21. Although the information that was provided to the oncoming shift was appropriate and specific to individuals, there is currently no standardization throughout the facility regarding what information should be addressed during shift reports.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Re-train nursing regarding assessments skill and required documentation for acute changes in status. 2. Re-train psychiatric technicians as to when nursing should be notified regarding changes in status. 3. Ensure that documentation guidelines/protocols specify criteria regarding acute changes in status, closure of problems, notification of physicians, and ER visits/hospitalizations. 4. Ensure that staff clearly document their titles in the progress notes. 5. Implement a system to track and monitor acute changes in status. 6. Revise current Change in Status monitoring form to reflect appropriate standards of nursing practice. 7. Revise Nursing Policy 218.0 regarding Shift Report to include elements of the WRP information. 8. Implement shift report monitoring.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial.</p>

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F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications.</p> <p>Findings: The implementation date for Nursing Policy 311.0, Medication Administration Orientation/Competency Validation, which includes medication administration competency observations, is November 2007. The data table below represents observation data for medication administration on Program IV by newly hired staff only. Due to the limited sample, the results cannot be accurately interpreted. Competency observation monitoring for existing nursing staff on all units is to begin on Program IV in November 2007. A system is being developed to ensure that all nurses are observed every five months but has not yet been implemented.</p> <table border="1" data-bbox="991 894 1864 1414"> <thead> <tr> <th colspan="6">Medication Administration Competency and Validation Monitoring Form</th> </tr> <tr> <th>2007</th> <th>Apr</th> <th>May</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #1 <i>Verbalizes generic and trade names of three medications administered</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #2 <i>Describes therapeutic effects, usual doses, and route of three medications administered</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #3</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Medication Administration Competency and Validation Monitoring Form						2007	Apr	May	Aug	Sep	Mean	N	3	1	2	1		n	3	1	2	1		%S	100	100	100	100		%C #1 <i>Verbalizes generic and trade names of three medications administered</i>	100	100	100	100	100	%C #2 <i>Describes therapeutic effects, usual doses, and route of three medications administered</i>	100	100	100	100	100	%C #3	100	100	100	100	100
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%C #3	100	100	100	100	100																																													

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		<i>Differentiates expected side effects from adverse reactions for these three meds</i>						
		%C #9 <i>Administers correct medications (including controlled medication)</i>	100	100	100	100	100	
		%C #9a <i>Administers correct dose</i>	100	100	100	100	100	
		%C #9b <i>Administers to correct individuals</i>	100	100	100	100	100	
		%C #9c <i>Administers by correct route</i>	100	100	100	100	100	
		%C #9d <i>Administers at correct time/date</i>	100	100	100	100	100	
		%C #50 <i>Verbalizes symptoms and appropriate interventions of hypo/hyperglycemia</i>	100	100	100	100	100	
		%C #53 <i>Explains "sliding scale" for regular insulin</i>	100	100	100	100	100	
		<p>N =# of LOC new nursing staff certified in medication administration on Program IV n = # of new LOC nursing staff medication pass observations on Program IV</p> <p>Recommendation 2, April 2007: Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.</p> <p>Findings: ASH indicated that starting in November 2007, the facility plans to observe 20% of all nursing staff for medication administration</p>						

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		<p>competency each month for five months to ensure 100% compliance rate with the requirement that all nursing staff passing medications are competent.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement observations of existing staff regarding medication administration competency. 2. Continue to monitor this requirement.
F.3.f.ii	<p>education is provided to individuals during medication administration;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Develop and implement a system addressing this requirement.</p> <p>Findings: From my interview with Nursing, they reported that the current system for medication administration does not ensure privacy for the individuals and they are working on a process to assure confidentiality and still provide medication education during medication administration.</p> <p>Recommendation 2, April 2007: Ensure staff competency regarding the implementation of this requirement.</p> <p>Findings: The Medication Administration Competency Validation Monitoring Form, item # 8 adequately addresses this recommendation.</p> <p>Other findings: ASH's data indicated that seven newly hired staff observed passing medications from April-September 2007 were 100% compliant with education being provided during medication administration. Again, this was a very small sample size and limited to only Program IV.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a process to ensure privacy during medication administration to facilitate medication education. 2. Expand medication administration observations to additional units. 3. Continue to monitor this requirement. 																																																
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a system monitoring this requirement.</p> <p>Findings: The following table summarizes ASH's data regarding appropriate medication administration protocols for newly hired staff on Program IV. As previously noted, the sample size is small and limited newly hired staff on one program.</p> <table border="1" data-bbox="991 857 1860 1406"> <thead> <tr> <th colspan="6">Medication Administration Competency and Validation Monitoring Form</th> </tr> <tr> <th>2007</th> <th>Apr</th> <th>May</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #11 <i>Applies principles of asepsis to medication administration</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #12 <i>Does not 'set up' (pour) medications prior to individual appearing in front of med person</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #13 <i>Uses two forms of</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Medication Administration Competency and Validation Monitoring Form						2007	Apr	May	Aug	Sep	Mean	N	3	1	2	1		n	3	1	2	1		%S	100	100	100	100		%C #11 <i>Applies principles of asepsis to medication administration</i>	100	100	100	100	100	%C #12 <i>Does not 'set up' (pour) medications prior to individual appearing in front of med person</i>	100	100	100	100	100	%C #13 <i>Uses two forms of</i>	100	100	100	100	100
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%C #13 <i>Uses two forms of</i>	100	100	100	100	100																																													

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		<i>identification to confirm individual's identity</i>						
		%C #14 <i>Describe process for checking for allergies</i>	100	100	100	100	100	100
		%C #15 <i>Opens/pours medication in front of individual</i>	100	100	100	100	100	100
		%C #16 <i>Correctly administers crushed and liquid medications</i>	100	100	100	100	100	100
		%C #18 <i>Ensures that the individual swallowed all medication</i>	100	100	100	100	100	100
		%C #19 <i>Ensures individual's privacy and confidentiality</i>	100	100	100	100	100	100
		%C #28 <i>Applies proper technique with use of safety syringes</i>	100	100	100	100	100	100
		%C #55 <i>Properly administers eye/ear drops, inhalers/spray</i>	100	100	100	100	100	100
		%C #56 <i>Measures, interprets & records B.P. & pulse before administering cardiac & antihypertensive medication. Withholds medication as indicated</i>	100	100	100	100	100	100
		<p>N = # of new nursing staff who being certified to in medication administration n = # of new nursing staff observed for medication certification/competency on Program IV</p>						

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expand monitoring of this requirement. 2. Continue to monitor this requirement. 																																																
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a monitoring instrument and tracking system addressing this requirement.</p> <p>Findings: The Medication Administration Monitoring Tool and the Nursing Policy 307.0.1 Documentation of Medication and Treatments adequately address this recommendation.</p> <p>Other findings: The table below is a summary of ASH's data for newly hired staff on Program IV regarding documentation related to medication administration. ASH's sample size is small and limited.</p> <table border="1" data-bbox="991 932 1837 1414"> <thead> <tr> <th colspan="6">Medication Administration Monitoring Tool</th> </tr> <tr> <th>2007</th> <th>Apr</th> <th>May</th> <th>Aug</th> <th>Sep</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>n</td> <td>3</td> <td>1</td> <td>2</td> <td>1</td> <td></td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td></td> </tr> <tr> <td>%C #48 <i>Verbalizes telephone orders and read back process</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #47 <i>Verbalizes process when medication not taken at scheduled time</i></td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>%C #54</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </tbody> </table>	Medication Administration Monitoring Tool						2007	Apr	May	Aug	Sep	Mean	N	3	1	2	1		n	3	1	2	1		%S	100	100	100	100		%C #48 <i>Verbalizes telephone orders and read back process</i>	100	100	100	100	100	%C #47 <i>Verbalizes process when medication not taken at scheduled time</i>	100	100	100	100	100	%C #54	100	100	100	100	100
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%C #54	100	100	100	100	100																																													

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		<p><i>Documents and signs out controlled medications correctly</i></p>						
		<p>%C #46 <i>Documents medication that is given on MTR immediately after administered</i></p>	100	100	100	100	100	
		<p>%C #47 <i>Documents on MTR when medication is not taken and notifies physician</i></p>	100	100	100	100	100	
		<p>N = # of new nursing staff who being certified to in medication administration n = # of new nursing staff observed for medication certification/competency on Program IV</p> <p>Current recommendation: Same as F.3.f.iii</p>						
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue revision of policies and procedures to address this requirement.</p> <p>Findings: ASH's Nursing Policy 303, Daily Care of the Bed-Bound Individual adequately addresses this recommendation.</p> <p>Recommendation 2, April 2007: Implement monitoring and tracking system addressing this requirement.</p>						

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		<p>Findings: There have been no bed-bound individuals at ASH in the past six months. However, ASH has the DMH Bed Bound Individuals Monitoring Form in the event that an individual becomes bed-bound.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Partial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a monitoring instrument and tracking system to address this requirement.</p> <p>Findings: ASH is in the process of developing a mandatory Psychiatric Nursing Education Course addressing mental health diagnoses and related symptoms. In addition, ASH's data indicated that 100% of newly hired level of care staff from April-September 2007 have completed the Medication Certification class. Also, the data indicated that 97% of the total nursing staff at ASH have completed the Medication Re-Certification class.</p> <p>Other findings: Additional training is needed regarding the assessment, documentation,</p>

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		<p>and reporting of change in status.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide nursing training regarding the assessment, documentation, and reporting of changes in status. 2. Continue to monitor this requirement.
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 recommendations:</p> <p>Recommendation 1, April 2007: Provide specific information regarding the elements of this requirement.</p> <p>Findings: ASH's data indicated that only 27% of direct care staff have been trained in the Therapeutic Milieu class. In response to this requirement, ASH has made this class mandatory for all direct-care staff. In addition, the class size has been increased from 25 to 40, and class times have been expanded to include times for night and evening staff.</p> <p>Also, ASH's data indicated that 100% of newly hired staff and 90% of existing direct care staff have completed the PMAB training, verified by training rosters.</p> <p>Recommendation 2, April 2007: Develop and implement a system to adequately monitor and track this requirement.</p> <p>Findings: ASH has developed and implemented the Therapeutic Milieu Observation Manual and Monitoring tool with instructional guidelines. This tool provides valuable and appropriate data regarding the</p>

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therapeutic milieu on the units. The following table summarizes ASH's data regarding observations of unit milieus.

Therapeutic Milieu Observation Monitoring Tool							
2007	Apr	May	Jun	Jul	Aug	Sep	Mean
N	34	33	33	31	31	28	
n	6	6	7	7	6	18	
%S	18	18	21	22	19	64	
%C #1 <i>More staff in milieu than office</i>	67	83	43	29	67	72	62
%C #2 <i>Staff in milieu interacting with individuals, not just observing</i>	67	100	29	29	67	72	62
%C #3 <i>There are unit recognition programs</i>	83	83	43	57	67	72	68
%C #4 <i>Recovery affirmations are posted on unit</i>	100	100	29	43	50	94	74
%C #5 <i>Unit rules posted in recovery language and principles</i>	67	50	0	29	17	61	42
%C #6 <i>Unit Bulletin Boards are posted with religious/cultural activities</i>	100	100	86	100	83	100	96
%C #7 <i>Staff respect confidentiality</i>	100	100	71	67	67	78	79
%C #8 <i>Staff observed praising, giving positive</i>	50	83	29	0	83	67	54

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		<i>feedback to individuals</i>							
		%C #9 <i>Staff heard acknowledging individuals strengths and abilities</i>	33	20	43	0	50	22	26
		%C #10 <i>Staff observed responding appropriately to requests for assistance</i>	83	83	71	29	100	94	80
		%C #11 <i>Staff observed offering choices</i>	50	17	29	29	33	44	36
		%C #12 <i>Staff observed discussing mall activities with individuals</i>	0	33	29	0	67	22	24
		%C #13 <i>Staff use label free language</i>	83	100	71	57	50	89	78
		%C #14 <i>Staff makes uses language & terms used in recovery training</i>	20	50	29	0	50	39	33
		%C #15 <i>Staff are actively engaged in listening</i>	83	100	43	29	100	83	74
		%C #16 <i>Staff interacts with individuals in a respectful and courteous manner</i>	50	100	86	100	67	100	88
		%C #17 <i>Staff encourages individuals to help each other</i>	50	33	0	0	17	17	18

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		<p>%C #18 <i>Staff encourages individuals to interact with each other</i></p>	50	17	0	0	17	11	14
		<p>%C #23 <i>Staff know individuals' wellness and recovery plans</i></p>	83	50	57	29	100	61	62
		<p>N = Total # of Units n = Total # of Units audited/observed</p> <p>The items on this instrument represent the elements of a therapeutic milieu. As the philosophy of the facility transitions to Wellness and Recovery, these data should also change to reflect a recovery-focused approach.</p> <p>Current recommendation: Continue to monitor this requirement.</p>							
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Develop and implement a system to ensure that nursing staff, including psychiatric technicians, attend competency-based PBS training.</p> <p>Findings: Although ASH's data indicated that 71% of level of care staff have received PBS training, nursing has only received two hours of the training. This does not constitute compliance with this requirement. Attendance for the full training is required for reporting compliance with this requirement.</p> <p>Recommendation 2, April 2007: Provide specific data/information addressing this requirement.</p>							

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		<p>Findings: The data provided by ASH does not accurately reflect compliance with PBS competency-based training.</p> <p>Recommendation 3, April 2007: Monitor and track attendance at PBS training.</p> <p>Findings: Attendance for the full PBS training is required for compliance with this requirement. The current data provided by ASH does not reflect an adequate monitoring and tracking system for PBS training attendance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all staff attend the entire PBS competency-based training. 2. Accurately track and monitor attendance for PBS training. 3. Continue to monitor this requirement.
F.3.i	<p>Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a system to ensure compliance with this requirement.</p> <p>Findings: See F.3.h.i under Findings. In addition, ASH's data for newly hired staff for April, May, August, and September 2007 indicated 100% compliance with correct documentation of controlled medication, documents on MTR immediately after medication is administered, and documents on MTR when medication is not taken and notifies the physician. No data was provided regarding existing staff.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendation: Same as F.3.f.iii</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. Ladonna DeCou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Supervising Rehabilitation Therapist 3. Terry Devine, Physical Therapist (contract) 4. Mary Jo Waugh, Nurse Supervisor for Central Medical Services 5. Alan Arebalo, Program Assistant, Central Program Services 6. Marna Scarry-Larkin, Speech Language Pathologist (contract) 7. Cheryl McLain, Recreation Therapist, Leisure Skills Group Facilitator 8. Matt Hennessy, Psychosocial Rehabilitation Mall Director 9. Angela McGregor, Recreation Therapist, Gym Group Facilitator 10. Steve Gastelum, Psychological Technician, Physical Wellness Group Co-facilitator 11. Janine Kirkpatrick, Arts in Mental Health Contracted Artist 12. Danielle Semenuk, Recreation Therapist, Arts and Crafts Clay Group Facilitator 13. Ai Fujimoto, Recreation Therapist, Arts and Crafts Group Facilitator 14. Carrie Dorsey, Music Therapist, Arts and Crafts Group Facilitator 15. Sue Christian, Vocational Instructor, Vocational Landscaping Group Facilitator 16. The following individuals participating in Rehabilitation Services groups: UW, HG, AJ, BR <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. DMH Rehabilitation Therapy Service Manual 2. Wellness and Recovery Manual 3. Rehabilitation Therapy Documentation Audit Form 4. Effective Group Leadership Strategies/Group Process Training curriculum and sign-in sheets for 9/27/07

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		<ol style="list-style-type: none"> 5. PSR Mall Facilitator Monthly Progress Note 6. DMH Admission Nursing Assessment 7. Physical Health Key Indicators List and Instructions (pilot) 8. Physical Health Key Indicator List sample report 9. Wheelchair Repair Request form 10. Monthly Wheelchair Maintenance Checklist 11. State of California ASH Occupational Therapy contract packet 12. State of California ASH Physical Therapy contract packet 13. Addendum to Physical Therapy contract to expand services (draft pending) 14. Physical Therapy Manual (draft) 15. ASH Nursing Procedure 206.7- Physical Therapy Services 16. ASH Nursing Procedure 212.0- Health Teaching 17. ASH Nursing Procedure 212.1- Medical Equipment Teaching 18. ASH Nursing Procedure 206.8- Referring Special Needs Patients for Nursing Consultation 19. ASH Nutrition Policy/Procedure 804- Adaptive Feeding Equipment (effective 9/01/07) 20. Adaptive Equipment List for Programs 1-7 for October 2007 21. Patient Education Teaching Tools Manual 22. DMH Mall Alignment Monitoring Form/ Instructions 23. PSR Mall Course Facilitator Consultation 24. Writing Recovery-Based Lesson Plan Training and sign-in sheets for 7/12/07 and 7/13/07, and Post-test template 25. WRP Training- Rehabilitation Service Staff roster dated 9/25/07 with competency-based WRP test scores <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Leisure Skills Group 2. Gym Group 3. Physical Wellness Group 4. Arts and Crafts Clay Group 5. Arts and Crafts Group facilitated by Ai Fujimoto
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		<p>6. Arts and Crafts Group facilitated by Carrie Dorsey</p> <p>7. Vocational Landscaping Group</p> <p>8. WRPC for an individual (LJ) on Unit 9</p>
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: Partial.</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 1, April 2007: Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles.</p> <p>Findings: See D.4.a for findings regarding this recommendation.</p> <p>Recommendation 2, April 2007: Obtain the services of OT.</p> <p>Findings: See D.4.a, Findings for Recommendation 1.</p> <p>Recommendation 3, April 2007: Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.</p> <p>Findings: See D.4 for findings regarding OT, PT, and SLP integration into the Rehabilitation Services department.</p>

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		<p>Currently, Physical and Speech therapists are contracted and do not attend WRPCs. Physical Therapists and Speech Therapists have not received training regarding the Wellness and Recovery model or the Enhancement Plan. Upon review of Speech and Physical Therapy documentation, it is noted that information related to treatment objectives and progress towards objectives are not being reported to the WRPT. Physical Therapy contract and Speech Therapy procedures do not specify when a Physical or Speech Therapist should attend WRPCs, or how to ensure that therapist input is reported to the WRPT if attendance is not possible.</p> <p>The CPS Language and Cognitive Services Manual states that documentation of progress for individuals receiving direct Speech Therapy services is to be completed daily in Speech Therapy notes, weekly in the Interdisciplinary Progress notes and monthly in the Mall Facilitator Monthly Progress Note. However, upon interview and review of procedures, it is noted that the Mall Facilitator Monthly Progress note is used for individuals in Mall Groups, rather than in 1:1 direct treatment. There is no system in place by which the Speech Therapist can provide documentation of objectives based on assessment findings and monthly documentation of progress towards these objectives, or changes in treatment (e.g., therapy frequency, discharge summary) to the WRPT.</p> <p>Physical and Occupational Therapy contracts state that progress toward treatment goals for individuals receiving direct therapy is to be documented, but does not specify the frequency or process for documentation. While the contract for Physical Therapy lists Physical Therapy Care Plans under the section for Specifications/Detailed Description of Work, Care Plans are not currently being developed or used for individuals receiving direct Physical Therapy Services, according to interview.</p>
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		<p>No monitoring or audit currently exists to examine whether Physical, Speech, or Industrial Therapists/Vocational Rehabilitation staff recommendations and objectives are implemented and appropriate, to ensure WRPC participation via attendance and/or monthly summaries, or to ensure appropriate and meaningful direct treatment. A draft of a Progress Notes section for the Rehabilitation Therapy Documentation Audit Form was reviewed and appears to audit for progress note completion and timeliness, progress and recommendations, and individual's attendance/participation level, but this tool has not been implemented.</p> <p>Currently, there is not a procedure in place to determine when an individual requires a Dining Plan, nor is there a consistent format by which a Dining Plan is developed, implemented with competency-based training as needed, and monitored as needed.</p> <p>Due to staffing shortages, it does not appear that adaptive equipment is recommended by Rehabilitation Therapists, but rather by physician and Nutrition Services staff. There is no procedure in place to determine when competency-based training or monitoring is needed for adaptive equipment implementation.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a procedure to specify WRPC attendance requirements per discipline, according to individualized needs (e.g., receiving direct treatment). 2. Develop and implement a procedure that specifies criteria for the need for and implementation of a 24-hour support plan related to physical and/or nutritional support. 3. Develop and implement a system by which assessment/consultation findings, recommended supports/objectives and progress toward these objectives can be reported to the WRPT by all Rehabilitation
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		<p>Therapy Services disciplines.</p> <ol style="list-style-type: none"> 4. Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation 3. 5. Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the Psychosocial Rehabilitation Mall. 6. Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), corresponding documentation of supports and progress, and incorporation of objectives and recommendations into the WRP. 7. Establish inter-rater reliability among staff performing audits prior to implementation of all audit tools.
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs. 2. Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring. <p>Findings: The Physical Therapist delivers all services to the individuals as indicated by physician order. This includes direct treatment and discharge with home exercise program as appropriate. Nursing staff does not currently implement Physical Therapy programs.</p> <p>Compliance: Unable to determine.</p>

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		<p>Current recommendation: Develop and implement a plan to ensure oversight and monitoring of Physical Therapy programs implemented by nursing staff.</p>
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to provide and document competency-based training on this requirement. 2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement. <p>Findings: Due to the lack of Occupational Therapy services and limited Physical Therapy services (.5 FTE), this recommendation has not been addressed.</p> <p>Compliance: Noncompliance.</p> <p>Current recommendation: Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence, occurs as needed.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop and implement a system to adequately monitor this requirement.</p>

