# REPORT 7

# ATASCADERO STATE HOSPITAL

October 19-23, 2009

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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**Acronyms used in Court Monitor reports:**

| | |
|---|---|
| AA | Alcoholics Anonymous |
| ACT | Administrative Clinical Team |
| AD | Administrative Directive |
| ADCAP | Audit-Driven Corrective Action Plan |
| ADR | Adverse drug reaction |
| AIMS | Abnormal Involuntary Movement Scale |
| A/N | Abuse/Neglect |
| A/N/E | Abuse/Neglect/Exploitation |
| ASH | Atascadero State Hospital |
| ASI | Addiction Severity Index |
| A-WRP | Admission Wellness and Recovery Plan |
| BCC | Behavioral Consultation Committee |
| BG | Behavior Guidelines |
| BMI | Body Mass Index |
| CA | Clinical Administrator |
| CAC | Cooperative Advisory Council |
| CAF | Corrective Action Form |
| CASAS | Comprehensive Adult Student Assessment Systems |
| CCA | Clinical Chart Auditing |
| CDC | Centers for Disease Control and Prevention |
| CDPH | California Department of Public Health |
| CET | Consistent Enduring Team |
| CEU | Continuing Education Units |
| CHF | Congestive heart failure |
| CIS | Clinical Information System |
| CIPRTA | Comprehensive Integrated Physical Rehabilitation Therapy Assessment |
| CM | Court Monitor |
| CON | Clinical Oversight Nurse |
| COPD | Chronic Obstructive Pulmonary Disease |

| | |
|---|---|
| COT | Community Outpatient Treatment |
| COVR | Classification of Violence Risk |
| C-PAS | Central Psychological Assessment Services |
| CPR | Cardio-pulmonary resuscitation |
| CRG | Council Representative Group |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CSW | Clinical Social Worker |
| CV | Curriculum vitae (i.e. resumé) |
| DBT | Dialectical behavioral therapy |
| DCAT | Developmental and Cognitive Abilities Team |
| DMH | Department of Mental Health |
| DOJ | Department of Justice |
| DPH | Department of Public Health |
| DPS | Department of Police Services |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision) |
| DTO | Danger(ousness) to others |
| DTR | Dietetic Technician, Registered |
| DTS | Danger(ousness) to self |
| DUE | Drug Utilization Evaluation |
| Dx | Diagnosis |
| EAP | Employee Assistance Program |
| EKG | Electrocardiogram |
| EMS | Emergency Medical Service |
| EP | Enhancement Plan |
| EPPI | Enhancement Plan Performance Improvement |
| EPS | Extrapyramidal symptoms |
| ETRC | Enhanced Trigger Review Committee |
| FRP | Forensic Review Panel |
| FSP | Family Services Program |
| FSSW | Family Services Social Worker |
| FTE | Full time employee, full time equivalent |
| GAF | Global Assessment of Functioning [Score] |

| | |
|---|---|
| H&P | History and Physical [Examination] |
| HAC | Hospital Advisory Council |
| HAI | Hospital-associated infection |
| HAR | Hospital administrative resident |
| HIMD | Health Information Management Department |
| HIV | Human Immunodeficiency Virus |
| HSS | Health Services Specialist |
| HTN | Hypertension |
| IAPS | Integration Assessment: Psychology Section |
| IA-RTS | Integrated Assessment—Rehabilitation Therapy Section |
| IC | Infection Control |
| ICA | Intensive Case Analysis |
| ICF | Intermediate Care Facility |
| ICPT | Infection Control Psych(iatric) Tech(nician) |
| IDN | Inter-Disciplinary Note |
| IMRC | Incident Management Review Committee |
| INPOP | Individualized Nursing Physical/Occupational Plan |
| IPA | Integrated Assessment: Psychology section |
| IRC | Incident Review Committee |
| IT | Information Technology |
| LPS | Lanterman-Petris-Short [Act] (re involuntary civil commitment) |
| LTBI | Latent tuberculosis infection |
| LVN | Licensed Vocational Nurse |
| MAPP | My Activity and Participation Plan |
| MAR | Medication Administration Record |
| MDO | Mentally Disordered Offender |
| MFT | Marriage and Family Therapist |
| MIRC | Mortality Interdisciplinary Review Committee |
| MMSE | Mini Mental Status Examination |
| MNT | Medical Nutrition Training |
| MOD | Medical Officer of the Day |
| MOSES | Monitoring of Side Effects Scale |

| | |
|---|---|
| MPPN | Monthly Physician's Progress Note |
| MRMC | Medical Risk Management Committee |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| MSH | Metropolitan State Hospital |
| MTR | Medication and Treatment Record |
| MVR | Medication Variance Report |
| NA | Narcotics Anonymous<br>Nurse Administrator |
| N/A | Not applicable |
| NAC | North Activity Center |
| NAMI | National Alliance on Mental Illness |
| NCHPPD | Nursing care hours per patient day |
| NCMT | Nutrition Care Monitoring Tool |
| NCS | Neuropsychological Consultation Service |
| NEC | Nurse Executive Council |
| NGA | New generation antipsychotic |
| NGRI | Not guilty by reason of insanity |
| NOC | Nocturnal shift |
| NOS | Not otherwise specified |
| NP | Nursing Policy; Nurse Practitioner |
| NPO | Nulla per Os (nothing by mouth) |
| NRT | Narrative Restructuring Therapy |
| NSH | Napa State Hospital |
| NST | Nutritional Status Type |
| OSI | Office of Special Investigations |
| OT | Occupational Therapy/Therapist |
| P&P | Policy and Procedure/Policies and Procedures |
| P&T | Pharmacy and Therapeutics [Committee] |
| PAC | Psychopharmacology Advisory Committee |
| PBS | Positive Behavior Support |
| PC | Penal Code |
| PCP | Primary Care Physician |