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		<p>Findings: On 9/17/07, training on the Mall Alignment Checklist was provided to Service Chiefs and Program Directors. The Supervising Lead RT was trained on the use of the PSR Mall course consultation monitoring form. Data from this monitoring form will be utilized to monitor Rehabilitation Therapy Services to determine if the individuals are receiving timely and adequate rehabilitation therapy services. As discussed in F.4.a, the facility has not developed any monitoring tools to audit the provision of Speech Therapy, Physical Therapy, or Vocational Rehabilitation services.</p> <p>Other findings: Psychosocial Rehabilitation Therapists received training regarding "Writing Recovery-Based Lesson Plans" on 7/12/07 and 7/13/07; corresponding sign-in sheets and post-test template were reviewed, but competency scores were not provided. Psychosocial Rehabilitation Therapists also received WRP training on 9/25/07; this is verified by review of roster listing competency-based WRP test scores.</p> <p>Upon review of a sample of WRPs of individuals who participated in Mall groups facilitated by Psychosocial Rehabilitation Therapists, and individuals who have received Integrated Rehabilitation Therapy Assessments, 43% of WRPs contained objectives with documentation of progress towards objectives and 61% attendance by Rehabilitation Therapist at WRPCs was noted.</p> <p>Upon review of treatment documentation and corresponding WRPs for direct Physical Therapy treatment, it was noted that 100% of records contained progress notes, 0% of WRPs contained progress note objectives/progress; 11% had functional and measurable objectives; and 0% had treatment plans.</p> <p>Upon review of treatment documentation and corresponding WRPs for</p>
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		<p>direct Speech Therapy treatment, it was noted that 100% of therapy charts contained progress notes, 0% of WRPs contained progress note objectives/progress; 0% had functional and measurable objectives; and 0% had treatment plans. 100% of individuals observed in Speech Therapy were engaging in treatment activities that corresponded to rehabilitation needs as determined by assessment findings.</p> <p>During observation of Mall groups, it was noted that 71% of groups had individuals who were engaged and participating in structured group activities. Of the groups observed facilitated by RT and Vocational Services, 29% had lesson plans/curricula, and 100% had treatment rosters.</p> <p>Upon review of WRPs for individuals observed in RT/Vocational Services led Mall groups, it was noted that 47% of individuals were in a group recommended by Rehabilitation Services assessment, 41% of WRPs listed the group that the individual was attending when observed, 0% of WRPs contained functional, meaningful and measurable outcomes related to group participation, and 0% of WRPs had documented progress towards objectives.</p> <p>No individuals have had Dining Plan assessments or Dining Plan implementation at this time. Individuals at high risk for aspiration are monitored by Speech Therapist and assessment/re-assessment is tracked on the Swallow Follow database.</p> <p>According to the MAPP Group Facilitators Report for the week of October 1-5, 2007, the average number of hours of active treatment scheduled per therapist was seven hours. The average number of hours of active treatment provided per therapist was six hours.</p> <p>Compliance: Partial.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs as indicated per revised procedure. 2. Ensure that audit tools monitor for inclusion in the WRP of recommendations/objectives made by Rehabilitation Therapy Services as well as progress towards objectives.
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, April 2007: Develop and implement a system to adequately monitor this requirement.</p> <p>Findings: The Physical Health Screening tool is currently being piloted on Program IV to assist with ongoing follow-up of individuals with adaptive equipment. There is currently no monitoring tool developed or used by Rehabilitation Services to audit for implementation of services related to adaptive equipment. According to facility report, a database for monitoring this requirement is being developed. Currently, individuals who have received adaptive equipment are tracked by program in the Adaptive Equipment database, which lists type of device, reason for use, date ordered, and whether it was received by the individual. According to this database, seven individuals are currently using adaptive dining equipment, and Nutrition Services staff provided training for this equipment. According to database, 67 individuals have received mobility devices, including wheelchairs, and 12 of these mobility wheelchairs are for PRN usage. Database reveals that 12 individuals have received hearing aids, two have received helmets, 19 have received braces or supports for knee, back, wrist or ankle, and one individual has received an adaptive shoe. The database does not currently list whether the individual is independent in the device,</p>

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		<p>requires assistance, or received training (individual or staff) if needed.</p> <p>Other findings: Currently, training for use of adaptive equipment is done by Nursing staff and documented in the Health Education section of the individual's record. The Teaching Tools Manual provides educational training sheets for various types of medical equipment, which includes adaptive equipment.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with the clinical expertise to determine compliance with both implementation and continued appropriateness of supports.2. Revise and implement current adaptive equipment log to track when a piece of equipment is ordered, the date of implementation, level of assistance of individual with device, whether training/monitoring is necessary, and when training/monitoring is provided if appropriate.
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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. Erin Dengate, Assistant Director of Dietetics 2. Dawn Hartman, Clinical Dietitian <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Statewide Dietetics Dysphagia and Aspiration policy (draft 8/31/07) 2. Statewide Dietetics Wellness and Recovery Plan Training policy (draft 7/18/07) 3. DMH WRP Manual 4. RD Dysphagia Training Post-tests 5. ASH Nutrition Services Procedure 800 Nutrition Care Process (revised 9/1/07) 6. ASH Nutrition Services Procedure 804 Adaptive Feeding Equipment (effective 9/1/07) 7. ASH Nutrition Services Procedure 805 Treatment Planning (revised 9/1/07) 8. ASH Nutrition Services Procedure 806 Nutrition Education (revised 9/1/07) 9. ASH Nutrition Services Procedure 807 Recording of Nutritional Observations (revised 9/1/07) 10. ASH Nutrition Services Procedure 808 Nutrition Referral Process (revised 9/1/07) 11. Nutrition Care Manual 305 Nutritional Management of Dysphagia 12. DMH Statewide Dietetics Department Policy: Clinical Nutrition - Weight Management Protocol (final draft 10/10/07) 13. Nutrition Services New Employee Orientation 14. "Teaching Responsible Eating and Exercise, Diabetes and Heart Health" 15. 12-Week Lesson Plan for Teaching Responsible Eating and Exercise

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		<p>(draft 8/07)</p> <ol style="list-style-type: none"> 16. 12-Week Lesson Plan for Diabetes Management (draft 8/07) (RD taught portions) 17. 12-Week Lesson Plan for Heart Health (draft 8/07) 18. DMH Nutrition Care Monitoring Tool and instructions revisions 19. Training reports for Nutritional Care: RN 20. "Nutrition assessment and incorporation into the WRP" training module (provided for RN by RD) and post-test template 21. Training records/sign in sheets, outline/objectives, post-tests, and scores for competency-based training "Dining with Dysphagia" for RDs <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Diabetes Management Group, facilitated by Elizabeth Ruebber, RD
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue process of implementing a system addressing weight-related triggers. 2. Ensure staff competency regarding weight-related triggers <p>Findings:</p> <p>A system was implemented by Standards Compliance in 4/07 to collect and report monthly weight data (triggers 4.1-4.13), with report distributed to Nutrition Services and Pharmacy. Linkage to morning report for clinical alerts and follow-through was implemented on Program IV on 8/1/07 for level 1 weight triggers 4.1-4.5 and all level 1 weight triggers (4.1-4.17) implemented on Program IV on 9/1/07. Sample morning reports were reviewed for September.</p> <p>The DMH WRP manual and Nutrition Services procedures/draft sufficiently address integration of medical/nutrition concerns (e.g. weight and related health concerns) into the WRP.</p>

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		<p>Recommendation 3, April 2007: Implement a monitoring instrument and tracking system addressing the elements of this requirement.</p> <p>Findings: The Meal Accuracy Report was implemented 9/07, though accuracy of modified diets has been audited routinely as part of the performance improvement process. The meal accuracy report will formalize tracking to ensure accurate implementation of the diet order component of nutrition recommendations. Target sample is $\geq 20\%$ of all diets (regular and modified). According to facility report, trays (regular and modified diets) audited in September were 91% accurate.</p> <p>Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings. According to record review, an average (weighted mean) of 74% of Nutrition Care Assessments (total of 52 reviewed) had evidence of Nutrition Training/Education and 79% had documentation of individual response to MNT (Medical Nutrition Training).</p> <p>Facility database for all assessment types per month for April-September 2007 was reviewed. A weighted mean was calculated and revealed that 87% of assessments audited from April-September had evidence of Nutrition Education/Training and 92% had evidence of individual response to MNT.</p> <p>Curriculum/12-week lesson plan drafts for Diabetes Management (RD portion), TREE (Teaching Responsible Eating and Exercise), and Heart Health were reviewed and found to be in consistent format, with objectives, methods, materials and outcome measures listed for each lesson/session. The drafts appear to be consistent with the requirements of the Psychosocial Mall Manual.</p>
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		<p>Facilitator hours by Dietitians are not currently tracked and were not provided to this reviewer, but have been requested for the next review.</p> <p>The Diabetes Management Group was observed and the individuals were observed to be engaged, though individuals in the group appeared to be functioning at different cognitive levels. Upon review of the Nutrition Care Assessment and corresponding WRPs for three individuals attending this group, it was noted that all three assessments listed a recommendation for the group, one out of three had measurable and functional objectives related to the group, none of the three had the group listed in the WRP, and two out of three WRP documents listed the RD as in attendance.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Track facilitator hours for Nutrition Services Mall groups. 2. Continue current practice.
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Implement system to address this requirement. 2. Conduct competency-based training as planned. 3. Develop schedule to include existing staff in nutrition training. <p>Findings: The current Nutrition Care Monitoring Tool and instructions have been revised to include a section to monitor whether the WRP addresses the recommendations of the Registered Dietitian.</p>

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		<p>A statewide training policy is being developed and training reports were developed and implemented in 9/07 for "Nutrition assessment and incorporation into the WRP" (Nutritional Care: RN). Statewide competency-based RN training module was incorporated into the monthly new employee orientation Nutrition class beginning May 2007. A one-time class using the same training module was offered for current RN's monthly starting in September 2007, with priority for Program IV. According to training records and facility report, seven of 31 RNs have been trained for existing staff on Program IV, and 100% of new RNs (total of 11) been received this training in New Employee Orientation.</p> <p>Recommendation 4, April 2007: Monitor this requirement.</p> <p>Findings: Upon record review of all Nutrition Care assessments (total of 52), it was noted that 39% of corresponding WRP documents contained Nutrition Care objectives/diagnosis/recommendations. The facility did not have any audit data related to WRP inclusion of Nutrition Care recommendations at this time, as they have not yet implemented this revision in procedure.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Begin to audit for WRP inclusion of Nutrition Care Assessment recommendations/objectives with revised Nutrition Care Monitoring Tool. 2. Continue current practices.
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<p>F.5.c</p>	<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 recommendations:</p> <p>Recommendations 1, 3, and 5 April 2007:</p> <ol style="list-style-type: none"> 1. Ensure that this requirement is met. 3. Develop and implement 24-hour, individualized dysphagia care plans. 5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/ dysphagia. <p>Findings: Assessment of swallowing, dysphagia risk, aspiration risk, and mealtime interventions/24-hour supports do not fall within the scope of practice for Registered Dietitians. The role of the Dietitian as a team member in serving individuals at risk for dysphagia and aspiration is well established within current procedures related to dysphagia.</p> <p>Recommendation 2, April 2007: Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia.</p> <p>Findings: This recommendation has been met as verified by review of Statewide Dietetics Dysphagia and Aspiration Policy (draft 8/31/07), Nutrition Services P&P 800 and 808 (revised 9/01/07), and Nutrition Care Manual section 305.</p> <p>Recommendations 4 and 6, April 2007:</p> <ol style="list-style-type: none"> 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia. 6. Develop and implement a monitoring system for this requirement. <p>Findings: All dietitians (12 out of 12) have received competency-based training</p>
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		<p>related to the risk of aspiration/dysphagia; this is verified by review of training records/sign-in sheets, outline/objectives, post-tests, and compliance scores. According to review of post-tests it is noted that all RDs have achieved compliance according to procedure (80%). However, 90% is required to meet substantial compliance for the Enhancement Plan, and 11 out of 12 RDs attained scores of 90% or higher.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Continue current practice.</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 recommendations:</p> <p>Recommendation 1, April 2007: Ensure staff competency-based training regarding the implementation of this requirement.</p> <p>Findings: See F.5.c for findings regarding this recommendation.</p> <p>Recommendation 2, April 2007: Develop and implement a monitoring system regarding this requirement.</p> <p>Findings: Training compliance and competency for RDs is currently monitored by review of training reports. At this time, all existing Nutrition Services staff has received competency-based training related to dysphagia. Competency-based dysphagia training will be added to Nutrition Services New Employee Training Checklist to ensure that all new employees receive this training. Thus, no monitoring system for this</p>

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		<p>requirement is needed at this time.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 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 recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Revise policies and procedures to reflect key elements of this requirement 2. Develop and implement a system to monitor this requirement. <p>Findings: The role of the dietitian related to individuals who are receiving enteral nutrition is clearly defined in the Statewide Dietetics Tube Feeding Policy. Assessment of P.O. status does not fall within the scope of practice for Registered Dietitians, but should be addressed by the WRPT with determination based on findings from Speech therapy, Physician, and Nurse assessments as well as objective diagnostic test findings.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current practice. 2. Collaborate with relevant disciplines (e.g., SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or

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		justification of continued NPO status.
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6. Pharmacy Services		
	<p>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>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Ronald O'Brien, PharmD, Acting Director of Pharmacy <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Draft Pharmacy Policy and Procedure #608, Clinical Interventions 2. Pharmacy data regarding new psychotropic medication orders and pharmacist's recommendations in response to these orders (April to September 2007) 3. Pharmacy log of recommendations not accepted by the prescribing physician (April to September 2007) 4. Memorandum from pharmacy service regarding recommendations not accepted by the prescribing physician, September 7, 2007
F.6.a	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Revise pharmacy policies and procedures to address this requirement.</p> <p>Findings: In August 2007, ASH developed and implemented Policy and Procedure #608, Clinical Interventions. This policy outlines the process of screening by pharmacists of all new orders by physicians and of communications between pharmacists and prescribing physicians regarding concerns by pharmacists about appropriateness of the regimen. This policy did not provide clarity regarding the dispensing and administration of medications if there is disagreement between the pharmacist and the physician. The policy was revised during this monitor's tour (October 16, 2007) to address this issue. The revised version is adequate.</p>

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		<p>Recommendations 2-3, April 2007:</p> <ol style="list-style-type: none">2. Develop and implement an electronic system to ensure consistent documentation.3. Provide IT assistance to pharmacy regarding electronic database and data collection systems. <p>Findings: ASH has resolved this issue without need for further IT support. To improve documentation by the pharmacists of their recommendations regarding the physicians' orders, the facility requires the pharmacists to make a copy of the order, save it and sign it. This process is intended to allow time to document the discussion in the electronic clinical interventions database at a later date, if needed.</p> <p>Recommendation 4, April 2007: Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.</p> <p>Findings: ASH has monitoring data based on a review of all new psychotropic medications ordered, including changes in existing orders (April to September 2007). The data showed that the pharmacists made 20 recommendations related to drug-drug interactions, five recommendations related to side effects and one recommendation related to the need for laboratory testing.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Finalize and implement revised Policy and Procedure #608, Clinical Interventions.2. Continue to monitor all new psychotropic medication orders and
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		<p>changes in existing orders, and provide data related to recommendations made by the pharmacists.</p>
<p>F.6.b</p>	<p>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. <p>Findings: Revised Pharmacy Policy and Procedure #608, Clinical Interventions addresses these recommendations.</p> <p>Recommendation 3, April 2007: Develop and implement a monitoring system for this requirement.</p> <p>Findings: As mentioned earlier, ASH monitored all new psychotropic medication orders (April to September, 2007). The data showed that only two recommendations were not followed (without documentation, in the chart, by the prescribing physician of his/her rationale). In both of these situations, the pharmacists documented conversations with the prescribing physicians (April 21, 2007 and September 7, 2007) regarding the physician's rationale for not following the recommendation. However, the facility's monitoring data did not include an incident on April 26, 2007 regarding a pharmacist's recommendation to increase the dose of a medication for pain management (methadone) and the physician's rationale for not following this recommendation.</p>

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		<p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Monitor all instances of pharmacist's recommendations that were not accepted by the physicians and documentation by the prescribing physician of the rationale.2. Analyze data and address factors related to recommendations not accepted by physicians.
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7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Douglas Shelton, Chief Physician and Surgeon 2. Hussein Akhavan, MD, Physician and Surgeon 3. John Cyole, MD, Physician and Surgeon 4. Willard Towle, MD, Physician and Surgeon 5. Ali Akhavan, MD, Physician and Surgeon 6. Emily Luk, MD, Physician and Surgeon 7. Susan Smith, MD, Physician and Surgeon 8. Ronald Staib, MD, Physician and Surgeon 9. Willard Towle, MD, Physician and Surgeon 10. Vicki Vinke, HSS, Central Nursing Service. <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of 10 individuals who required emergency evaluations/transfers for acute care during this review period (BG, CD, COH, DJ, EAJ, EDM, JER, RH, TC and WST) 2. ASH database regarding Emergency Medical Care (April to August 2007) 3. Admission Medical Evaluation and Treatment Monitoring Form 4. Admission Medical Evaluation and Treatment Monitoring summary data (April to September 2007) 5. Ongoing Medical Care Monitoring Form 6. Ongoing Medical Care Monitoring summary data (May to July 2007) 7. ASH data regarding timeliness of consultations/laboratory testing (April to September 2007) 8. ASH data regarding availability of outside hospital records upon individual's return from hospitalization (April to September 2007) 9. ASH Diabetes Care Monitoring Form 10. Diabetes Care Monitoring summary data (May and August 2007) 11. ASH Hypertension Care Monitoring Form

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		<p>12. Hypertension Care Monitoring summary data (May and August 2007)</p> <p>13. ASH Management of Hepatitis C Monitoring Form</p> <p>14. Management of Hepatitis C Monitoring summary data (June 2007)</p>
<p>F.7.a</p>	<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, April 2007: Continue current practice.</p> <p>Findings: The current staffing level and the range of specialty services are adequate to meet the needs of individuals at the facility. However, ASH reports that since the last review, one Physician and Surgeon departed the facility to join the California Department of Corrections and Rehabilitation (CDCR) due to salary disparity between the two organizations. The facility reports that efforts to recruit for a replacement have been frustrated by higher compensation at the CDCR for these positions.</p> <p>The facility continues to provide on-site specialty clinic services in Dermatology, Orthopedics, Urology, General Surgery, Podiatry, Optometry, Ophthalmology, Physical Therapy, Audiology and Orthotics through a contracting process. In addition, outside contractual services are available in the specialties of Oncology, Radiation Oncology, Neurosurgery, Thoracic and Peripheral Vascular Surgery, Otorhinolaryngology, Cardiology, Nephrology, Rheumatology, Pulmonary and Anesthesiology. Pending contracts include Gastroenterology, Hepatology, Cardiovascular Surgery, and Pain Management. The current staffing level and the range of specialty services are adequate to meet the needs of individuals at the facility.</p>

		<p>Recommendation 2, April 2007: Develop and implement policy and procedure to codify the facility's standards and expectations regarding the following areas:</p> <ul style="list-style-type: none"> a. Requirements regarding completeness of all sections of initial assessments; b. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals; c. Requirements for preventive health screening of individuals; d. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition; e. Emergency medical response system, including drill practice; f. Communication of needed data to consultants; g. Timely review and filing of consultation and laboratory reports; h. Follow-up on consultant's recommendations; i. Assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks; and j. Parameters for physician participation in the WRP process to improve integration of medical and mental health care. <p>Findings: ASH has yet to implement this recommendation. The facility reports that a Department of Medicine Policies and Procedures Manual is being compiled, and that policies for ensuring continuity of medical care for individuals requiring hospitalization and for individuals having a significant change in physical status during the weekend/off hours have been formulated and approved by the Department of Medicine. However, ASH did not provide specific information regarding these policies. The facility acknowledges that further work is needed to address all the areas outlined in the recommendation.</p>
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		<p>Recommendation 3, April 2007: Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions.</p> <p>Findings: The Chief Physician and Surgeons of all the California state hospitals met in May of 2007 and agreed upon monitoring instruments for Diabetes Care, Hypertension Care, Asthma Care, COPD Care, Dyslipidemia Care, Admission Medical Assessments, Emergency Medical Care, and Chronic Medical Care. These tools are currently in the process of being developed and approved for use statewide.</p> <p>Recommendation 4, April 2007: Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.</p> <p>Findings: ASH is in the process of implementing this recommendation. The following is an outline of the activities that have been completed during this review period:</p> <ol style="list-style-type: none">1. As of this month, all the physicians and surgeons at ASH have access to computers. The Laboratory Department has requested software to allow interface of the Laboratory Information System computer data with the ASH Local Access Network (LAN). This would allow physicians to access lab data on their computers and on computers in the examination rooms. Computers are still needed in each examination room.2. The X-Ray Department has acquired a digital x-ray system, which is currently functional and is sending x-ray data via CD-ROM to outside physicians. The facility is currently working on a LAN
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		<p>connection to the X-Ray Department at ASH to allow transmission of x-ray data directly to outside offices and the ASH physicians' computers.</p> <p>3. The Health Information Management Department began to compile the Physicians' Orders, Physicians' Progress Notes, Consultations, Ancillary Reports (x-rays reports, EKGs, etc.), and Lab Report sections in one section of the chart. This facilitates availability of reports to the physicians in Sick Call and to the Medical-Surgical Clinics.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals who were transferred to outside medical facilities during this review period (DJ, EAJ, RH, BG, COH, TC, JER, EDM, CD and WST). The staff physicians and surgeons who were involved in their care were interviewed. The following table outlines the individuals' initials, the date and time of the medical evaluation (upon the transfer) and the reason for the transfer.</p> <table border="1" data-bbox="991 857 1873 1424"> <thead> <tr> <th>Individual</th> <th>Date and time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>DJ</td> <td>6/9/07 23:45</td> <td>R/O Drug Overdose</td> </tr> <tr> <td>EAJ</td> <td>8/19/07 20:00</td> <td>Urinary Retention</td> </tr> <tr> <td>RH</td> <td>4/23/07 07:45</td> <td>CHF with Renal Failure and Hyperkalemia</td> </tr> <tr> <td>BG</td> <td>08/10/07 16:00</td> <td>R/O Bowel Obstruction</td> </tr> <tr> <td>COH</td> <td>04/26/07 time unspecified</td> <td>Chest Pain and Tachycardia</td> </tr> <tr> <td>TC</td> <td>05/11/07 1500</td> <td>R/O CVA</td> </tr> <tr> <td>JER</td> <td>4/06/07 time unspecified</td> <td>Chest Pain</td> </tr> <tr> <td>EDM</td> <td>8/7/07 08:15</td> <td>R/O Head Injury</td> </tr> <tr> <td>CD</td> <td>4/6/07 15:15</td> <td>R/O Acute Pancreatitis 4/7/07 8:45</td> </tr> </tbody> </table>	Individual	Date and time of MD evaluation	Reason for transfer	DJ	6/9/07 23:45	R/O Drug Overdose	EAJ	8/19/07 20:00	Urinary Retention	RH	4/23/07 07:45	CHF with Renal Failure and Hyperkalemia	BG	08/10/07 16:00	R/O Bowel Obstruction	COH	04/26/07 time unspecified	Chest Pain and Tachycardia	TC	05/11/07 1500	R/O CVA	JER	4/06/07 time unspecified	Chest Pain	EDM	8/7/07 08:15	R/O Head Injury	CD	4/6/07 15:15	R/O Acute Pancreatitis 4/7/07 8:45
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		WST	5/14/07 15:20	R/O DVT
<p>The review showed that, in general, the facility has maintained adequate and timely care to these individuals. However, there are a number of significant deficiencies that must be corrected in order to achieve substantial compliance with requirements of the EP. The following are case examples:</p> <ol style="list-style-type: none"> 1. There is evidence of delay for approximately 12 hours in assessing an individual for possible suicidality upon return from a general medical facility following an episode of drug overdose (DJ). This individual's treatment (with lithium) was later discontinued without appropriate clinical evaluation and laboratory workup. At the same time, treatment (with lorazepam) was continued, without appropriate evaluation, despite a recent episode consistent with overdose of the same medication. 2. The physician's evaluation upon return from the general hospital does not include the diagnosis established at that facility. 3. There is failure to revise regular medication regimen (with chlorpromazine) for an individual following transfer to a general hospital despite reports of limited therapeutic benefits with this medication and possible contribution to the problem that required the transfer (BG). 4. There is no consistent system of documentation of the physician's evaluation upon transfer to the general hospital (Progress Notes or Urgent Care Room Record). Examples include CH and JD. 5. There is no documentation of the time of the physician's evaluation upon transfer to the general hospital (CH and JER). 6. There is discrepant documentation of the time of medical evaluation between nursing and medical (TC). 7. In almost all the charts reviewed, there is no documentation in the chart of the time of transfer. 8. There is delay in the transfer of an individual receiving treatment 				

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		<p>with divalproex and suffering from markedly abnormal laboratory finding (serum amylase >800) that suggests a potentially fatal side effect of this medication (CT)</p> <p>9. There is delay of nursing notification of a physician regarding leg swelling in an individual with a history of recurrent leg cellulitis (WST).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Revise the Medical Policies and Procedures to address and correct the deficiencies outlined by this monitor under Recommendation #1 above. It is suggested that the facility organize the required information within the following three main documents: <ol style="list-style-type: none"> a) <u>Medical Attention to Individuals Policy and Procedure</u>. This document should provide requirements for: <ol style="list-style-type: none"> i) Initial medical assessment of individuals upon admission and for regular reassessments during the hospital stay; ii) Assessing changes in the physical status by nursing and medical staff, including physician-nurse communications; iii) Transfer and return transfer of individuals for care at a general medical facility; iv) Integration of medical and mental health care; and v) Monitoring the timeliness and quality of these services. b) <u>Medical Emergency Response Policy and Procedure</u>. This document should provide requirements regarding: <ol style="list-style-type: none"> i) The organization, training, equipment and operations of a medical emergency response system for the immediate assessment and initial care of individuals pending transfer to a general medical facility; ii) Medical emergency drills procedure, including frequency of drills, composition of the teams, adequate scenarios of
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		<p>simulated emergencies, drill evaluation sheets and a performance improvement system, and</p> <p>iii) Monitoring the timeliness and quality of these services.</p> <p>c) <u>Medical Diagnostic Testing and Consultations</u>. This document should provide requirements for:</p> <p>i) Obtaining medical diagnostic testing and consultation services;</p> <p>ii) Providing appropriate follow up regarding these services; and</p> <p>iii) Monitoring of the timeliness and quality of these services.</p> <p>2. Implement the revised policy and procedures.</p> <p>3. Monitor this requirement based on at least 20% sample.</p> <p>4. Address and correct factors related to low compliance and deficiencies outlined by this monitor under Other Findings above.</p>						
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 1, April 2007: Continue to monitor this requirement and ensure at least 20% sample.</p> <p>Findings: ASH used the Medical Evaluation & Treatment Monitoring Form to assess compliance (April to September 2007). The facility reviewed an average sample of 17% of the number of admissions per month. The following is an outline of the monitoring indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="989 1341 1871 1414"> <tr> <td data-bbox="989 1341 1058 1377">1.</td> <td data-bbox="1058 1341 1766 1377"><i>Admission history within 24 hours</i></td> <td data-bbox="1766 1341 1871 1377">99%</td> </tr> <tr> <td data-bbox="989 1377 1058 1414">2.</td> <td data-bbox="1058 1377 1766 1414"><i>Admission Physical within 24 hours</i></td> <td data-bbox="1766 1377 1871 1414">99%</td> </tr> </table>	1.	<i>Admission history within 24 hours</i>	99%	2.	<i>Admission Physical within 24 hours</i>	99%
1.	<i>Admission history within 24 hours</i>	99%						
2.	<i>Admission Physical within 24 hours</i>	99%						

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		<table border="1"> <tr> <td>3.</td> <td><i>Admission review of system within 24 hours</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>All medical needs/conditions identified</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate consultations ordered</i></td> <td>92%</td> </tr> <tr> <td>6.</td> <td><i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i></td> <td>97%</td> </tr> </table>	3.	<i>Admission review of system within 24 hours</i>	100%	4.	<i>All medical needs/conditions identified</i>	100%	5.	<i>Appropriate consultations ordered</i>	92%	6.	<i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i>	97%
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6.	<i>Admission labs and labs specific to the medical condition(s) identified (are) ordered and completed</i>	97%												
		<p>The facility also has data based on the Ongoing Medical Care Monitoring Form (May to July 2007). In this process, ASH reviewed an average sample of 39% of the number of annual physical examinations performed for the month. The facility recognizes that the above data are limited by lack of inter-rater reliability on several questions. The following is an outline of the monitoring indicators and corresponding mean compliance rates:</p>												
		<table border="1"> <tr> <td>1.</td> <td><i>Annual history and physical completed on anniversary month</i></td> <td>78%</td> </tr> <tr> <td>2.</td> <td><i>All medical conditions identified</i></td> <td>73%</td> </tr> <tr> <td>3.</td> <td><i>An appropriate medical work up has been done for each condition</i></td> <td>86%</td> </tr> <tr> <td>4.</td> <td><i>Appropriate consultations (done), with timely completion</i></td> <td>78%</td> </tr> </table>	1.	<i>Annual history and physical completed on anniversary month</i>	78%	2.	<i>All medical conditions identified</i>	73%	3.	<i>An appropriate medical work up has been done for each condition</i>	86%	4.	<i>Appropriate consultations (done), with timely completion</i>	78%
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4.	<i>Appropriate consultations (done), with timely completion</i>	78%												
		<p>Recommendation 2, April 2007: Address and correct factors related to low compliance with the timeliness of the annual H&P examinations.</p> <p>Findings: ASH reviewed the data regarding the late Annual Physicals and found that majority of these were individuals refusing the Annual History and Physical. To address this issue, the facility plans to put into place a method of keeping track of the refusals whereby the Chief Physician and Surgeon is notified of all refusals for a month and a memo is sent to the respective WRPT to address this subject with the individual.</p>												

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		<p>ASH intends to include this requirement in the <i>General Medical Services Policy and Procedures Manual</i>.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement based on at least 20% sample, and analyze and correct factors related to low compliance. 2. Ensure that monitoring indicators address the completeness and quality of the assessments. 															
F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Continue to monitor this requirement and ensure at least a 20% sample.</p> <p>Findings: ASH used a variety of monitoring forms to assess compliance with this requirement. The data show general improvement in the timeliness of evaluations in the specialty clinics on-site and outside the facility. The following is an outline of the monitoring processes, relevant indicators and corresponding mean compliance rates.</p> <table border="1" data-bbox="991 1079 1873 1421"> <tr> <td data-bbox="991 1079 1060 1193">1.</td> <td data-bbox="1060 1079 1768 1193">Admission Medical Evaluation & Treatment Monitoring Form April to September 2007 Average sample: 17% of number of admissions per month</td> <td data-bbox="1768 1079 1873 1193"></td> </tr> <tr> <td data-bbox="991 1193 1060 1269">a.</td> <td data-bbox="1060 1193 1768 1269"><i>Has there been a change in interventions in response to a change in medical needs?</i></td> <td data-bbox="1768 1193 1873 1269">64%</td> </tr> <tr> <td data-bbox="991 1269 1060 1346">b.</td> <td data-bbox="1060 1269 1768 1346"><i>Has the individual received management for the acute medical conditions identified?</i></td> <td data-bbox="1768 1269 1873 1346">90%</td> </tr> <tr> <td data-bbox="991 1346 1060 1385"></td> <td data-bbox="1060 1346 1768 1385"></td> <td data-bbox="1768 1346 1873 1385"></td> </tr> <tr> <td data-bbox="991 1385 1060 1421">2.</td> <td colspan="2" data-bbox="1060 1385 1873 1421">Ongoing Medical Care Monitoring Form</td> </tr> </table>	1.	Admission Medical Evaluation & Treatment Monitoring Form April to September 2007 Average sample: 17% of number of admissions per month		a.	<i>Has there been a change in interventions in response to a change in medical needs?</i>	64%	b.	<i>Has the individual received management for the acute medical conditions identified?</i>	90%				2.	Ongoing Medical Care Monitoring Form	
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		<p>May to July 2007 Average sample: 39% of annual physical examinations performed for the month</p> <table border="1"> <tr> <td>a.</td> <td><i>Has there been a change in interventions in response to changes in medical needs?</i></td> <td>85%</td> </tr> <tr> <td>b.</td> <td><i>Has the physician reviewed and followed up on the test results and the recommendations of the consultants?</i></td> <td>63%</td> </tr> <tr> <td>c.</td> <td><i>Has the individual received appropriate vision care within acceptable time-frames?</i></td> <td>90%</td> </tr> </table>	a.	<i>Has there been a change in interventions in response to changes in medical needs?</i>	85%	b.	<i>Has the physician reviewed and followed up on the test results and the recommendations of the consultants?</i>	63%	c.	<i>Has the individual received appropriate vision care within acceptable time-frames?</i>	90%												
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		<p>3. Timeliness of consultations/laboratory testing, including on-site and off-site medical and specialty Care April to September 2007 Sample: 100% of clinic appointments per month</p> <table border="1"> <tr> <td>a.</td> <td><i>On-site Foot Clinic: within four weeks</i></td> <td>93%</td> </tr> <tr> <td>b.</td> <td><i>On-site Medical clinic: within two weeks</i></td> <td>92%</td> </tr> <tr> <td>c.</td> <td><i>On-site Podiatry clinic: within six weeks</i></td> <td>89%</td> </tr> <tr> <td>d.</td> <td><i>On-site Ophthalmology clinic: within four weeks</i></td> <td>90%</td> </tr> <tr> <td>e.</td> <td><i>On-site Optometry clinic: within six weeks</i></td> <td>65%</td> </tr> <tr> <td>f.</td> <td><i>Outside medical care: within eight weeks</i></td> <td>84%</td> </tr> <tr> <td>g.</td> <td><i>In-house Stat lab reported within 90 minutes of order</i></td> <td>81%</td> </tr> </table> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement based on at least a 20% sample, and analyze and correct factors related to low compliance.</p>	a.	<i>On-site Foot Clinic: within four weeks</i>	93%	b.	<i>On-site Medical clinic: within two weeks</i>	92%	c.	<i>On-site Podiatry clinic: within six weeks</i>	89%	d.	<i>On-site Ophthalmology clinic: within four weeks</i>	90%	e.	<i>On-site Optometry clinic: within six weeks</i>	65%	f.	<i>Outside medical care: within eight weeks</i>	84%	g.	<i>In-house Stat lab reported within 90 minutes of order</i>	81%
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F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	Current findings on previous recommendation:																					

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		<p>Recommendation, April 2007: Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures.</p>
F.7.b.iv	<p>ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue current practice.</p> <p>Findings: The facility has maintained an adequate system of after-hours coverage by both a Psychiatric and a Medical Officer of the Day.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the</p>	<p>Current findings on previous recommendation:</p>

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	<p>individual is treated in another medical facility.</p>	<p>Recommendation, April 2007: Develop and implement an adequate tracking system.</p> <p>Findings: ASH has developed a tracking system with daily monitoring for individuals' hospitalizations. Upon the individual's return to ASH, a request is faxed to the community hospital's HIMD for the individual's record. The fax is tracked for a response within seven days. The facility has data, based on a 100% sample, that indicate average compliance of 81% (April to September 2007). This rate represents significant improvement compared to the previous review period (49%).</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor all hospitalizations. 2. Ensure that upon the individual's return to ASH, there is physician documentation that summarizes the outcome of hospitalization and implications for future care. 		
<p>F.7.c</p>	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue current monitoring and ensure at least a 20% sample.</p> <p>Findings: ASH used a variety of monitoring processes to assess compliance. The following is an outline of the monitoring instruments, relevant indicators and corresponding mean compliance rates.</p> <table border="1" data-bbox="991 1339 1871 1414"> <tr> <td data-bbox="991 1339 1060 1414">1.</td> <td data-bbox="1060 1339 1871 1414">Admission Medical Evaluation & Treatment Monitoring Form April to September 2007</td> </tr> </table>	1.	Admission Medical Evaluation & Treatment Monitoring Form April to September 2007
1.	Admission Medical Evaluation & Treatment Monitoring Form April to September 2007			

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			Average sample: 17% of number of admissions per month
		a.	<i>Have all Focus 6 conditions (except health maintenance conditions) been addressed with WRP objectives and interventions?</i> 76%
		b.	<i>Has there been a change in interventions in response to changes in medical needs?</i> 56%
		c.	<i>Was any progress, lack of progress, need for changes in services noted in the Present Status section of the Case Formulation (WRP)?</i> 34%
		d.	<i>Has there been a change in interventions in response to changes in medical needs?</i> 79%
		2.	Ongoing Medical Care Monitoring Form May to July 2007 Average sample: 39% of annual physical examinations performed for the month
		a.	<i>Have all Focus 6 conditions (except health care maintenance) been addressed with WRP objectives and interventions?</i> 69%
		b.	<i>Have services/treatment as outlined in the WRP been consistently provided for all the needs/conditions addressed?</i> 78%
		c.	<i>Was any progress, lack of progress, or need for changes in services noted in the Present Status section of the Case Formulation (WRP)?</i> 61%
		d.	<i>Has there been a change in interventions in response to changes in medical needs?</i> 92%
		<p>Recommendations 2-3, April 2007:</p> <p>2. Address and correct above-mentioned areas of low compliance.</p> <p>3. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.</p>	

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		<p>Findings: ASH has yet to implement these recommendations. The facility is in the process of developing a mechanism to ensure that the WRPs address the identified medical needs of the individuals and are appropriately modified to meet these needs.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue current monitoring and ensure at least a 20% sample and analyze and correct factors related to low compliance. 2. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 2, April 2007: Continue monitoring of physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the trigger/key indicators for medical care.</p>

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		<p>Findings: ASH has continued monitoring of physicians' adherence to current guidelines regarding the management of individuals suffering from Diabetes, Hypertension and Hepatitis C Virus. The following is an outline of the monitoring processes, with relevant indicators and corresponding mean compliance rates:</p> <table border="1" data-bbox="991 451 1871 1395"> <tr> <td data-bbox="991 451 1060 597">1.</td> <td data-bbox="1060 451 1766 597">Diabetes Care Monitoring Form May and August 2007 Average sample: 22% of all individuals taking diabetic medication</td> <td data-bbox="1766 451 1871 597"></td> </tr> <tr> <td data-bbox="991 597 1060 638">a.</td> <td data-bbox="1060 597 1766 638"><i>If the blood pressure is high, has it been treated?</i></td> <td data-bbox="1766 597 1871 638">82%</td> </tr> <tr> <td data-bbox="991 638 1060 711">b.</td> <td data-bbox="1060 638 1766 711"><i>Is the blood glucose currently monitored at least weekly?</i></td> <td data-bbox="1766 638 1871 711">85%</td> </tr> <tr> <td data-bbox="991 711 1060 751">c.</td> <td data-bbox="1060 711 1766 751"><i>Is the quarterly HgbA1C < or = 7% done?</i></td> <td data-bbox="1766 711 1871 751">68%</td> </tr> <tr> <td data-bbox="991 751 1060 792">d.</td> <td data-bbox="1060 751 1766 792"><i>Has the lipid profile been done at least annually?</i></td> <td data-bbox="1766 751 1871 792">90%</td> </tr> <tr> <td data-bbox="991 792 1060 833">e.</td> <td data-bbox="1060 792 1766 833"><i>If dyslipidemia is present, has it been treated?</i></td> <td data-bbox="1766 792 1871 833">76%</td> </tr> <tr> <td data-bbox="991 833 1060 906">f.</td> <td data-bbox="1060 833 1766 906"><i>If no albuminuria present, has a urine microalbuminuria been ordered at least annually?</i></td> <td data-bbox="1766 833 1871 906">47%</td> </tr> <tr> <td data-bbox="991 906 1060 946">g.</td> <td data-bbox="1060 906 1766 946"><i>If the BMI > or = 27, has it been addressed?</i></td> <td data-bbox="1766 906 1871 946">98%</td> </tr> <tr> <td data-bbox="991 946 1060 987">h.</td> <td data-bbox="1060 946 1766 987"><i>Has a dietary consultation been ordered on admission?</i></td> <td data-bbox="1766 946 1871 987">91%</td> </tr> <tr> <td data-bbox="991 987 1060 1027">i.</td> <td data-bbox="1060 987 1766 1027"><i>Has diabetes education been given?</i></td> <td data-bbox="1766 987 1871 1027">98%</td> </tr> <tr> <td data-bbox="991 1027 1060 1101">j.</td> <td data-bbox="1060 1027 1766 1101"><i>Was diabetes reevaluated quarterly by the physician and documented?</i></td> <td data-bbox="1766 1027 1871 1101">71%</td> </tr> <tr> <td data-bbox="991 1101 1060 1174">k.</td> <td data-bbox="1060 1101 1766 1174"><i>Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the patient?</i></td> <td data-bbox="1766 1101 1871 1174">43%</td> </tr> <tr> <td data-bbox="991 1174 1060 1247">l.</td> <td data-bbox="1060 1174 1766 1247"><i>Has the ophthalmologist/optometrist completed and eye exam at least annually with the individual?</i></td> <td data-bbox="1766 1174 1871 1247">78%</td> </tr> <tr> <td data-bbox="991 1247 1060 1287">m.</td> <td data-bbox="1060 1247 1766 1287"><i>Has foot care been given at least annually?</i></td> <td data-bbox="1766 1247 1871 1287">86%</td> </tr> <tr> <td data-bbox="991 1287 1060 1328">n.</td> <td data-bbox="1060 1287 1766 1328">Overall compliance</td> <td data-bbox="1766 1287 1871 1328">78%</td> </tr> <tr> <td data-bbox="991 1328 1060 1395">2.</td> <td data-bbox="1060 1328 1871 1395">Hypertension Care Monitoring Form</td> <td data-bbox="1766 1328 1871 1395"></td> </tr> </table>	1.	Diabetes Care Monitoring Form May and August 2007 Average sample: 22% of all individuals taking diabetic medication		a.	<i>If the blood pressure is high, has it been treated?</i>	82%	b.	<i>Is the blood glucose currently monitored at least weekly?</i>	85%	c.	<i>Is the quarterly HgbA1C < or = 7% done?</i>	68%	d.	<i>Has the lipid profile been done at least annually?</i>	90%	e.	<i>If dyslipidemia is present, has it been treated?</i>	76%	f.	<i>If no albuminuria present, has a urine microalbuminuria been ordered at least annually?</i>	47%	g.	<i>If the BMI > or = 27, has it been addressed?</i>	98%	h.	<i>Has a dietary consultation been ordered on admission?</i>	91%	i.	<i>Has diabetes education been given?</i>	98%	j.	<i>Was diabetes reevaluated quarterly by the physician and documented?</i>	71%	k.	<i>Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the patient?</i>	43%	l.	<i>Has the ophthalmologist/optometrist completed and eye exam at least annually with the individual?</i>	78%	m.	<i>Has foot care been given at least annually?</i>	86%	n.	Overall compliance	78%	2.	Hypertension Care Monitoring Form	
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			<p>May and August 2007 Average sample: 52% of all individuals prescribed antihypertensive medications in the month</p>
		a.	<p><i>Is the blood pressure < 140/90?</i> 80%</p>
		b.	<p><i>Is dyslipidemia present? If dyslipidemia is present, has a lipid profile been checked at least annually?</i> 74%</p>
		c.	<p><i>If dyslipidemia is present, has it been treated?</i> 88%</p>
		d.	<p><i>If the individual has a BMI > or = 27, has it been addressed?</i> 96%</p>
		e.	<p><i>Has a dietary consultation been ordered within 30 days of diagnosis?</i> 80%</p>
		f.	<p><i>If the individual is currently a smoker, is smoking cessation discussed by the physician/nursing staff?</i> 46%</p>
		g.	<p><i>Has the ophthalmologist/optometrist completed an eye exam at least annually with the individual?</i> 48%</p>
		h.	<p><i>Unless contraindicated, (and if the individual is age 40 or older), has aspirin been ordered for the individual?</i> 39%</p>
		i.	<p>Overall compliance 69%</p>
		3.	<p>Management of Hepatitis C Monitoring form June 2007 Sample: 21% of total individuals with positive Hepatitis C antibodies per month</p>
		a.	<p><i>Has the individual been tested for HIV or encouraged to be tested?</i> 94%</p>
		b.	<p><i>Has the individual been tested for Hepatitis A?</i> 96%</p>
		c.	<p><i>Is the individual with advanced liver disease screened for hepatocellular carcinoma (imaging and/or AFP)?</i> NA</p>
		d.	<p><i>Is the individual who is not being treated but has detectible virus evaluated in clinic at least every six months for signs and symptoms of liver disease?</i> 100%</p>
		e.	<p><i>If an individual is not being treated but has detectible</i> 100%</p>

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			<i>virus, is a CBC and ALT level completed at least every six months?</i>	
		f.	<i>If the individual is being treated for Hepatitis C, has he had a pre-treatment psychiatric evaluation?</i>	NA
		g.	<i>If the individual is being treated for Hepatitis C, has he had all recommended pre-treatment tests?</i>	NA
		h.	<i>Is the individual under treatment receiving the recommended tests at appropriate intervals?</i>	NA
		i.	<i>Is there documentation that an individual receiving interferon/ribavirin is receiving psychiatric monitoring?</i>	NA
		j.	Overall compliance	98%
		<p>Recommendation 3, April 2007: Ensure monitoring of emergency medical care and response system.</p> <p>Findings: ASH has yet to implement this recommendation. An Emergency Medical Care Monitoring Tool has been agreed upon by the state hospitals in May 2007 and is pending approval.</p> <p>Recommendation 4, April 2007: Ensure collaboration between medical services, standards compliance and information technology to provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 5, April 2007: Identify trends and patterns based on clinical and process outcomes.</p>		

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		<p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 6, April 2007: Expedite efforts to automate data systems to facilitate data collection and analysis.</p> <p>Findings: ASH has installed the Plato data reporting software in Central Medical Services and data gathered by the physician monitors are being entered by the Chief Physician and Surgeon as well as the Office Technician. Nine physicians have taken on monitoring duties that should continue on a regular basis.</p> <p>The current physician monitoring system is based on physicians performing monitoring duties during their off hours in an additional position, all of the physicians equaling a half-time position. With the need for more timely monthly data reporting, the facility plans to request two additional Physician and Surgeon positions to perform monitoring data collection and performance improvement activities.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.2. Continue monitoring of physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the trigger/key indicators for medical care.3. Ensure monitoring of emergency medical care and response system.
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		<ol style="list-style-type: none">4. Ensure collaboration between medical services, standards compliance and information technology to provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care.5. Identify trends and patterns based on clinical and process outcomes.
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Carol Whitney, PHN II 2. Gina M. Dusi, PHN II 3. Brandi Norico, PHN I <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. ASH Hepatitis B Auditing Form 2. ASH Hepatitis C Auditing Form 3. ASH Immunization Auditing Form 4. ASH Infection Control Auditing Form 5. ASH MRSA Auditing Form 6. ASH Annual TST Auditing Form 7. ASH TST Admission Auditing Form 8. ASH TST +TST History Auditing Form 9. ASH Individual Refusing Admission TST Auditing Form 10. ASH Individual Refusing Annual TST Auditing Form 11. Memo dated 8/8/07 regarding Record of Ancillary Services Form—Immunizations 12. Infection Control Risk Assessment Plan (Draft) 13. Memo dated 8/28/07 regarding Enhancement Plan Infection Control Audit Findings and Recommendations 14. Memo dated 7/1/07 regarding Individuals Refusing Annual TSTs 15. Memos dated 7/16/07 and 10/18/07 regarding Summary of Findings and Corrective Actions June 2007 and August 2007 16. Medical records for the following individuals: TN, RC, JD, JE, JD, DW, MV, LB, MA, AB, LM, CC, FA, VY, MW, YM, SS, RH, OM, RC, TJC, CRD, EAJ, WST, COH, GG, EJ, RL 17. ASH progress report and data

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		<p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Demonstration of Infection Control database
F.8.a	Each State hospital shall establish an effective infection control program that:	<p>Compliance: Partial.</p>
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Provide prompt assistance to the Infection Control Departments in all four state facilities in developing and implementing a monitoring system in alignment with the requirements of the EP.</p> <p>Findings: ASH has developed a set of monitoring instruments using PSH's monitoring instruments as a template. However, the data provided for this review was generated using PSH's original tools. Consequently, some of the indicators from the tools did not apply to ASH's Infection Control program. ASH's monitoring instruments will be implemented in October 2007. According to ASH's progress report, inter-rater reliability was assessed and resulted in revisions to the tools and instructions. However, no percentage for inter-rater reliability was reported. Currently, the Public Health Services are completing as many chart reviews as possible on individuals that meet the review criteria in Program IV. As the facility progresses in the process, it is expected that all units will be audited regarding Infection Control and the requirements of the EP.</p> <p>The current monitoring instruments at ASH include:</p> <ol style="list-style-type: none"> 1. ASH Hepatitis B Auditing Form 2. ASH Hepatitis C Auditing Form 3. ASH Immunization Auditing Form 4. ASH Infection Control Auditing Form

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		<p>5. ASH MRSA Auditing Form 6. ASH Annual TST Auditing Form 7. ASH TST Admission Auditing Form 8. ASH TST +TST History Auditing Form 9. ASH Individual Refusing Admission TST Auditing Form 10. ASH Individual Refusing Annual TST Auditing Form</p> <p>Other findings: <u>Hepatitis A</u> There are currently no individuals at ASH who have Hepatitis A.</p> <p><u>Hepatitis B</u> According to Hepatitis B auditing data for July-September 2007, there was one individual newly admitted who tested Hepatitis B antigen positive. The audit data indicated that appropriate notification was made by the contracted lab to Public Health Services of a positive Hepatitis B Surface Antigen; appropriate notification was made by the contracted lab to the housing unit of the individual that the Hepatitis B Surface Antigen test was positive; and the Public Health Services Hepatitis database was updated for this individual testing positive for Hepatitis B Surface Antigen.</p> <p>From my review of four individuals (FA, CC, TN, VY) with Hepatitis B, I found that in all four cases there was notification by the contracted lab to Public Health Services of a positive Hepatitis B Surface Antigen; notification by the contracted lab to the housing unit of the individual that the Hepatitis B Surface Antigen test was positive; and that the Public Health Services Hepatitis database was updated for each individual testing positive for Hepatitis B Surface Antigen.</p> <p><u>Hepatitis C</u> ASH's data indicated that there were a total of 71 individuals newly admitted who tested Hepatitis C antibody positive from June-</p>
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		<p>September 2007. From a sample size of 18, 100% compliance was reported for notification by the contracted lab to Public Health Services of a positive Hepatitis C Antibody test; notification by the contracted lab to the unit housing of the individual that the Hepatitis C Antibody test was positive; and the Public Health Services Hepatitis database was updated for each individual testing positive for Hepatitis C Antibody.</p> <p>From my review of four individuals (SS, LB, RC, RL) with Hepatitis C, I found that all four cases were in compliance with notification by the contracted lab to Public Health Services of a positive Hepatitis C Antibody, notification by the contracted lab to the individual's unit housing that the Hepatitis C Antibody test was positive; and the Public Health Services Hepatitis database was updated for each individual testing positive for Hepatitis C Antibody.</p> <p><u>Immunizations</u> According to ASH, 332 newly admitted individuals from June-September 2007 needed to be evaluated for immunizations within 90 days. A sample size of 67 (20%) was audited and the data indicated 99% compliance for notification by the contracted lab to the Public Health Services of the individual's immunity status; 100% compliance for notification by the contracted lab to the individual's unit housing of his/her immunity status, and 100% compliance for notification by the Medical Surgical Clinic of the individual's refusal of the immunization(s) to Public Health Services.</p> <p><u>Methicillin Resistant Staph Aureus (MRSA)</u> The data from ASH indicated that there were seven individuals who tested positive for MRSA from June-September 2007. All seven cases were audited and the data indicated 100% compliance for notification by the contracted lab to Public Health Services of a positive culture for MRSA; 100% compliance for notification by the contracted lab to</p>
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		<p>the individual's unit housing that a positive culture for MRSA was obtained; and that there was no transmission of MRSA to other individuals in these living areas.</p> <p>My review of five individuals (JD, GG, EJ, MV, DW) diagnosed with MRSA indicated that all five cases were in compliance with notification by the contracted lab to Public Health Services of a positive culture for MRSA; notification by the contracted lab to the unit housing of the individual that a positive culture for MRSA was obtained; and that there was no transmission of MRSA to other individuals in these living areas since the five individuals were from different units.</p> <p><u>Annual Tuberculin Skin Test (TST)</u></p> <p>ASH's data indicated that a total of 164 individuals needed an annual Tuberculin Skin Test (TST) from June-September 2007. The facility audited 30 records that indicated 100% compliance that TST was ordered by the Physician/FNP; 100% compliance that the TST was administered; 100% compliance that the TST was read; and 100% compliance that Public Health Services was notified when an individual refused his annual TST.</p> <p>From my review of five individuals (TJC, CRD, EAJ, WST, COH), I found that all five had a TST ordered by the Physician/FNP and included documentation that indicated that the TST was administered and read. I found no documentation indicating that there were any TST refusals.</p> <p><u>Admission Tuberculin Skin Test (TST)</u></p> <p>ASH's data indicated that a total of 330 newly admitted individuals needed an admission TST from June-September 2007. A sample of 61 was audited and indicated 100% compliance that a TST was ordered by the Physician/FNP; 100% compliance that the TST was administered; 100% compliance that the TST was read; and 100% compliance that</p>
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		<p>Public Health Services was notified when an individual refused his admission TST.</p> <p>From my review of seven individuals (TN, MW, YM, SS, RH, OM, RC) admitted in September 2007, I found that all seven were in compliance with the above indicators. There was no indication that any of the seven had refused their admission TSTs.</p> <p><u>History of positive TST</u> The current monitoring instruments do not adequately reflect indicators relating to this issue. Consequently, there was no data provided addressing positive TSTs.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement revised monitoring instruments. 2. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as F.8.a.i.</p> <p>Findings: The table data provided by ASH regarding this requirement could not be interpreted. It was discussed during the review that either narrative data discussing data trends and/or graphs and meeting minutes identifying data trends would provide more meaningful information as well as supporting documentation of compliance with the EP.</p> <p>From my interview with the Public Health Nurses, they noted and provided documentation indicating that the trends they had identified from their monitoring indicated that Focus 6 on the Medical Condition</p>

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		<p>Form was not consistently initiated on many communicable disease issues including MRSA, +TST history, +TST, refusing immunizations, Hepatitis C, and Hepatitis B. In addition, they identified that overall, clinicians were not specifically addressing signs and symptoms of tuberculosis (TB) on admission history and physical assessments or when the individual had a +TST history. They also noted that they saw a need to develop standardized work flow sheets on each monitoring aspect to ensure that follow-up regarding these issues is implemented. A memo dated 8/28/07 to the Chief Physician and Surgeon outlined these issues with associated recommendations for correction and validated compliance with this requirement.</p> <p>From my review of 14 WRPs (TN, RC, JD, JE, JD, DW, MV, LB, MA, AB, LM, CC, FA, VY), only three had open problems for Focus 6.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data in a format that demonstrates compliance with this requirement. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: The table data provided by ASH regarding this requirement could not be interpreted. However, the narrative information in the progress report for ASH indicated that issues regarding inconsistencies for opening a Focus 6 problem on the Medical Condition form for communicable diseases and histories and physicals not addressing signs and symptoms for tuberculosis are scheduled to be presented at the September Department of Medicine meeting. Since ASH has a</p>

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		<p>centralized communicable disease clinic, the Public Health Nurses suspect that physicians/FNPs assume that the Public Health Physician will always open the Focus 6 on the Medical Condition form. The Memo dated 8/28/07 validates that inquiries into these issues have been brought to the Chief Physician and Surgeon.</p> <p>An additional problematic trend regarding obtaining clear information from the Med-Surg Clinic vaccination clinic on the reasons why immunizations were not given and rescheduling individuals was addressed in a memo dated 8/8/07 outlining a protocol for this issue. Also, memos were provided that validated that trends regarding the documentation of education provided to individuals who refuse TSTs are being followed up.</p> <p>Current recommendations: Same as F.8.a.ii.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: The table data provided by ASH was not able to be interpreted. However, a memo dated 8/28/07 provided by ASH verifies that recommendations/corrective actions for problematic trends have been identified, clearly outlined, and have been sent to the Chief Physician and Surgeon. These issues will be discussed at the September Department of Medicine meeting which had not yet taken place at the time of this review. In addition, a memo dated 8/8/07 verified that a process had been developed to capture immunization data and initiate a process so the WRPT can be informed of individuals' refusals.</p>

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		<p>I would recommend that a system to monitor and track the implementation of recommendations/corrective actions be developed and implemented.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as F.8.a.ii. 2. Develop and implement a system to monitor and track the implementation of recommendations/corrective actions.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: There are a number of items contained in the monitoring instruments that do not lend themselves to accurate and meaningful interpretations. For example, items such as "the information obtained from this result will be used to ensure appropriate remedies were achieved" and "the information obtained from this result will be used to benchmark and compare problematic trends against other facilities" do not provide useful data. Explanations and examples would be better suited to provide data relating to these items.</p> <p>As mentioned in previous cells, ASH's data indicated that the opening of a Focus 6 problem and documentation on the history and physicals of signs and symptoms of tuberculosis are problematic trends that have been identified. ASH's monitoring instruments include these items for continual monitoring and assessment of progress.</p> <p>ASH has also revised the Ancillary Services record regarding reason(s) for missed appointments and appointments rescheduled to monitor data relating to immunizations. A memo dated 8/8/07 verifies this action.</p>

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		<p>Also, revisions were made to the current "tickler system" for residents refusing annual TSTs to ensure a 90-day review process and involvement of the WRPT. I observed a demonstration of this system and found it to be reliable.</p> <p>Other findings: I was very impressed with the Infection Control database, which contains current as well as historical information. This system allows the department to assess systemic and individual trends throughout the facility for certain issues. However, there is much data that are maintained "by hand." Data for MRSA, Body Substance Exposure, antibiotic tracking, infection reporting, and refusals are not included in the current database. Assistance from IT is needed to include these issues in the Infection Control database.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Same as F.8.a.ii 2. Provide IT support to automate infection control data.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as above.</p> <p>Findings: As above.</p> <p>Other findings: The Public Health Nurses currently complete a monthly Executive Summary that will now include the findings from the monthly audits to be integrated into the quarterly Performance Improvement/Risk Assessment Report. From my discussion with the Public Health Nurses, it was agreed that these reports will be provided during the reviews to</p>

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		<p>determine compliance with this requirement. The data tables provided by ASH did not reflect this requirement.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide reports reflecting compliance with this requirement.2. Continue to monitor this requirement.
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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. Nolan Nelson, DDS <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Dental records for the following individuals: DRJ, JAM, JR, RC, OM, IM, LC, LJ, SW, SL, ER, CB, LT, CW, BC, MB, DH, JD, ADG, RTA, LAV, RDB, DN, AD, AHH, JM, ALS, AAC, PEP, FA, AHL, RF, SO, DR, SS, JB, VT, JC, JD, DI, JJ, CE, JS, KC 2. ASH's progress report and data 3. Memo dated 8/2/07 regarding Dental Records 4. Memo regarding Refused/Missed Dental Appointments 5. ASH Dental Health Care Plan (revised 8/31/07) 6. Dental Care Services Monitoring Form
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 recommendations:</p> <p>Recommendation 1, April 2007: Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department.</p> <p>Findings: ASH has recently hired two fulltime dentists. One started during the week of this review and the other will begin in early November 2007. Since there was only one allocated vacant dental position, a position from the pharmacy was reassigned to the Dental Department, enabling the facility to hire two dentists. In securing these positions, ASH's Dental Department should be able to provide more services to individuals as well as regularly monitor data regarding the EP.</p>

		<p>Recommendation 2, April 2007: Develop and implement a policy to adequately and appropriately address the management of after-hours dental emergencies.</p> <p>Findings: From my interview with Dr. Nelson, this issue has continued to be unresolved. The problem has not been obtaining the services of an on-call dentist since Dr. Nelson has been taking call even when he was the only dentist at ASH. This main problem regarding the management of after-hours dental emergencies has been the Medical Officers of the Day (MODs) not consistently calling in a dentist to evaluate dental emergencies. However, the current policy dictates that the MOD is to call the dentist on-call for dental emergencies.</p> <p>In the case of DRJ, he had two teeth knocked out during an altercation with another individual. The progress notes indicated that one tooth was lost in the courtyard and the other was taken by the facility police as evidence. The on-call dentist was not notified until the next day. Due to the delay, the tooth could not be restored.</p> <p>In a second case, JAM's tooth was fractured while eating dinner. The progress notes indicated that he described shooting pain to the left side of his face, which the nurse noted also looked inflamed. The Nurse on Duty (NOD) and physician were notified. However, JAM was not seen that evening and the note indicated that he was to use his available ibuprofen and to see the dentist the next day. The dental noted indicated that although he was given this medication, the pain continued throughout the night. Again, the on-call dentist was not notified. The tooth was extracted.</p> <p>After a discussion with Dr. Nelson and the Executive Director regarding this issue, a memo was generated advising staff that the policy regarding after-hours dental emergencies would be changed to</p>
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		<p>include notification of the on-call dentist by the NODs. The Dental Department needs to continue to monitor this issue to ensure that the interventions implemented are effective.</p> <p>Recommendation 3, April 2007: Continue to evaluate and then obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data.</p> <p>Findings: The efforts by DMH regarding obtaining a dental software package has resulted in the purchase of the Patterson Dental "Eaglesoft" program by consensus of the dentists at the facilities. No date for implementation of the software has yet been set.</p> <p>Recommendation 4, April 2007: Reconfigure dental data to yield compliance rates regarding the provision of timely routine and emergency dental care.</p> <p>Findings: Based on a 100% sampling of individuals who were to have an annual dental exam from May-August 2007, ASH reported a mean compliance rate of 29% for seeing individuals within 30 days of the annual exam target date. ASH's progress reported indicated that the low compliance rate was due to having only one dentist providing services and the number of individuals on court leave and/or discharged. Data for September was not available due to the staffing issue. However, with the addition of two full-time dentists, the facility believes that the compliance rates should dramatically increase within the next six months.</p> <p>From my review of eight individuals (JC, JD, DI, JJ, CE, JS, KC, JR) who were to have an annual dental exam, five had not been seen (JC,</p>
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		<p>JD, DI, KC, JR); one refused (JJ); one was out to court (JS); and two were seen timely (CE, JS).</p> <p>According to ASH's data regarding timeliness of dental emergencies during clinic hours from May-August 2007, 100% of exams were completed within 24 hours. From my review of eight individuals (RF, JR, SO, DR, LJ, SS, JB, VT) with dental emergencies, seven were seen within 24 hours. One individual refused to be seen (SS). Additionally, all seven were seen on the same day that the dental clinical was called regarding the emergency. In these situations, the Dental Department has exceeded the timelines of their current policy.</p> <p>Recommendation 5, April 2007: Monitor and document incidents of inappropriate emergency dental care.</p> <p>Findings: See Findings for Recommendation #2 above.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement revised policy addressing management of after-hours dental emergencies. 2. Provide training to NODs regarding dental emergencies. 3. Continue to monitor and document incidents of inappropriate emergency dental care. 4. Implement dental software package. 5. Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	Compliance: Partial.

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<p>F.9.b.i</p>	<p>comprehensive and timely provision of dental services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Revise dental policies and procedures to ensure that they are in alignment with the language of Wellness and Recovery.</p> <p>Findings: Although revisions have been made to ASH's Dental Health Care Plan noted on 8/10/07, the document continues to contain the term "patient" rather than the "individual." In addition, there were no criteria addressing comprehensive dental treatment plans. It was unclear from the revised Dental Health Care Plan how needed treatment is to be documented during an admission exam as opposed to the treatment that is rendered. This issue is common to all four facilities. There needs to be a uniform statewide Dental Manual addressing dental issues.</p> <p>Recommendation 2, April 2007: Separate and independently report data regarding the annual dental review and the 90 days from admission data.</p> <p>Findings: The data contained in ASH's progress report in this cell regarding annual dental exams did not match the data provided in F.9.a regarding the annual dental exams. No explanation for the discrepancies was provided.</p> <p>According to ASH's progress report, the average rate of compliance regarding admission dental exams completed within 90 days of admission was 42% for May-August 2007. The low compliance rate was attributed to the number of individuals scheduled for exams that were discharged or on court leave.</p>
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		<p>From my review of 13 individuals' records (ADG, RTA, LAV, RDB, DN, AD, AHH, JM, ALS, AAC, PEP, FA, AHL), five refused, four were seen after 90 days, and four were seen within 90 days.</p> <p>Recommendation 3, April 2007: Continue to monitor and track comprehensive dental services.</p> <p>Findings: The Dental Department at ASH as well as at the other facilities has struggled with the development and implementation of monitoring tools that clearly address compliance with the requirements of the EP. Much of the data provided in the ASH progress report for Section F.9 did not accurately reflect the information required by the EP. The development and implementation of statewide monitoring tools for dental services is clearly needed to accurately measure and indicate compliance.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Implement a statewide committee to review standards of practice and unification of documentation for dental services. 2. Develop and implement statewide monitoring instruments for dental services in alignment with the EP. 3. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Ensure that dental information contained in individuals' records is accurate and up-to-date.</p> <p>Findings: ASH has begun to put a copy of the individual's dental clinic record</p>

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		<p>under the consultation tab in the unit chart to ensure that dental information is accurate and up-to-date. In addition, this allows the WRPT to access information regarding the individual's dental condition in assessing overall health issues and issues with refusal of dental treatments. However, not all the unit charts have been updated with this information. From my review of 15 charts (BC, IM, LC, LJ, SW, SL, ER, CB, JR, MB, DH, JD, MB, LT, CW), four charts did not contain a copy of the clinic dental record. (BC, MB, DH, JD)</p> <p>Recommendation 2, April 2007: Continue efforts to ensure that staff brings individuals' records to all dental appointments.</p> <p>Findings: According to ASH's data for August 2007 from the Daily Dental Appointment schedule, 87% of individuals' charts were on hand at the time of appointment. (Data collection for this issue was implemented in August.) In an interview, Dr. Nelson described a three-tiered process regarding appointments and having the chart present at the appointments. First, the units are notified the day prior to an individual's dental appointment. Then, an appointment slip is sent to the individual's unit reminding them of the dental appointment. Lastly, the units are called on the morning of the individual's appointment to remind them that the individual's chart needs to be brought to the Dental Clinic. Treatment is not provided to the individual unless the chart is present to review clinical issues.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to ASH's data for May-August 2007, 100% of descriptions of findings were documented, 100% of treatment provided was</p>
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		<p>documented, and 100% of the documentation contained a plan of care. From my review of 13 individuals' dental records (JR, RC, OM, IM, LC, LJ, SW, SL, ER, CB, JR, LT, CW), all 13 had documentation of findings and the treatment provided. However, I did not find a plan of care for any of the 13 records I reviewed.</p> <p>From my discussions with Dr. Nelson, it appears that he uses his clinical judgment and expertise in interpreting the dental record as a plan of care. However, there is no clearly documented plan of care that can be easily accessed from a record review. This issue becomes significant when integrating the WRPT into an individual's dental status. Developing and implementing a statewide system for dental documentation would assist with this issue.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that all unit records have a copy of the Dental Clinic record. 2. Same as recommendations in F.b.9.i
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to ASH's data for May-August 2007, the facility reported an average of 92% compliance for preventive dental care and 97% compliance for restorative dental care. However, due to having only one dentist providing services, low compliance rates for annual and admission dental exams, and indistinct documentation of dental plans of care, these compliance rates do not accurately reflect the elements of this requirement.</p> <p>In reviewing this data with Dr. Nelson, only those treatments provided</p>

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		<p>rather than treatments that were needed were used by ASH in the auditing process to generate the data. This has been a common problem among all the Dental Departments in the facilities. In addition, without a clearly documented dental plan of care, it is impossible to determine an accurate compliance rate regarding preventative and restorative dental care.</p> <p>Current recommendations: Same as recommendations in F.b.9.i.</p>
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Specify the necessary criteria used regarding this requirement.</p> <p>Findings: ASH's revised Dental Health Care Plan includes the following criteria regarding tooth extractions: Extractions are performed on unrestorable teeth: caries into pulp chamber, abscessed, periodontitis, mobility, fracture of substantial crown structure, retained roots, radiographic pathology. However, clinical judgment and radiographic documentation is implied in making the decision for extraction, which is not clearly documented in the dental notes.</p> <p>ASH's data covering May-August 2007 indicated 100% compliance regarding justification for tooth extractions and 100% regarding use of extraction as the treatment of last resort. However, from my review of the documentation for 13 individuals who had tooth extractions (JR, RC, OM, IM, LC, LJ, SW, SL, ER, CB, JR, LT, CW) I did not consistently find the specific criteria for the extraction included. In some cases the documentation indicated that a tooth was unrestorable. However, no specific reasons were clearly documented. The time-out procedure was consistently documented in all the records</p>

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		<p>I reviewed.</p> <p>Recommendation 2, April 2007: Continue to monitor this requirement.</p> <p>Findings: A statewide monitoring instrument needs to be developed and implemented to adequately address this requirement.</p> <p>Recommendation 3, April 2007: Same as Recommendation #1 in F.9.b.ii.</p> <p>Findings: See Findings for Recommendation #1 in F.9.b.ii.</p> <p>Current recommendations: Same as recommendations in F.b.9.i.</p>
F.9.c	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to ASH's data for May-August 2007, the mean compliance rates were 96% for reviewed an individual's physical health/medical conditions, 96% for reviewed an individual's medications, 98% for reviewed allergies, and 100% for reviewed current dental status.</p> <p>My review of 15 individuals' dental records (JR, RC, OM, IM, LC, LJ, SW, SL, ER, CB, JR, LT, CW, DRJ, JAM) indicated 100% review of physical health/medical conditions, 100% review of medications, 100% review of allergies, and 100% review of dental status.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendations: Same as recommendations in F.b.9.i.</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 recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a system to monitor and track issues that preclude individuals from attending dental appointments.</p> <p>Findings: According to ASH's progress report, this recommendation was partially addressed. However, the information provided addressed dental appointment refusals, not transportation or staffing issues precluding attendance at dental appointments as noted in the EP.</p> <p>Recommendation 2, April 2007: Continue efforts to improve the communication between the unit staff and residents regarding dental appointments.</p> <p>Findings: See F.9.b.ii. In addition, ASH has implemented a policy that requires that memos are sent to the units and Program IV units and are to be sent back to the Dental Department indicating the reason individual did not keep his dental appointment. However, according to ASH's data for May-August 2007, an average of only 16% of memos addressing the refusals have been returned to the Dental Department.</p> <p>Recommendation 3, April 2007: Develop and implement a system to monitor outcomes of interventions</p>

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		<p>implemented to address this requirement.</p> <p>Findings: The Dental Department is currently using a Refusal Log to track the memos that have been sent to the units. Thus far, this system has not been effective in that the units generally do not respond.</p> <p>Recommendation 4, April 2007: Develop procedures/protocols addressing this requirement and provide staff training.</p> <p>Findings: No supporting data was provided regarding this recommendation.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Develop and implement a system to monitor and track issues that preclude individuals from attending dental appointments. 2. Implement strategies to increase unit responses to refusal memos. 3. Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a system to monitor outcomes of interventions implemented to address this requirement.</p> <p>Findings: See F.9.d under Recommendation #3.</p>

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		<p>Recommendation 2, April 2007: Develop procedures/protocols addressing this requirement and provide staff training.</p> <p>Findings: This recommendation was not addressed.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. See F.9.d, Recommendation #2.2. Continue to monitor this requirement.
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G. Documentation		
<i>G</i>		<p>Summary of Progress: Please refer to Sections D, E, F and H for judgments on the progress ASH has made towards aligning documentation practices with the requirements of the EP.</p>
<i>G</i>	<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>Current findings on previous recommendations:</p> <p>Recommendations 1-3, April 2007:</p> <ol style="list-style-type: none"> 1. Monitor and track the quality of documentation regarding all the required elements in the plan. 2. Address and correct factors related to inconsistent compliance. 3. Provide ongoing training regarding documentation requirements. <p>Findings: Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance⁰ and recommendations pertaining to documentation.</p>

Section H: Restraint, Seclusion and PRN and Stat Medication

H. Restraint, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. ASH has revised a number of policies in alignment with the EP. 2. ASH has made significant progress in reducing the use of seclusion and restraints. 3. ASH has developed and implemented a number of appropriate monitoring instruments related to Restraint, Seclusion and PRN and Stat medications.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Donna Nelson, Standards Compliance Coordinator 2. Al Joachim, Acting Nurse Administrator 3. Vickie Vinke, HSS 4. Joe Cormack, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Revised Restraint Flow Chart (draft) 2. Nursing Administration of PRN/Stat Medication monitoring form and instructions 3. Restraint and Seclusion Monitoring form 4. Key Indicator Trigger Reporting (draft) 5. Outcome Indicator data for Seclusion and Restraint from September 2006-September 2007 6. Monthly Trigger Frequency data from January 2007-September 2007 7. AD 518, Restraint or Seclusion dated 10/10/07 8. Nursing Policy 308.0, Noting Physician Orders dated 9/19/07 9. Nursing Policy 307.1, Administration of Oral Medications dated 8/23/06 10. Nursing Policy 307.0.1, Documentation of Medication and

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		<p>Treatments dated 9/19/07</p> <ol style="list-style-type: none"> 11. Trigger Meeting Minutes dated 10/14/07 and 10/28/07 12. Initial Instructions for Administration of PRN/Stat Medication (draft) 13. Special Incident Report Monitoring form 14. Nursing Policy 203.1, Falls Prevention Program dated 9/19/07 15. Nursing Policy 104.0, Nursing Care of Individuals in Restraints or Seclusion dated 8/14/07 16. ASH Restraint and/or Seclusion SIR Documentation Review tool 17. ASH's progress report and data 18. Medical records for the following individuals: BA, SA, JB, SD, HE, GG, DH, RM, JW, CW, AS, SB, ZS, LS, RE, DQ, AC, OA, DB, SM, PP, OR, RE, JR, FA, SM, JM
<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Continue to review and revise policies and procedures that currently allow the use of prone containment.</p> <p>Findings: Revisions to AD 518, Restraint and Seclusion and Nursing Policy 104, Nursing Care of Individuals in Restraint or Seclusion adequately addressed this recommendation.</p> <p>Recommendation 2, April 2007: Ensure that all policies and procedures prohibit the use of prone restraints, prone containment, and prone transportation.</p> <p>Findings: Same as above.</p>

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		<p>Other findings: From my review of the records of 10 individuals (BA, SA, JB, SD, HE, GG, DH, RM, JW, CW) who have been placed in seclusion and/or restraints, I found documentation indicating that "fading" procedures were being used. This procedure prolongs the use of restrictive measures by stepping down the initial restrictive devices to a less limiting device rather than fully releasing an individual when he or she has regained control. From my discussion with Donna Nelson, Standards Compliance Coordinator, Vickie Vinke, HSS, Al Joachim, Acting Nurse Administrator, and Jon De Morales, Executive Director, it was agreed that this practice would stop and be taken out of policies/procedures related to seclusion and restraints.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Prohibit staff from using fading techniques regarding seclusion and restraints. 2. Ensure all policies/procedures prohibit the use of fading regarding seclusion and restraints. 3. Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	<p>Compliance: Partial.</p>
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Review and modify current monitoring instrument to adequately address the elements of this requirement.</p>

		<p>Findings: The Restraint and Seclusion Monitoring Form and instructions have been appropriately revised addressing this recommendation.</p> <p>Recommendation 2, April 2007: Separate data for seclusion and restraints.</p> <p>Findings: Starting in August 2007, restraint and seclusion data are being reported separately.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: According to the ASH restraint monitoring data for August and September 2007, 81% of restraint episodes were used only when an individual posed an imminent danger to self or others. In addition, 61% and 50% of seclusion episodes for August and September respectively were used only when an individual posed an imminent danger to self or others.</p> <p>From my review of the records of 10 individuals (BA, SA, JB, SD, HE, GG, DH, RM, SB JW, CW) who were placed in restraints, I found that the documentation for SB, SD and SA, did not indicate that they posed an imminent danger to self or others. In addition, from my review of the records of seven individuals (DH, ZS, SA, RM, SD, JB, BA) who were placed in seclusion, the documentation for RM and SD did not indicate that they posed a danger to self or others.</p> <p>Other findings: From my review of the above 12 cases (six individuals experienced both restraint and seclusion), I found that only two contained documentation</p>
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		<p>indicating that specific alternative methods were tried prior to seclusion and/or restraints.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data reflecting this requirement. 2. Continue to monitor this requirement.
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Review and modify monitoring indicator criteria to ensure that data accurately reflect indicators.</p> <p>Findings: See H.2.a</p> <p>Recommendation 2, April 2007: Provide staff training regarding appropriate procedures for use of seclusion and/or restraints.</p> <p>Findings: ASH had added additional training on hierarchy of least restrictive measures and proper documentation to the curriculum of the PMAB annual and new employee orientation training, confirmed by review of the training curriculum. In addition, Aggression Reduction Training was added in June 2007. Also, training rosters indicated that training was provided to each Program's management team regarding EP requirements in the area of restraint/seclusion. ASH indicated that the HSSs will increase oversight of restraint and seclusion application and documentation.</p> <p>Recommendation 3, April 2007: Evaluate staffing patterns as a part of assessing for restraint and</p>

		<p>seclusion use and staff convenience.</p> <p>Findings: Since August 2007, ASH has implemented a procedure regarding a review of all Serious Incident Reports (SIRs) by Standards Compliance and provision of feedback to the Clinical Administrator regarding any trends that have been identified. At the time of this review, ASH has recently begun reviewing this feedback with the Program Directors at the weekly trigger meetings. In addition, these trends are to be reviewed in the weekly Incident Management Committee. ASH indicated that starting in November 2007, a database will be developed to assess staffing issues such as unit vacancies and overtime rates with incidences of restraint and seclusion.</p> <p>Recommendation 4, April 2007: Increase auditing sample size.</p> <p>Findings: ASH's progress report indicated that since August 2007, over 90% of all restraint and seclusion episodes were audited. However, data provided from the ASH Seclusion and Restraint Monitoring form for August and September 2007 does not support this.</p> <p>Recommendation 5, April 2007: Continue to monitor this requirement.</p> <p>Findings: The data provided by ASH for May-July 2007 could not be interpreted since seclusion and restraint data were combined. The data for August and September respectively indicated that 36% and 47% of restraints were not used in the absence of or as an alternative to active treatment; 36% and 47% of restraints were not used as punishment, and; 37% and 58% of restraints were not used for the convenience of</p>
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		<p>staff.</p> <p>In addition, data for August and September 2007 respectively indicated that 19% and 50% of seclusion episodes were not used in absence of or as an alternative to active treatment; 36% and 47% of seclusion episodes were not used as punishment, and; 19% and 50% of seclusion episodes were not used for the convenience of staff.</p> <p>ASH indicated that the documentation was inadequate in many instances, which accounted for the low rates of compliance. ASH's progress report indicated that in response to the low compliance rates, the SIR Documentation training class will become a mandatory annual review class for all nursing staff beginning in December 2007. However, from my review, I found that the documentation in many of the progress notes in addition to the SIRs was inadequate in describing the episodes of seclusion and/or restraint.</p> <p>From my review of the records of 15 individuals who were placed in seclusion and/or restraints (BA, AS, JB, SD, HE, GG, DH, RM, SB JW, CW, ZS, LS, RE, DQ), I found that all 15 had inadequate involvement in active treatment in Mall groups. In addition, I found documentation indicating that 10 individuals (AS, RM, SD, SB, RE, DQ, HE, BA, GG, LS) were placed in seclusion and/or restraints for staff convenience and/or for punishment.</p> <p>In the case of AS, he was placed in full-bed restraints (FBR) by his own request without staff trying alternative strategies to assist him in dealing with his feelings. There were no indications from the documentation that his WRPT was working with him to find other more appropriate and functional ways to deal with his issues rather than restraints. The application of restraints clearly was a pattern that had been developed for staff when dealing with AS.</p>
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		<p>In another example, the documentation indicated that SB was placed in wrist restraints for being "unpredictable and dangerous." However, there was no explanation of what behaviors he was demonstrating to warrant restraints. The progress notes indicated that along with walking restraints, a Posey belt was considered but not applied because SB was going to be interviewed by the admitting psychiatrist in the treatment area. Consideration of such a device should be based on the behaviors of the individual rather than on the staff's needs.</p> <p>In the case of RM, the progress notes described him as a 13-year-old trapped in a 46-year-old body and included comments that his treatment plan has fallen apart and he had ruined the unit milieu. In addition, the progress notes indicated that prior to the use of seclusion or restraints he was doing "his usual nightly routine" behaviors. He was then described as "unpredictable and dangerous." Clearly, this documentation indicated a power struggle between RM and the staff of the unit. However, in reviewing his WRP, I found no documentation addressing the "routine" behaviors that warranted seclusion and restraints.</p> <p>The case of SD was discussed extensively with the facility during this review. Numerous examples from the documentation indicated contradictions between behaviors that were documented such as sedated, sleeping, showing no remorse and concluding the note with the statement "continues highly dangerous and unpredictable."</p> <p>ASH has made a sincere commitment to decreasing the use of seclusion and restraints. They have already significantly decreased the use of these devices in a short period of time. In addition, they have acknowledged that there must be a dramatic shift in the philosophy of the staff to continue to decrease the use of seclusion and restraints. ASH's monitoring data regarding this requirement provided a more true and more accurate picture of the issues surrounding seclusion and</p>
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		<p>restraints than their data from past reviews. It is expected that better identification of the issues will facilitate change in the culture of the staff.</p> <p>Other findings: I found no documentation addressing the frequent use of restraints and/or seclusion in the WRPs for the 15 individuals noted above. In addition, there were no recommendations for strategies or changes in strategies noted on the debriefing forms for any of the episodes that I reviewed.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Initiate a system to review the WRPs of individuals frequently placed in seclusion and restraints to ensure that alternative strategies are being addressed by the teams. 2. Ensure that progress notes are reviewed along with SIRs in monitoring this requirement. 3. Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 3, April 2007:</p> <ol style="list-style-type: none"> 1. Report data regarding this requirement according to the accepted template. 3. Ensure that restraint and seclusion are not used as part of behavioral intervention. <p>Findings: ASH's progress report indicated that as of May 1, 2007, the inclusion of restraint or seclusion as an intervention in any behavioral plan was prohibited and that no behavior plans at the facility included restraint/seclusion. From my review, I found no indication that seclusion or restraints were contained in any plans.</p>

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		<p>Recommendation 2, April 2007: Revise roles of psychology/behavior and PCMC in alignment with appropriate functions of each discipline.</p> <p>Findings: ASH's progress report, validated by my discussion with the Clinical Director, indicated that the PCMC has been relegated back to its original role as defined in the Medical Staff By-Laws.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Clarify data to reflect this requirement. 2. Continue to monitor this requirement.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement interventions immediately to ensure that the use of restraints and seclusion are within appropriate guidelines and practices.</p> <p>Findings: Although ASH reported that training for this recommendation is being provided, the findings in H.2.b indicate that problematic issues continue to exist regarding appropriate guidelines and practices for the use of seclusion and restraints.</p> <p>Recommendation 2, April 2007: Develop and implement a reliable system to monitor and track this requirement.</p> <p>Findings: Data from the Seclusion/Restraint Monitor audit indicated 53% and 39% compliance for restraints and seclusion, respectively with</p>

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		<p>termination as soon as the individual was no longer an imminent danger to self or others.</p> <p>From my review of the documentation for 15 individuals who were placed in seclusion and/or restraints (BA, AS, JB, SD, HE, GG, DH, RM, SB JW, CW, ZS, LS, RE, DQ), I found that none of the restraint or seclusion episodes were terminated as soon as the individual was no longer an imminent danger to self or others. In most of the records that I reviewed, the fading procedure was used even if the individual was no longer a danger. Also, there were several instances in which the individual was sleeping and was kept in these limiting devices. As discussed with the facility during this review, this practice is not appropriate or acceptable. Once an individual is calm, they must be released from seclusion and/or restraints.</p> <p>Recommendation 3, April 2007: Retrain staff regarding restraint and seclusion guidelines and practices.</p> <p>Findings: Although ASH's progress report indicated that training on the revised AD 518, Restraint or Seclusion will be completed by the end of November 2007, the practice of using the fading procedure at the time of this review was internally acceptable. From my discussion with the facility, an agreement was made to stop this practice immediately. Consequently, training regarding restraint and seclusion needs to include this change in practice and procedure.</p> <p>Other findings: Exit criteria that were included in the physicians' orders were noted to be generic and usually stated when the individual is no longer a danger to self or others. From my discussion with the Medical Director, it was agreed that the physicians would begin to include specific exit criteria</p>
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		<p>for seclusion and restraints.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that training regarding seclusion and restraints prohibits the use of fading. 2. Ensure that exit criteria for seclusion and restraints contained in physicians' orders are specific and individualized. 3. Continue to monitor this requirement.
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Separate seclusion and restraint data.</p> <p>Findings: As of August 2007, ASH's data regarding seclusion and restraints have been separated, although prior data for May-July have been included in the data tables provided by ASH.</p> <p>Recommendation 2, April 2007: Increase audited sample size.</p> <p>Findings: Sample size audited by ASH regarding this requirement ranged from 88% to 10% for August and September.</p> <p>Recommendation 3, April 2007: Modify monitoring instrument to accurately reflect all elements of this requirement.</p> <p>Findings: The Seclusion/Restraint monitoring form reflects the elements of this requirement.</p>

		<p>Recommendation 4, April 2007: Continue to monitor this requirement.</p> <p>Findings: ASH's monitoring data for August and September indicated that 81% and 95% of the restraint and seclusion episodes respectively were assessed by a physician, registered nurse or licensed clinical professional within one hour.</p> <p>From my review of the records of 15 individuals who were placed in seclusion and/or restraints (BA, AS, JB, SD, HE, GG, DH, RM, SB, JW, CW, ZS, LS, RE, DQ) I found that all 15 were assessed within one hour by a licensed clinical professional, usually a registered nurse.</p> <p>ASH's data regarding the competency-based training for staff who administer seclusion and restraints could not be interpreted. ASH reported problems in data collection related to the legibility of signatures on the restraint/seclusion flow records.</p> <p>Other findings: The documentation contained in the restraint flow records was very difficult to read and in many cases the time of day documented on the flow records did not coincide with the times documented in the progress notes. ASH reported that they are currently in the process of revising these forms to make the documentation easier to interpret.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Provide data regarding competency-based training.2. Continue to monitor this requirement.
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<p>H.4</p>	<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 recommendations:</p> <p>Recommendation, April 2007: Continue to develop and implement a system to monitor and ensure accurate data and compliance with all elements of this requirement.</p> <p>Findings: ASH is using the ORYX system to validate data regarding seclusion and restraints and the Quick Hits system for PRN and Stat medications.</p> <p>Other findings: ASH's restraint and seclusion data from May-September 2007 indicated 45% and 73% compliance respectively regarding matching event start and stop times with the ORYX report data. In addition, ASH's data for August and September indicated a compliance rate of 98% for medical record documentation match regarding PRN data with the Quick Hits data. No data was provided regarding Stat medication accuracy.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Expand data monitoring to additional programs. 2. Evaluate reasons for low accuracy rates for seclusion and restraint data. 3. Provide data regarding accuracy of Stat data. 4. Continue to monitor this requirement.
<p>H.5</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of</p>	<p>Current findings on previous recommendation:</p>

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	<p>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>Recommendation 1, April 2007: Develop and implement a reliable trigger system to ensure that all individuals in restraints and/or seclusion are timely and regularly reviewed in alignment with this requirement.</p> <p>Findings: ASH has implemented a review of the trigger database queries by the Standards Compliance Department. In addition, the restraint/seclusion monitoring form requires a comparison of trigger data with medical record documentation. Also, the daily Nurse on Duty (NOD) log entries are compared to the daily restraint/seclusion reporting to ensure reliability. In October 2007, ASH added the trigger for this requirement to the daily Level 1 trigger report which is provided to the WRPTs.</p> <p>Recommendation 2, April 2007: Develop and implement a monitoring system to ensure that the restraint and seclusion trigger system is being used and generates the appropriate review.</p> <p>Findings: ASH activated this trigger in September and found that no individuals met the criteria for this requirement. This positive finding is largely due to the facility's recent efforts to decrease in the use of seclusion and restraint.</p> <p>Recommendation 3, April 2007: Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs 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>
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		<p>Findings: To monitor this requirement, ASH reviews the level 1 trigger report from each unit each weekday morning. As noted above, there were no individuals who met these criteria in September 2007.</p> <p>Compliance: Partial.</p> <p>Current recommendations: 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: Partial.</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 1, April 2007: Develop and implement policy/procedure to outline the facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP.</p> <p>Findings: ASH has adequately revised AD 518, Restraint and Seclusion; Nursing Policy 308, Noting Physician's Orders which specifies the required clinical justifications for PRN medications; and Nursing Policy 307.01, Administration of Oral Medications to address this recommendation.</p> <p>Recommendation 2, April 2007: Develop and implement triggers for review and follow-through by medical and nursing leadership for PRN and Stat medications.</p>

		<p>Findings: ASH has made all PRN/Stat trigger data for Program IV available for review by the professional at the Program level. Additional programs will be added to include all programs within a year. In addition, in September 2007 ASH implemented a weekly Trigger meeting that includes the Program Directors, Physicians, and Nurse Administrators to review trends and high-profile restraint/seclusion and PRN/Stat medication use. Since this meeting was only recently begun, there has been no outcomes addressed as of yet. Meeting minutes validated this assertion.</p> <p>Recommendation 3, April 2007: Develop and implement a monitoring and tracking system addressing this requirement.</p> <p>Findings: ASH is using the Nursing Administration of PRN/Stat Medication Monitoring Form, which includes the elements of this requirement.</p> <p>Other findings: The data from the Nursing Administration of PRN/Stat Medication Monitoring audit for August-September 2007 indicated 70% of behavioral PRNs are used in a manner that is clinically justified and 43% of behavioral PRNs are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</p> <p>In addition, ASH's data regarding Stat medications for the same time period indicated that 72% of Stat medications were used in a manner that is clinically justified and 36% of Stat medications were not used as a substitute for adequate treatment of the underlying cause of the individual's distress.</p>
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		<p>From my review of the records of 12 individuals who received a number of PRN medications (AS, AC, OA, FA, DB, SM, PP, RM, SD, OR, SB, RE), I noted a number of problems with the documentation of these medications. In the case of SD, the progress notes indicated that sometime during the day he had received a PRN. However, there was no initial note documenting what medication was given, when it was given, the route or the clinical justification. In the case of AS, the progress notes indicated that he had received a PRN, but no documentation of the PRN being given was found. The same issue was noted in the documentation for SB and RE. In 11 of 12 charts that I reviewed, I found deficits in the documentation that included lack of clinical justification for giving the PRN and lack of documentation of times, dosages and routes. I found adequate follow-up documented in only one record.</p> <p>From my review of the records of five individuals who received a Stat medication (JR, FA, SM, JM, RE), I found that all five had clinical justification documented. However, in most cases the documentation was nonspecific to the individuals' behaviors, instead indicating that the individual was agitated or anxious.</p> <p>A review of five individuals (RE, SRB, DQ, SRD, SNA) was conducted regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. My review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on the seclusion/restraints events.</p> <p>In the case of RE, the progress notes indicated that he was escalating to a point that warranted the use of a spit-net while he was placed in full bed restraints with a Posey belt over his thighs. The documentation indicated that he received an injection of Haldol, Ativan, and Cogentin after being placed in restraints. However, there was no indication that he was offered a PRN in the course of escalating, which</p>
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	<p>may have obviated the need for restraints.</p> <p>In the case of SRB, the progress notes indicated that he received medication for agitation. However, there was no note indicating what type of medication was given or the route. In addition, no specific behaviors were documented indicating that he was agitated. He was placed in walking restraints and staff documented that they would not apply a Posey belt because he was to be seen by the psychiatrist in the treatment room. The documentation did not indicate a need for a PRN or the use of restraints.</p> <p>The documentation for DQ indicated that he refused the offer of a PRN twice when he was becoming threatening to staff. Unfortunately DQ became loud, threatening and aggressive while in the courtyard and was placed in wrist restraints. He was escorted to the unit and placed in full bed restraints. However, the documentation did not indicate a need for full bed restraints once he was escorted out of the courtyard. In addition, the progress notes indicated that he was given thorazine (no route documented) while he demonstrated slurred speech, tremors, and a blood pressure of 140/110. There was no indication that the physician was notified of his symptoms at that time to assess if it was safe to give the thorazine in light of the existing symptoms.</p> <p>From my review of SRD's progress notes, issues regarding his limited water intake appear to be a trend related to some of his restraint episodes. However, his WRP does not address the frequent use of restraints or identified patterns related to restraints. The documentation indicated that he had received a PRN of Thorazine and Ativan earlier that day. However, there was no initial note documenting the time it was given. Consequently, there is no way of determining if it was given proactively or reactively.</p> <p>In the case of SNA, the documentation indicated that he had</p>
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		<p>requested to be placed in full bed restraints and was offered a PRN at that time. His response was that it would take too long to work so he was placed in full bed restraints. The following progress note indicated that he was given a PRN but did not indicate what medication was given or when. In addition, there was no mention in his WRP of alternative strategies to use when he requests to be placed in restraints.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to provide training to staff regarding the appropriate use and documentation of PRN and Stat medications. 2. Provide minutes of the trigger meetings. 3. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Findings: ASH's data for August-September 2007 for Program IV indicated that 24% of PRN medications (other than analgesics) were prescribed for specified and individualized behaviors.</p> <p>From my review of 30 PRN orders, I found that 26 were prescribed for generic behaviors such as agitation and aggression.</p> <p>Recommendation:</p> <ol style="list-style-type: none"> 1. Ensure that PRN medications, other than for analgesia are prescribed for specific and individualized behaviors. 2. Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	<p>Findings: ASH's data for August-September 2007 for Program IV indicated that 99% of the PRN medications prescribed were appropriately time limited. My review of 30 PRN orders found that all 30 were appropriately time-limited.</p>

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		<p>Recommendation: Continue to monitor this requirement.</p>
<p>H.6.d</p>	<p>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>	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Retrain staff regarding this requirement.</p> <p>Findings: ASH is currently training the level of care staff on Nursing Policies 307, Medication Administration and 307.0.1, Medication Administration Documentation. However, from my review of the documentation for PRN and Stat medications, the training has not yet affected practice.</p> <p>Recommendation 2, April 2007: Same as in H.6.a, Recommendation #3.</p> <p>Findings: See H.6.a.</p> <p>Recommendation 3, April 2007: Continue to monitor this requirement.</p> <p>Findings: ASH's data for August-September 2007 for Program IV indicated that for 88% of psychiatric PRN medication given, the individual was assessed within one hour of administration and that for 79% of psychiatric Stat medications given, the individual was assessed within one hour of administration.</p> <p>Due to the problems with the documentation noted from my review of PRNs (see H.6.a), I was unable to determine in a number of cases when exactly the PRN was administered. Consequently, I was not able to</p>

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		<p>determine if an assessment was conducted within one hour.</p> <p>From my review of five individuals who received a Stat medication (JR, FA, SM, JM, RE), I found that all five were assessed within one hour of administration.</p> <p>Current recommendations: Continue to monitor this requirement.</p>
H.6.e	<p>A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in D.1.</p> <p>Findings: Same as in D.1f, F.1.b and H.6.a.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	<p>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>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement competency-based training on this requirement.</p> <p>Findings: ASH provides PMAB training and medication certification training, which are competency-based.</p>

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		<p>Recommendation 2, April 2007: Develop and implement a monitoring instrument to accurately monitor this requirement.</p> <p>Findings: The data provided by ASH in their progress report did not address the monitoring system that ensures staff receive the training outlined in the EP for this requirement.</p> <p>Other findings: ASH's data indicated that 95% of staff who are required to be PMAB-certified have completed the training and that 97% of staff who are required to be medication-certified have been certified.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide data regarding monitoring system addressing this requirement. 2. Continue to monitor this requirement.
H.8	Each State hospital shall:	<p>Compliance: Partial.</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 recommendations:</p> <p>Recommendation 1, April 2007: Ensure that the policy and procedure outlining the facility's standards regarding side rail use are accurate and consistent with the requirements of the EP.</p>

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		<p>Recommendation 2, April 2007: Provide staff training regarding this requirement.</p> <p>Recommendation 3, April 2007: Provide a monitoring instrument for use during court monitor review.</p> <p>Findings: ASH revised Nursing Policy 203.1, Falls Prevention Program, adequately addressing EP requirements. In addition, ASH uses a split-type side rail only on their infirmary unit. The one individual who is currently using side rails at night has only half the rail elevated. Thus, it is not used as a restraint device.</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 recommendations:</p> <p>Recommendation 1, April 2007: Develop and implement a system to 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>Findings: See H.8.a.</p> <p>Current recommendation: Continue to monitor this requirement.</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. ASH has adopted several new Administrative Directives to guide the reporting, investigation and review of incidents and the identification of and response to triggers. 2. ASH reconstituted the Incident Management Review Committee in September 2007. The Committee has looked critically at one serious incident and identified areas of improvement and is in the process of recommending corrective/preventive measures. 3. The Department of Police Services has adopted the use of the Investigation Compliance Monitoring form that is used at the other hospitals under the EP. It has also adopted a standardized face sheet, facilitating the conduct, supervision and review of incidents. 4. DMH has made a commitment to ensure that the revised SIR definitions are included in Incident Management training and in the first two modules of that training that are used in new employee orientation. 5. The hospital has made significant progress in ensuring that staff are current in taking annual Abuse/Neglect Prevention and Reporting training. In the last five months, it has trained approximately 400 staff members who were not current. 6. ASH has made a commitment to undertake a thorough review of its incident management system to ensure the effective and efficient identification, reporting, investigation and review of incidents and the validity of the data for tracking and trending. 7. The hospital has developed procedures for identifying and monitoring triggers and has begun limited monitoring of implementation of WRPT responses.

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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. S. Jowell, Standards Compliance 2. S. Chavez, Standards Compliance 3. M. McNally, Dept. of Police Services 4. D. Landrum, Police Lieutenant 5. L. Holt, Chief of Police 6. D. Nelson, Director, Standards Compliance 7. L. Persons, Acting Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Seventeen investigations completed by the Office of Special Investigations (OSI) 2. Thirteen investigations completed by the Department of Police Services (DPS) 3. Six death investigation files 4. Seven Headquarters Reportable Brief forms 5. Mortality Review Committee minutes for April-June 2007 6. Incident Review Committee minutes for September 13 and September 27 7. AD #825: Duty to Report Abuse/Neglect of Elder/Dependent Adults and Children 8. AD #801: Department of Police Services 9. AD #807: Office of Special Investigations 10. AD #223: Incident Management Review Committee 11. Special Order #416.02: Minimum Training Standards for Hospital Police 12. Rights Acknowledgement forms for 17 individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management	<p>Compliance: Partial.</p>

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	<p>policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:</p>	
<p>I.1.a.i</p>	<p>that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue efforts to have Unit Supervisors and Program Directors review SIRs closely. 2. Match SIRs with the database entries on a sample basis regularly to check on the integrity of the data. <p>Findings: These recommendations have been implemented. SIRs are reviewed for accuracy and completeness on the unit and in Standards Compliance. The Standards Compliance reviews began in August when the department was provided additional staff for monitoring work.</p> <p>Other findings: All of the drop-down elements (check boxes) were completed accurately in the SIRs contained in the investigation files that I reviewed. This finding is consistent with the ASH data which indicates a 94% compliance rate for SIR accuracy in August and September.</p> <p>AD #825 (Abuse and Neglect Reporting), effective 8/8/2007, states, "Any staff member witnessing or suspecting an incident of patient abuse, physical, verbal, or psychological will immediately report this to his/her immediate supervisor." The requirement to report an incident "that reasonably appears to be neglect" is cited in this same Administrative Directive.</p>

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		<p>Current recommendation: Continue current practice</p>
<p>I.1.a.ii</p>	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Revise AD #518 and AD #906 as described above.</p> <p>Findings: AD #825 notes that physical abuse includes, but is not limited to, unreasonable physical constraints, chemical restraints, restraint or isolation use that does not follow the policies laid out in AD #518. This meets the intent of this recommendation as it clearly identifies the misuse of restraint and seclusion as abuse.</p> <p>Recommendation 2, April 2007: Ensure the Department receives follow-up information as required.</p> <p>Findings: No analysis of the contributing factors to the incident and no corrective actions were identified in the seven Headquarters Reportable briefing forms reviewed. In each case, the incident under review had occurred at least ten weeks earlier, allowing adequate time for completion.</p> <p>Other findings: DMH Headquarters staff reported that the Special Order (SO) governing Headquarters Reportable incidents is still being developed, as it is part of an SO covering other incident management functions as well. When completed, the SO will include timelines for the completion of various sections of the form. However, it was not the intention of DMH that hospitals not complete the forms while waiting for the SO.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. DMH Headquarters: Write and distribute the Special Order governing Headquarters Reportable incidents as expeditiously as possible. 2. ASH: Begin completing the Analysis and Corrective Actions sections of the briefing forms. The Incident Review Committee has been designated as an appropriate forum for these discussions.
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 recommendations:</p> <p>Recommendation 1, April 2007: Continue use of the Consideration of Employee Removal form.</p> <p>Findings: This form was present in several of the investigations I reviewed.</p> <p>Recommendation 2, April 2007: Further revise AD #906 as recommended above to include those instances where there is credible evidence that abuse/neglect may have occurred.</p> <p>Findings: AD #825 states that when there is reasonable suspicion that continued contact between the alleged subject and the victim "may pose a risk to the safety or quality of treatment of the victim," the investigator will complete a Consideration of Employee Removal form and hand-carry it to the Human Resources (HR) director, who will determine if removal is necessary in collaboration with the Department Head. Immediate removal of a staff member will occur in the following conditions: substantiated abuse, abuse witnessed by staff, acts of retaliation, and containment not within PMAB Training standards and "aggressive acts to individuals."</p>

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		<p>Other findings: In one investigation reviewed, the chronology of events and the logic leading to the determination by HR not to remove a staff member accused of physical abuse raises questions about the implementation of the procedures described in the AD cited above. An allegation was made by Mr. A that he was abused during a restraint on 8/27/2007. The investigation report was completed on 10/1/07 and the case was forwarded to the District Attorney. The decision not to remove the named staff member was documented as having been made on 9/14/07, which is too late in the investigation.</p> <p>Current recommendation: Review the timing and implementation of the procedure for determining whether to remove a staff member as part of the review of incidents by the Incident Management Review Committee.</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, April 2007: Continue efforts to train all staff members on A/N and keep their training status in compliance with the requirement for annual training.</p> <p>Findings: ASH reported in April 2007 that Abuse and Neglect training was not current for 566 staff members. In mid-September the number was reduced to 179, representing 11% of the staff. A review of the April data, which included the names and job titles of staff not current, indicated that 41 members of the Department of Police Services had not had A/N training within the last year. Special Order #416.02 lists the successful completion of Abuse and Neglect reporting/recognition training as one of the minimum training standards for hospital police.</p>

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		<p>Other findings: The revised SIR definitions, distributed in late July 2007, have not been incorporated into the Incident Management Training. The first two modules of that training are used for new employee orientation.</p> <p>Review of the training records of 10 staff members randomly selected while reviewing documents indicated that all had received abuse/neglect training between April and July 2007.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Add the revised definitions to Incident Management Training and distribute the revised PowerPoint presentation as quickly as possible. 2. Instruct Abuse and Neglect orientation and annual refresher trainers to teach/review the definitions with all classes. 3. Ensure that all hospital police receive annual A/N training and are familiar with the revised SIR definitions.
I.1.a.v	<p>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Review pertinent laws to determine whether interns are mandatory reporters and should sign the acknowledgement.</p> <p>Findings: The hospital determined that interns are mandatory reporters.</p> <p>Other findings: Provided a list of the names of ten staff members chosen from various sources, the hospital provided the date on which each signed the mandatory reporter acknowledgement form. All had signed the form on or before the date of hire.</p>

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		<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, April 2007: Complete the work product for informing conservators how to identify and report abuse and neglect.</p> <p>Findings: The facility has written a draft cover letter to accompany information about ASH's policies on the reporting of abuse and neglect. The letter also provides the phone number of the Office of Special Investigations, should the conservator want additional information. This draft was forwarded several months ago to the state's Protection and Advocacy main office for approval. That office had not responded at the time of our visit.</p> <p>Current recommendation: Move the task of getting approval of the letter to the Hospital Administrator, if the P&A office has not responded.</p>
I.1.a.vii	<p>posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue current practice.</p> <p>Findings: The posters on several units visited cited the name of the former Patient Rights Advocate, not the current one.</p> <p>Other findings: Review of the records of 17 individuals revealed that ASH has an</p>

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		<p>effective system for ensuring that the rights acknowledgement forms are signed annually. Fifteen individuals had signed the acknowledgement of rights form in 2007, and the annual reviews for the other two individuals were due in November.</p> <p>Current recommendation: Place the name of the current Patient Rights Advocate on the posters.</p>
I.1.a.viii	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Identify one department where all SIR and 341 reports are logged in, matched, reviewed for accuracy and completeness and from which they are forwarded to the appropriate investigative body. 2. Adequately equip this department to fulfill these responsibilities. <p>Findings: Standards Compliance Department has been expanded to include 40 staff members and has been designated as the department to log all SIRs into the database and review them for accuracy and completeness. This review began in August 2007.</p> <p>Other findings: The review of incident data indicated that all incidents are not being recorded on SIR forms and hence are not being entered into the SIR database. This will become an even more serious problem when the statewide incident management system is implemented, as that database will be the source for much of the protection from harm data. Specifically, the trigger data for August 2007 shows 11 incidents of alleged abuse/neglect/exploitation. Closer inspection reveals that all of these incidents were peer-to-peer sexual activity. The Department of Police Services (DPS) log indicates that the Office of Special Investigations opened three abuse cases during the month of August.</p>

		<p>It appears that these three cases were each recorded on an SOC 341 form (mandatory reporting of dependent adult abuse form), but not on an SIR form. Similarly, the trigger data for June 2007 cites three allegations of abuse and neglect (although the trigger asks for the number of individuals alleging abuse and neglect, the number of allegations was actually being collected and reported.) In the same month, the DPS log shows five allegations of abuse/neglect/exploitation. ASH policy requires that whenever an SOC 341 is completed an SIR must also be completed.</p> <p>The Investigation Compliance Monitoring form was revised in December 2006 to include question #30: <i>Does the investigation file include a copy of the Special Incident Report, if applicable.</i> The purpose of this question was to trigger a report to Standards Compliance whenever an SIR form was missing. This objective was not met because many of the monitoring forms were incomplete or inaccurately completed. Specifically, in the review of 13 DPS investigations, seven were problematic: two monitoring forms left questions #29 and #30 not completed, four contained only the clinical record note (which ensured the note was written but not that an SIR was completed) and one contained no note or SIR. In the five latter instances, the monitoring form erroneously indicated the SIR form was in the investigation file.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Clarify the expectation that every investigation file, whether completed by DPS (criminal cases in most instances) or by the Office of Special Investigations (administrative investigations) contain a completed SIR. 2. Institute on at least a sample basis an independent review of the investigations and monitoring forms completed by DPS and the Office of Special Investigations.
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I.1.a.ix	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue current practice.</p> <p>Findings: AD #825 states that the hospital will not tolerate any form of retaliation against any person making a good faith report of abuse. It further notes that this shall include reprimands, discipline, harassment, threats, or censure, except for appropriate counseling. Staff are expected to report threats or acts of retaliation immediately.</p> <p>Current recommendation: Examine critically for possible fear of retaliation those instances when individuals decide they no longer want an investigation into an allegation they have made or when they change their telling of the circumstances of the incident to free the staff person of any wrong-doing.</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 recommendations:</p> <p>Recommendation 1, April 2007: Stop allowing Unit Supervisors to complete investigations of allegations of abuse on their own units.</p> <p>Findings: Unit Supervisors no longer investigate allegations of abuse and neglect on their or any other units.</p>

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		<p>Recommendation 2, April 2007: Develop a procedure whereby all allegations of abuse/neglect made to the PRA are filed on an incident reporting form.</p> <p>Findings: When the Patient Rights Advocate's office informs a program that an allegation has been made that would require an SIR, the Program Director is responsible for completing the SIR.</p> <p>Recommendation 3, April 2007: Continue plans to provide investigations training to all staff who will be completing investigations and/or reviewing them.</p> <p>Findings: Incident Management training was provided on September 21, 2007 for Executive staff, Department Heads and Program Directors by the Headquarters Law Enforcement CRIPA representative.</p> <p>Recommendation 4, April 2007: Do not permit untrained staff to conduct investigations.</p> <p>Findings: The practice of permitting untrained staff to conduct investigations has ceased.</p> <p>Recommendation 5, April 2007: Develop procedures that identify improperly conducted investigations and refuse to make determinations based on flawed investigations. Redo flawed investigations from this point forward.</p> <p>Findings: Several of the 17 investigations conducted by the Office of Special</p>
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		<p>Investigations were problematic and the deficiencies were not identified on the Investigations Compliance Monitoring form. Some of the investigations completed by DPS also did not meet investigative practice standards. In each case, the Compliance Monitoring forms failed to identify the problem in these investigations. Problems associated with particular investigations are discussed in the succeeding cells.</p> <p>Recommendation 6, April 2007: Ensure that all allegations of abuse are investigated by the Office of Special Investigations.</p> <p>Findings: AD #807, effective January 16, 2007, outlines the duties of the Office of Special Investigations. The investigation of "all instances of suspected or alleged patient abuse, alleged staff misconduct, and all patient deaths" are among the duties of the Office listed.</p> <p>In the review of DPS investigations, one allegation of abuse was discovered which was not investigated by the Office of Special Investigations. Mr. A claimed that he was physically abused during an 8/27/07 restraint when staff members held him down on the bed. DPS undertook a criminal investigation of battery. Contrary to policy, there was no administrative investigation of employee misconduct by the Office of Special Investigations. After this was discovered during our visit, the Office was requested to complete an investigation.</p> <p>Recommendation 7, April 2007: Ensure that all investigations completed by the Office of Special Investigations are reviewed by the Incident Management Review Committee (described later in this report).</p>
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		<p>Findings: The Incident Management Review Committee was recently reconstituted. It began meeting in September 2007 and had at the time of our visit reviewed one incident.</p> <p>Recommendation 8, April 2007: Include in the operating procedures for the Mortality Review Committee language that states that all reports related to a death will be considered during deliberations. Document the review of these documents in the minutes.</p> <p>Findings: This recommendation has not yet been implemented. There is too little information available to determine whether the review of deaths is a comprehensive and critical search for recommendations to improve the quality of care provided to individuals.</p> <p>Other findings: The Mortality Review Committee reviewed the suicide of an individual during its April meeting and developed a list of eight questions and discussion points to be forwarded to the Medical Executive Committee. A May 24 addendum to those minutes shows six rather than eight questions/discussion points. A May 27 addendum contains no questions or discussion points, and the final minutes were approved "with the deletion of recommendations to the Medical Executive Committee." There is no explanation for the deletion and no documentation to indicate that the questions/discussion points were raised again in a forum where corrective actions could be identified and monitored.</p> <p>Current recommendation: The Court Monitor will be working with the hospitals to develop a format for Mortality Review Committee deliberations and documentation. Implementation of his recommendations should occur</p>
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		as quickly as possible.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Continue plans to provide investigation training to all persons who will be conducting investigations and reviewing investigations. 2. Ensure investigations are conducted only by trained personnel. <p>Findings: Incident Management training was provided on September 21, 2007 for Executive staff, Department Heads and Program Directors. These staff members will be reviewing investigations, some as members of the Incident Management Review Committee. All investigations are now conducted by staff of the Department of Police Services, which includes the Office of Special Investigations.</p> <p>Recommendation 3, April 2007: Provide thorough review of all investigations to ensure they meet current practice standards.</p> <p>Findings: As noted previously, the completed Investigation Compliance Monitoring Tools did not identify problems in some of the investigations reviewed. Specific problems are detailed in this report.</p> <p>Current recommendation: Implement a process whereby at least on a sample basis investigations and the monitoring tools are reviewed by staff members not associated with the Dept. of Police Services.</p>
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of	Current findings on previous recommendation:

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	<p>evidence;</p>	<p>Recommendation, April 2007: Continue current practice.</p> <p>Findings: Several investigations reviewed indicated that the investigator had secured evidence, such as photos and clinical records (in death incidents).</p> <p>Current recommendation: Continue current practice</p>
<p>I.1.b.iv</p>	<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, April 2007: Continue to expand the scope of the Incident Management Review Committee to include the identification of programmatic and systemic issues related to incidents.</p> <p>Findings: The Incident Management Review Committee has been operating only two months. It is working on identifying programmatic and systemic issues related to its first review of an investigation.</p> <p>Other findings: In four of the 13 DPS investigations reviewed, one of the critical persons in the incident was not interviewed. In these instances, a peer-to-peer altercation resulted in one individual being restrained. The restrained individual was not interviewed. This violates standard investigation protocol.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Require the interview of all persons relevant to an investigation and use the Investigation Compliance Monitoring Tool to ensure

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		<p>compliance with this expectation.</p> <p>2. Continue to expand the work of the Incident Management Review Committee to identify corrective action recommendations.</p>
I.1.b.iv.1	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Define the terms "investigation commenced" as it is used in the Investigation Compliance Monitoring Tool. Does the time measurement begin at the time of the incident or from the time the Office of Special Investigations is notified of the incident? Is the unit review being considered part of the investigation?</p> <p>Findings: ASH determined that the date on which the OSI is notified of the incident marks the beginning of the 24-hour period in which to commence an investigation.</p> <p>Other findings: All DPS investigations reviewed commenced as soon as the department was notified of a problem. There is some evidence suggesting that referrals to OSI and assignment to a Special Investigator are not timely. For example, the allegation of psychological abuse made by VC on 8/13/07 was not assigned to a Special Investigator until 9/5/07. The investigation by OSI of the death of TG (7/7/07) was delayed for five weeks pending receipt of the coroner's report. The facility reports that the delays were due to its policy of not beginning administrative investigations by the Special Investigator until criminal investigations have been completed.</p> <p>Current recommendation: Address the lack of timely initiation of OSI investigations by determining the source of the problem and taking corrective actions.</p>

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<p>I.1.b.iv. 2</p>	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Calculate the 30-business-day compliance rate using all cases closed during the month, regardless of the month they were opened.</p> <p>Findings: This recommendation has not yet been implemented.</p> <p>Other findings: A review of the incident date and date of completion of the OSI investigations reviewed revealed problems in seven investigations.</p> <table border="1" data-bbox="1003 711 1850 1130"> <thead> <tr> <th>Individual</th> <th>Incident Date</th> <th>Investigation Completed</th> </tr> </thead> <tbody> <tr> <td>AA</td> <td>6/10/07</td> <td>10/3/07</td> </tr> <tr> <td>EM</td> <td>8/7/07</td> <td>10/2/07</td> </tr> <tr> <td>MM (death)</td> <td>8/10/07</td> <td>10/5/07</td> </tr> <tr> <td>VC</td> <td>3/13/07</td> <td>9/29/07</td> </tr> <tr> <td>LS</td> <td>5/14/07</td> <td>9/2/07</td> </tr> <tr> <td>Individuals not given medications</td> <td>7/11/07 request for OSI investigation</td> <td>Not yet complete</td> </tr> <tr> <td>RJ (death)</td> <td>3/2/07</td> <td>Not yet complete</td> </tr> <tr> <td>TG (death)</td> <td>7/7/07</td> <td>8/21/07</td> </tr> </tbody> </table> <p>The DPS log of investigations indicates that as of August 31, 2007, only seven investigations had been open more than 30 days.</p> <p>Current recommendation: Calculate the number of cases not closed within 30 business days using the date open and the date closed, even when this spans more than one month.</p>	Individual	Incident Date	Investigation Completed	AA	6/10/07	10/3/07	EM	8/7/07	10/2/07	MM (death)	8/10/07	10/5/07	VC	3/13/07	9/29/07	LS	5/14/07	9/2/07	Individuals not given medications	7/11/07 request for OSI investigation	Not yet complete	RJ (death)	3/2/07	Not yet complete	TG (death)	7/7/07	8/21/07
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<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 recommendation:</p> <p>Recommendation, April 2007: Same as in I.1.b.i.</p> <p>Findings: A written investigation report was completed for all the incidents reviewed. With the exception of those cases of substantiated staff misconduct in which a recommendation was made to forward the case to Human Resources, the investigations do not contain recommendations for corrective actions. In fact, the DPS believes the identification of corrective actions is outside the scope of their responsibilities. This places a significant burden on the Incident Management Review Committee to review investigations and identify corrective actions.</p> <p>The administrative investigations completed by OSI should identify areas of concern, if not make recommendations for corrective action. To fail to alert the hospital to relevant observations made during the course of the investigation (e.g. unit observations, issues raised in interviews, record irregularities) potentially robs the administration of information pertinent to improving the quality of life at the hospital. A theoretical example should clarify my meaning. In the investigation of a peer-to-peer assault, the investigator may have determined that a single staff person was supervising 30 men waiting to enter the dining room. While the supervision ratio was not directly related to the assault, the identification of the low staffing in the investigation report as an Area of Concern alerts the hospital to the issue, and a review of the problem can be undertaken.</p> <p>Current recommendation: Identify in an appropriately labeled section of the investigation report any Areas of Concern identified during the investigation.</p>
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<p>I.1.b.iv. 3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-2, April 2007:</p> <ol style="list-style-type: none"> 1. Review investigations looking for failure to report wrongdoing. 2. Take appropriate disciplinary action when a failure to report is uncovered. <p>Findings: I saw no evidence of a failure to report wrongdoing in the investigations reviewed.</p> <p>Current recommendation: Continue to identify instances where there is reason to believe that a staff member had reason to report an incident and failed to do so.</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, April 2007: Do not overlook other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.</p> <p>Findings: This recommendation has not been implemented consistently.</p> <p>Other findings: In the physical abuse allegation made by EM on 8/7/07, the alleged use of excessive force during a restraint that led to a slight head injury requiring CT scan evaluation occurred in the hallway. There was no documentation of efforts by the investigator to identify other individuals who may have witnessed the incident. Similarly, in the investigation of the 8/16/07 incident of staff's use of vulgar,</p>

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		<p>demeaning language, there was no documentation of attempts to find other witnesses to this incident, which occurred in the dayroom. In contrast, in the investigation report of the 6/27/07 allegation of physical abuse made on behalf of SD, the investigator specifically stated that there were no other persons in the bathroom who could have witnessed the event.</p> <p>The timeliness of interviews was problematic in several of the OSI investigations reviewed and threatens the integrity of the investigations, as individuals and staff members are less able to clearly recall what occurred. Furthermore, it impedes the identification of witnesses not initially reported on the SIR. For example, in the incident cited above, although the investigation was assigned on 8/7/07, the first interview did not occur until 9/9/07. The staff person engaged in the restraint was not interviewed until 9/30/07. Each of the interviews in the investigation of the misuse of seclusion on 5/16/07 occurred a month after the event.</p> <p>Current recommendation: Conduct interviews as quickly as possible and document attempts to identify witnesses (individuals and staff) not identified on the SIR.</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, April 2007: Continue current practice.</p> <p>Findings: All investigations reviewed clearly identified the names of alleged victims and perpetrators. Two investigation reviewed that were opened the day before the review did not contain the Record Management System Form (created by the DPS software program). This form supplies critical information such as the names and titles of all persons</p>

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		<p>involved, the location, the type of incident, the date and time, etc. The two investigation files were the 9/21/07 allegation of neglect made on behalf of LM and the 9/20/07 allegation of verbal abuse made by JL.</p> <p>Current recommendation: Ensure that all DPS investigations are entered into the Record Management System as they are assigned and a copy of the data record is placed in the investigation folder as soon as the investigation is begun.</p>
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: List all relevant persons on the investigation face sheet and interview them or provide a rationale explaining why a person was not interviewed.</p> <p>Findings: All OSI investigations reviewed contained the names of all persons interviewed and a summary of the contents of the interview. As noted earlier, DPS investigations commonly did not document attempts to interview an individual who had been involved in an incident after he was removed from restraints.</p> <p>Current recommendation: Change the protocol for DPS investigations to require the interview of all relevant parties.</p>
I.1.b.iv. 3(v)	a summary of each interview;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: List all relevant persons on the investigation face sheet and interview them or provide a rationale explaining why a person was not</p>

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		<p>interviewed.</p> <p>Findings: All persons initially identified as involved in an incident were interviewed or there were plans to interview him/her in the OSI investigation reports reviewed. As noted earlier, the OSI investigations showed very limited attempts to identify additional witnesses, and the DPS investigations often failed to interview one of the relevant parties.</p> <p>Recommendation 2, April 2007: Question and document where staff was when the incident occurred.</p> <p>Findings: ASH has yet to implement this recommendation.</p> <p>Recommendation 3, April 2007: Ask follow-up questions to attempt to reconcile conflicting information.</p> <p>Findings: The investigations reviewed did not contain documentation of follow-up interviews.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Question and document where all staff were when the incident occurred, and verify whether any individuals could have seen or heard the incident. 2. Ask follow-up questions to attempt to reconcile conflicting information.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	Current findings on previous recommendation:

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		<p>Recommendation, April 2007: Continue expanding the scope of the Incident Management Review Committee to include the review of investigations and the identification of corrective/preventive measures.</p> <p>Findings: AD #223 includes these duties as part of the functions of the Incident Management Review Committee.</p> <p>Other findings: In all of the investigations reviewed, documents reviewed were clearly identified.</p> <p>Current recommendation: Continue expanding the work of the Incident Management Review Committee as described in AD #223.</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 recommendations:</p> <p>Recommendation 1, April 2007: Develop the capacity for the SI, unit supervisors and relevant administrators to review the incident history of any individual or staff member.</p> <p>Findings: This recommendation has not yet been implemented. Since Unit Supervisors are no longer doing investigations, there is no need for them to have access to the incident history of staff members.</p> <p>Recommendation 2, April 2007: Use this information appropriately to identify recommendations for corrective measures.</p>

		<p>Findings: The Incident Management Review Committee has been empowered to identify systemic and programmatic issues and recommendations for corrective and preventive measures. In the first two meetings since its reconstitution, it has worked on areas of concern and corrective and preventive measures related to one incident.</p> <p>Recommendation 3, April 2007: Reconsider the compliance rate reported on the Investigation Compliance Monitoring Forms for special investigations in light of these findings.</p> <p>Findings: The monitoring data from an approximately 58% sample of the Investigation Compliance Monitoring Forms for the DPS investigations completed in the period April through September is not consistent with my findings in several areas. The ASH data states:</p> <ul style="list-style-type: none">• 100% compliance for following standard investigative procedures.• 100% compliance in providing recommendations for corrective actions.• 100% compliance in providing a clear basis for its conclusion.• 100% compliance in identifying all staff involved <i>and present</i>.• 100% compliance with review by a supervisor to ensure thoroughness and completeness. <p>There is no data available for July, August and September 2007 for OSI investigations because, according to Lt. Landrum, OSI did not close any investigations opened within the same month during that time period. This three-month absence of data indicates that the present methods for determining which OSI investigations will be monitored and for calculating the sample need revision.</p>
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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Report monitoring data on a substantial sample of cases closed during any given month regardless of the month in which they were opened. 2. Ensure that both DPS officers and supervisors understand the rigorous standards embodied in the Investigation Compliance Monitoring form and apply those standards appropriately. 3. Ensure that a sample of investigations and monitoring forms are reviewed by a party independent of DPS. 4. Ensure that the Incident Management Review Committee reviews the investigations of staff misconduct, including allegations of abuse/neglect, and the investigations of deaths and serious injuries, regardless of the determination (substantiated or unfounded).
<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 1, April 2007: Write guidelines and incorporate them into the appropriate document that describes the conditions under which a matter is referred to HR. Include in the guidelines the documentation required, the staff member(s) responsible, and a timeline for action.</p> <p>Findings: AD #825 fulfills this recommendation.</p> <p>Recommendation 2, April 2007: Encourage the full functioning of the Incident Management Review Committee.</p> <p>Findings: The Incident Management Review Committee was reconstituted in September 2007 and has reviewed one incident during its two</p>

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		<p>September meetings. Review of the minutes of those two meetings reveal stronger analysis of problem areas in the second of the two meetings.</p> <p>Current recommendation: Continue to expand the work of the Incident Management Review Committee until it is undertaking all of its duties described in AD #223.</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, April 2007: Write summary statements providing the rationale for the disposition by addressing the substantive findings, the evidence standard and the reconciliation of conflicting evidence.</p> <p>Findings: Problems remain in the analysis of evidence and in the rationale for dispositions as described below.</p> <p>Other findings: The allegation of psychological abuse made by VC on 8/13/07 had two components: he was wrongly medicated against his will and staff made false entries in his record. The investigator did a competent job of documenting that the medication over objection was appropriate since an Involuntary Medication Order was in force. The investigator concluded that the actions of the staff related to both allegations were "justified, lawful and proper." While there was adequate evidence to support this finding as related to the involuntary medication, there was no evidence presented that the actions of staff related to record documentation met this same standard. Rather, the rationale for the disposition for this part of the allegation should have read that there was no evidence found to support the allegation of false entries.</p>

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		<p>A physician was alleged to have ordered seclusion on 5/14/07 for LS that violated the proper use of this restriction. The investigation revealed that LS (who was on 1:1 and uses a wheelchair) was sleeping at the time the seclusion order was written. The physician defended the order, saying he feared that LS would engage in annoying and disruptive behaviors such that others might harm him.; thus, the seclusion was for LS's protection. The investigator unfounded the allegation of misuse of seclusion on the grounds that LS was a danger to himself because his disruptive behavior had led to peers threatening him and because less restrictive measures had been tried and failed. Actually, LS was on 1:1 and he had not hurt anyone and had not been hurt by anyone, so there was no evidence that the enhanced observation had failed. The investigator disregarded the requirement for imminent danger.</p> <p>Current recommendation: The Incident Management Review Committee should review the investigation of the allegation of misuse of seclusion described above and determine what, if any, corrective actions are appropriate.</p>
<p>I.1.b.iv. 4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As 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</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Consider the advisability of training all Unit Supervisors, as they are the front-line responders to incidents who can identify and implement corrective measures.</p> <p>Findings: Training has been provided to Program Directors (September 2007), but not to Unit Supervisors.</p> <p>Other findings: All investigations reviewed except one (8/16/07 allegation of verbal</p>

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	standards of care.	<p>abuse by GL) were signed by a supervisor. However, as indicated, the supervision of the investigations has not consistently identified problems in completeness and thoroughness.</p> <p>Current recommendation: Consider using the Investigation Compliance Monitoring form as a supervisory tool, since it includes the elements of the EP that characterize an investigation that meets current practice standards.</p>
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement an incident management reorganization plan.</p> <p>Findings: ASH has made a commitment to undertake a top-to-bottom review of its incident management system. This review will look at procedures for ensuring that every incident is recorded on an SIR; all SIRS are accurately entered into the database, so that this database will be a source of accurate incident and key indicator data; investigations are competently completed in a timely fashion; the Incident Management Review Committee identifies corrective actions; and Headquarters Reportable Briefs are completed.</p> <p>Recommendation 2, April 2007: Continue to encourage and empower the Incident Management Review Committee to become fully operational.</p> <p>Findings: AD #223, effective October 2, 2007, defines the purpose, function and membership of the committee. This reconstituted committee began its work in September 2007 and has reviewed one incident in both of its September meetings.</p>

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		<p>Review of the findings and recommendations in this report related to the quality of the investigations should help the committee in the review of OSI investigations.</p> <p>Other findings: ASH's response to the substantiated allegation of verbal abuse of MM (6/17/07) was handled appropriately. It resulted in the reassignment of the named staff person and additional disciplinary measures.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue to expand the work of the Incident Management Review Committee so that it is fulfilling all of its functions.</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: Partial.</p>
I.1.d.i	type of incident;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Assign the production of a monthly incident report to a department, beginning by identifying who is being hurt and who is responsible for the harm and move on to more sophisticated tracking.</p> <p>Findings: ASH reported that it would begin tracking and trending incident data in November 2007. Notwithstanding, the Clinical Safety Project has produced a monthly incident tracking report.</p>

		<p>Recommendation 2, April 2007: Distribute the monthly report widely and assign the Incident Management Review Committee to review it.</p> <p>Findings: AD #223, effective October 2, 2007, cites as one of the duties of the Incident Management Review Committee the review of trends identified by Standards Compliance to "identify opportunities for improvement." There is no documentation in the minutes of the Incident Management Review Committee that it has reviewed the Clinical Safety Project data for September—the first month under the reconstituted committee.</p> <p>Other findings: The Clinical Safety Project data for April through September divides incidents into three types: Aggression, Suicide/Self-Harm, and Other. Over the six-month period, aggression has accounted for approximately 72% of incidents. In each of the six months covered, aggression to an individual was the leading incident type. In June, July and August, physical aggression to staff ranked #2. In September, #2 was Suicide/Self-Harm.</p> <p>The data related to type does not identify allegations of abuse by a caretaker, as required by the revised SIR definitions.</p> <p>Current recommendations.</p> <ol style="list-style-type: none">1. Distribute the trending data widely throughout the facility and to the Incident Management Review Committee. Accompany the numbers with a short narrative analysis.2. Conform the "type" data to the revised SIR definitions.3. Match type, location and time of incident data to help identify corrective measures.
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I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Same as I.1.b.i.</p> <p>Findings: There is no document produced regularly identifying staff who have been involved in multiple incidents.</p> <p>Current recommendation: Develop a quarterly report on staff members who have been involved in incidents. Identify any patterns.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Same as I.1.b.i.</p> <p>Findings: There is no document produced regularly that identifies individuals who have been involved in multiple incidents.</p> <p>Current recommendation: Identify individuals who are repeat aggressors and those who are repeat victims as a first step.</p>
I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as I.1.b.i.</p> <p>Findings: The Clinical Safety Project data indicates that the day hall and hallway</p>

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		<p>are the leading locations for incidents and they trade first position regularly. Seventy-nine percent of all incidents occurred in these locations in the six-month period April through September 2007.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Distribute the trending data widely throughout the facility and accompany the numbers with a short narrative analysis. 2. Match location with other incident data, e.g. type and time to enhance the hospital's ability to identify and implement corrective measures.
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as I.1.b.i.</p> <p>Findings: The Clinical Safety Project data indicates that two two-hour periods-- 8:00-10:00AM and 7:00-9:00PM--consistently accounted for approximately 40 percent of the incidents in each of the six months studied.</p> <p>Current recommendation: Gather and analyze time and day data, matching it with other incident data to identify trends and contributing factors that can be mitigated.</p>
I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation 1, April 2007: Use the new Headquarters Briefing Form to identify factors that contributed to serious incidents.</p>

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		<p>Findings: A review of eight Headquarters Reportable Briefs, all of which reported incidents that occurred at least 10 weeks prior, revealed that none of the Analysis and Corrective Actions sections of the reports had been completed.</p> <p>Recommendation 2, April 2007: Review the HQ Briefing Forms in the meetings of the Incident Management Review Committee and identify and track corrective measures.</p> <p>Findings: This recommendation has yet to be implemented.</p> <p>Other findings: The Headquarters Liaison reported that the Special Order, which in part addresses Headquarter Reportable Briefs, is still being developed. When completed, it will provide guidance on how to complete the concluding sections of the form and will provide timelines for completion.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Begin completing the concluding sections of the Headquarters Reportable Brief forms, as the identification of contributing factors is essential to the development of corrective measures. 2. DMH Central Office should continue work on the Special Order that will address Headquarters Reportable Briefs.
I.1.d.vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Ensure that the new incident management system developed by the Department includes the disposition of the case.</p>

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		<p>Findings: It is estimated that the inter-hospital Incident Management System will be operational sometime in early 2008.</p> <p>Other findings: Presently, there is no regular report on the disposition of the OSI cases or those DPS cases that have a disposition. Disposition (unfounded or substantiated) is not one of the elements of the current SIR database.</p> <p>Current recommendation: Ensure that the statewide Incident Management System includes the disposition of the investigation as a variable.</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, April 2007: Ensure that the database contains complete information on all staff members.</p> <p>Findings: This recommendation has been implemented. Figures for April through September indicate all staff members hired have been cleared.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. S. Jowell, Standards Compliance 2. S. Chavez, Standards Compliance 3. D. Nelson, Director, Standards Compliance 4. L. Holt, Chief, DPS 5. L. Person, Acting Hospital Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Aggregate Key Indicator data, SIR data, Office of Special Investigations data and Dept. of Police Services data 2. Sample of trigger reporting forms 3. Draft AD #102.5.5: Performance Improvement Program
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Partial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: IT, Standards Compliance and the Clinical Safety Project should meet to match query language to the established business rules for collecting trigger data.</p> <p>Findings: The staff person from the Clinical Safety Project involved in data collection and reporting has been reassigned to Standards Compliance, so this should no longer be a problem.</p>

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		<p>Recommendation 2, April 2007: Establish a cleaning schedule and protocol for the SIR database that includes, but is not limited to, matching SIRs with their data entries.</p> <p>Findings: Standards Compliance has undertaken this function as of August 2007. ASH reports 99% compliance for SIR accuracy and 95% data entry accuracy on a 67% sample of the SIRS for August and September.</p> <p>Current recommendations: Continue current practice.</p>
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 1, April 2007: Review recommendations regarding PCMC plans in this report and determine if the exemption from review is appropriate.</p> <p>Findings: ASH reported that the use of PCMC plans has been discontinued.</p> <p>Recommendation 2, April 2007: Establish a protocol whereby programs report semi-monthly to Standards Compliance all outstanding triggers, i.e., activated triggers where no response has been received from the unit.</p> <p>Findings: Beginning in September, the Clinical Administrator has been holding semi-monthly meetings to deal with trigger reports. Initially, the focus was on the process of collecting and monitoring data. Processes for dealing with delinquent trigger responses by WRPTs will be the subject of the meetings shortly.</p>

		<p>ASH data indicates that over August and September, 89% of the WRPTs responded to triggers, but only 29% did so in a timely manner.</p> <p>Recommendation 3, April 2007: Establish a protocol whereby the programs identify a sample of the activated trigger forms and review the implementation of the measures identified on the form. Include this information in the semi-monthly report to Standards Compliance.</p> <p>Findings: ASH is in the process of refining a draft AD (#102.5.2). This draft articulates the principles of performance improvement and the methods by which these will be realized. The Standards Compliance department is given responsibility for data aggregation and analysis.</p> <p>Other findings: ASH has only recently begun the work of monitoring the response of WRPTs to triggers on Program IV, making it far too early to make judgments on its effectiveness. The number of triggers in Program IV increased dramatically between August and September, rising from 82 to 366. (Standards Compliance monitored 322 trigger responses in September.) The early data indicates that WRPTs are responding to the triggers and are implementing a corrective action, but not in a timely manner.</p> <p>Effective August 2007, Program IV has implemented the Level 2 trigger review, which is set in motion when an individual has reached three Level 1 triggers in a 30-day period. The Level 2 trigger meeting is comprised of the Senior Psychologist, Senior Psychiatrist and Program Director. At the time of the visit, this group had addressed one individual. No individual has yet required a Level 3 review, which includes a review by the Behavioral Consultation Committee.</p>
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		<p>Current recommendation: Continue current plans to monitor the quality and the implementation of WRT responses to triggers.</p>
I.2.a.iii	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Continue work on improving the accuracy of the trigger data.</p> <p>Findings: Matching SIR data with the DPS and OSI investigation logs and trigger data revealed inconsistencies. It appears that some allegations of abuse/neglect are not included in the SIR database. There is also evidence that the number of <i>allegations</i> of abuse/neglect are being reported on the trigger data, but the business rules call for the number of <i>individuals</i>.</p> <p>Other findings: Trigger data for September for abuse/neglect shows six allegations. This number was supplied by DPS to Standards Compliance. The SIR database shows four allegations, three of which relate to peer-to-peer sexual activity.</p> <p>At the present time, because all peer-to-peer intimate sexual contact (even if consensual) is considered criminal, these contacts are counted in the trigger data as abuse/neglect/exploitation. In other hospitals, only non-consensual sexual activity is counted in this trigger. This is making hospital-to-hospital comparison unreliable.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Consider changing the business rules and eliminating the sexual activity component of the abuse/neglect/exploitation trigger statewide and collect this information as a separate trigger.

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		<p>2. Meet with all staff providing data to Standards Compliance for the protection from harm triggers to ensure they have a clear understanding of the business rules governing their data. This will be necessary until the SIR database becomes the single reliable data source of the protection from harm triggers.</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, April 2007: Identify teams for Level 2 and 3 reviews.</p> <p>Findings: See I.2.a.ii.</p> <p>Current recommendation: Continue plans to expand the role of Standards Compliance in monitoring the quality and implementation of WRPTs' responses to triggers.</p>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue work on ensuring the integrity of the data sources for the triggers, so that pattern identification and trending can begin and will provide useful information.</p> <p>Findings: As described in I.1.a.v.iii, there is confusion on the rules for counting</p>

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		<p>abuse and neglect allegations—count of individuals versus a count of allegations. This would suggest that a review of the business rules with providers of data for other sections may be necessary as well.</p> <p>Other findings: ASH has not yet undertaken pattern identification. While trends could be developed from the data collected over the past months, if ASH can not be assured of the accuracy of the data, trending would serve no purpose.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Review the business rules for data counts with all providers of data. 2. Begin looking for data patterns and trends as soon as the hospital is confident the data is accurate and reliable.
I.2.b.iii	<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, April 2007: Develop the capacity to undertake Level 2 and 3 reviews of triggers.</p> <p>Findings: This recommendation has been implemented. See I.2.a.ii.</p> <p>Other findings: The hospital has a system for notifying teams when an individual has reached a trigger. Presently the trigger database identifies the trigger, the individual and the closure date, but does not identify the actions taken. In a discussion with Standards Compliance, it was agreed that the fix described in the recommendation below would provide useful information while requiring only minimal additional work for programs.</p>

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		<p>Current recommendation: Train programs in the use of the drop-down action list in the database to identify the corrective action taken in response to a trigger.</p>
I.2.b.iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Same as in I.2.a.ii</p> <p>Other findings: See findings and recommendations for I.2.b.iii.</p> <p>Current recommendation: See I.2.b.iii.</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 recommendations:</p> <p>Recommendation, April 2007: Same as in I.2.a.ii.</p> <p>Findings: Standards Compliance has begun to audit some aspects of compliance with trigger response expectations. This has included the identification of programs which have not responded. See I.2.a.ii.</p> <p>Current recommendation: Continue with plans to expand the trigger reporting and monitoring.</p>
I.2.c	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue present work to establish components of an effective system for monitoring triggers and the hospital response.</p>

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		<p>Findings: As reported in earlier cells, ASH has begun to fully implement and monitor the trigger system in Program IV. ASH administrators reported that an off-site retreat is planned for November 2007 for strategic planning around hospital-wide data management and to identify and develop performance improvement activities.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Move forward with the strategic planning and its implementation.</p>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. S. Everett, Health and Safety Department 2. A. Joachim, Acting Nurse Administrator 3. E. Dawson, Plant Operations 4. J. Caneti, Health and Safety Department <p>These two staff supplied information as we toured the units.</p> <ol style="list-style-type: none"> 5. Four individuals 6. Four staff members <p><u>Review</u></p> <ol style="list-style-type: none"> 1. Draft AD #222: Suicide Prevention PMT 2. AD #512: Suicide/Self-Harm Prevention 3. AD #504: Personal Relationships and Sexuality Between Individuals <p><u>Toured:</u></p> <ol style="list-style-type: none"> 1. Seven units—26, 30, 25, 30 ,28 ,9 and 6.
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Review all incidents of suicide/attempted suicide, self-harm and aggression with a weapon in 2006 and forward to determine other hazards and take appropriate action.</p> <p>Findings: ASH reported that a Process Management Team will begin reviewing all incidents of suicide and self-harm to identify risks and areas for improvement.</p>

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		<p>Other findings: In response to two suicide deaths by hanging using wardrobes, the hospital took immediate action and removed the large wardrobes from bedrooms. These wardrobes had been bolted to the wall in an effort to ensure that they could not be overturned or used to barricade a bedroom door. This unintentionally created a sturdy support for hanging apparatus. The wardrobes were replaced with small lockers in the dayroom.</p> <p>The facility also replaced protruding showerheads with surface mounted ones.</p> <p>ASH has identified aggressive acts with weapons. July through September data identified seven such incidents. Responses included restraint, PRN medication, and removal of the object. Spitting was identified in four of the seven incidents.</p> <p>Other findings: The removal of wardrobes and the substitution of one-cubic-foot lockers has resulted in deterioration of individuals' personal environments. During the tour, the floor was commonly the holding place for clean and dirty clothes, food, garbage and personal materials, including hygiene supplies.</p> <p>Individuals interviewed mentioned dirty bathrooms as a problem they find distressing.</p> <p>Toilet paper holders were identified as a possible suicide hazard during the tour of the units. The hospital needs to ensure that they are no higher than 18 inches off the floor and are in a location in the stall where an individual could not freely access the holder or wedge himself between the holder and the toilet.</p>
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		<p>The mesh guards in the stairwells, and the bathroom and bedroom partitions should also be reviewed to determine how significant a hazard they present and what can be done to mitigate the risk.</p> <p>July through September data entitled Suicide Prevention Compliance indicates 98% compliance with the 25 items reviewed. One item "Area is free of devices that could be used for hanging" was graded 83%, 90% and 100% in the each of the three months respectively. This is not consistent with the findings of the tour.</p> <p>ASH is tracking the areas where environmental inspections are conducted and the date on which the plan of correction is due and when it is actually received. Two areas inspected between July and September have not responded. This represents approximately 4.5% of the inspected areas in that time period.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Include the review of suicide attempts in the duties of the Process Management Team listed in AD #222. 2. Review the toilet paper holder, partitions in bedrooms and bathrooms and the mesh guards in the stairwells to determine what can be done to lessen their potential for completing suicide. 3. Require reviewers to identify hanging hazards on the inspection forms to ensure that reviewers are all identifying the hazards.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p>Current findings on previous recommendations:</p> <p>Recommendation, April 2007: Keep a record of air temperature on the units during the hottest months of the year.</p>

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		<p>Findings: ASH provided day room temperatures for August and September. The highest temperature recorded was 78 degrees. The temperatures in the individuals' dining room were recorded in September. With the exception of September 4, when temperatures of 85-87 degrees were recorded, the temperatures recorded were comfortable.</p> <p>Other findings: When toured, the units were a comfortable temperature.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice of recording temperatures during the hottest months of the year.</p>
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Implement a procedure for assembling an accurate list of individuals who are incontinent.</p> <p>Findings: ASH has identified four individuals in Program IV who are incontinent.</p> <p>Recommendation 2, April 2007: Ensure that this issue is addressed appropriately in the individual's WRP.</p> <p>Findings: ASH data indicated that incontinence was identified in Focus #6 in the</p>

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		<p>WRPs of two of the four individuals.</p> <p>Other findings: Effective November 1, 2007, ASH will begin to identify and monitor the care of those individuals who are incontinent throughout the hospital. Training for this expansion has been scheduled for late October.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Expand, as planned, the monitoring of persons with incontinence to all units and move the monitoring beyond the review of documentation. Include an observation of the individual and conversation if possible, asking if the individual feels his needs are being met. Include these activities on the monitoring form.</p>
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>Current findings on previous recommendations:</p> <p>Recommendation 1, April 2007: Review the definition of "bartering behavior" in AD #504 to ensure it is not so broad as to prohibit all sexual expression between consenting adults.</p> <p>Findings: The hospital has determined that the definition of "bartering behavior" is appropriate.</p> <p>Recommendation 2, April 2007: Continue follow-up of sexual incidents for compliance with hospital standards.</p>

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		<p>Findings: The hospital has continued to monitor compliance with standards for handling sexual incidents. The hospital reviewed the handling of all of sexual incidents. "Nursing assessment and documentation," "medical assessment conducted," and "psychiatrist notified for evaluation of appropriate psychological care" scored most poorly. Since September 1, Standards Compliance has taken over responsibility for this monitoring from the Clinical Administrator.</p> <p>Other findings: Questions have been raised about ASH's operating assumption that all sexual contact between individuals in the hospital (even if consensual) is criminal. These incidents are commonly forwarded to the District Attorney, who chooses not to prosecute.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Seek legal advice about the status of consensual activity among individuals living at ASH and make any necessary changes in policies and procedures based on that advice. 2. Ensure physicians, psychiatrists and nurses are advised of the results of the hospital's self-monitoring of the handling of sexual incidents so that they will focus on improving performance.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with	<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Develop a curriculum so that staff who do not ordinarily provide services directly to individuals are able to facilitate/co-facilitate mall groups.</p>

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	individuals with mental health concerns.	<p>Findings: The hospital has identified 17 non-clinical staff persons who are providing Mall training. These staff are required to complete PMAC, Abuse and Neglect, BY CHOICE, and Mall Overview training. Eleven have completed all of the courses. These staff will be paired with clinical Mall providers, according to ASH administrators.</p> <p>Compliance: Partial.</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 Hospital Advisory Council, which meets monthly, is active in soliciting and addressing the concerns expressed by individuals in an organized fashion. 2. Participants in the Hospital Advisory Council Chairman's Meeting praised the administration for its responsiveness to concerns expressed through the Hospital Advisory Council. The Executive Director attended this meeting and was personally helpful to a number of individuals. 3. Participants also offered high praise for the handling of the power outage in July, citing the perception that staff and individuals were working together to get through a difficult time. 4. In response to survey results indicating that approximately 40% of the respondents had not had the terms abuse and neglect explained, the Office of Patient Rights began teaching a Mall group. The hospital will be tracking future responses to see if this figure improves.
J	<p>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>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Four staff members during the tour of the units 2. Four individuals during the tour of the units <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Quality Council Meeting Minutes <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Hospital Advisory Council Chairmans' Meeting

<p>J</p>		<p>Current findings on previous recommendation:</p> <p>Recommendation, April 2007: Continue plans to analyze the data from the surveys, present it to the appropriate bodies, and take necessary actions to address the findings.</p> <p>Findings: The results of the ASH Individual Survey were reviewed in the October 2, 2007 Quality Council Meeting. Particular attention was paid to questions related to the grievance/complaint process and resolution, whether the individual received an explanation of what is meant by abuse or neglect, and whether the individual was ever restrained as punishment. The results indicated that 75% of respondents believe the complaint process works, 61% have had abuse and neglect explained, and 57.6% answered they were restrained as punishment.</p> <p>Other findings: At the Hospital Advisory Council Chairmans' Meeting, the participants were asked for suggestions for handling future hospital-wide emergencies should they occur. Individuals praised the Town Meeting, meals on the unit, the subdued lighting, and the Executive Director's role as coach during the crisis.</p> <p>Privacy violations were discussed when female staff are assigned to monitor the bathroom. The Executive Director responded that only male staff will be given this duty.</p> <p>Dirty bathrooms and furniture in poor condition were also raised.</p> <p>Staff members interviewed offered two observations for consideration: 1) the inaccessibility of some Mall groups conducted on the second floor to individuals in wheelchairs or who find climbing stairs difficult and the fact that some groups are 1/8 of a mile away</p>
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		<p>and some men find it difficult to walk that far and 2) the main courtyard remains open during the AM Mall group time, which discourages participation.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Continue with plans to increase educational opportunities for individuals on their rights and responsibilities.</p>
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