| | |
|---|---|
| PFA | Psychology Focused Assessment |
| PHN | Public health nurse |
| PIO | Public Information Officer |
| PMAB | Prevention and Management of Assaultive Behavior |
| PMHNP | Psychiatric Mental Health Nurse Practitioner |
| PMOD | Psychiatric Medical Officer of the Day |
| POS | Physician Order System |
| POST | Physical, Occupational, and Speech/Language Pathology |
| PPD | Purified Protein Derivative (skin test for tuberculosis) |
| PPN | Physician's Progress Note |
| PRA | Patient Rights Advocate |
| PRC | Program Review Committee |
| PRN | Pro re nata (as needed) |
| PSH | Patton State Hospital |
| PSR | Psychosocial Rehabilitation |
| PSS | Psychology Specialty Services |
| PSSC | Psychology Specialty Services Committee |
| PT | Physical Therapy/Therapist (in Sections D.4 and F.4)<br>Psychiatric Technician (in Sections D.3 and F.3) |
| R&R | Rule(s) and Regulation(s) |
| RBANS | Repeatable Battery for the Assessment of Neuropsychological Status |
| RD | Registered Dietician |
| RIAT | Rehabilitation Integrated Assessment Team |
| RMS | Record Management System; Recovery Mall Services |
| RN | Registered nurse |
| RNA | Restorative Nursing Assistant |
| R/O | Rule out |
| S&R | Seclusion and Restraint |
| SA | Substance abuse; suicide attempt |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SB-5 | Stanford-Binet Intelligence Scales, Fifth Edition |
| SCD | Standards Compliance Department |

| | |
|---|---|
| SI | Suicidal ideation |
| SIB | Self-injurious behavior |
| SLP | Speech Language Pathology/Pathologist |
| SNF | Skilled Nursing Facility |
| SO | Special Order |
| SOC [341] | State of California [form used to report dependent adult/elder abuse] |
| S/P | Status post |
| S/R | Seclusion/restraint |
| SRA | Suicide Risk Assessment |
| SRT | Supervising Rehabilitation Therapist |
| SSI | Supervising Special Investigator |
| TB | Tuberculosis |
| TD | Tardive dyskinesia |
| TEC | Treatment Enhancement Coordinator |
| TMET | Therapeutic Milieu Enhancement Team |
| TSI | Therapeutic Strategies and Interventions |
| TST | Tuberculin skin test |
| URN | Utilization Review Nurse |
| VRA | Violence Risk Assessment |
| VRAT | Vocational Rehabilitation Assessment Tool |
| WAIS-III | Wechsler Adult Intelligence Scale, Third Edition |
| WaRMSS | Wellness and Recovery Model Support System |
| WRAP | Wellness and Recovery Action Plan |
| WRP | Wellness and Recovery Plan |
| WRPC | Wellness and Recovery Planning Conference |
| WRPT | Wellness and Recovery Planning Team |

## Introduction

### A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Ramasamy Manikam, PhD; Victoria Lund, PhD, MSN, ARNP; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Atascadero State Hospital (ASH) from October 19 to 23, 2009 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

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

## B. Methodology

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

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

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

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

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

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

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

## C. Statistical Reporting

The following statistical abbreviations that may be 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) |

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.

## D. Findings

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

1. Key Indicator Data

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

factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by ASH at the time of this review indicate stable or improved performance in a number of domains over the past six months.

2. Monitoring, mentoring and self-evaluation

   a. The facility has made further refinements to training and mentoring programs regarding the process and content of Wellness Recovery Planning, including the following:
      i. Initiated the "real time" reviews of draft WRPs in August;
      ii. Implemented the Mall alignment workbook;
      iii. Refined the WRP responsibilities list;
      iv. Strengthened the Metro modules with further practical examples and templates;
      v. Developed databases to track restrictive interventions and aggression; and
      vi. The Master WRP trainer provided further focused training to address behavioral incidents, the use of restrictive interventions and the content of the case formulation (Predisposing, Precipitating and Perpetuating Factors).
   b. Regarding the process of self-assessment, this monitor has requested the following:
      i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:
         - Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
         - Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
         - A review of the facility's assessment of barriers towards compliance; and
         - A plan of correction.
      ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.
      iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.
   c. ASH presented its self-assessment data and data comparisons as requested above and the facility's data appeared to be internally consistent.
   d. ASH has utilized all available DMH standardized auditing tools for all applicable sections of the EP.
   e. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.

f. The DMH has developed sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. At this juncture, there appears to be no need to develop new monitoring tools in this process. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.
g. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
h. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. At this point in the court monitoring process, all facilities should be either in compliance or on the cusp of compliance with Enhancement Plan requirements. Since the last review, ASH has made significant progress in most sections of the EP. In general, this progress met the court monitor's expectations, particularly in the following areas:
   i. The process of WRP reviews;
   ii. The content of WRPs;
   iii. Services that address subpopulations with special needs;
   iv. The quality of all disciplinary assessments;
   v. The process of medication management; and
   vi. Many other clinical services.

   This progress is outlined in each corresponding section in the body of the report.
b. The facility has made further progress in the implementation of the DMH Special Order regarding Risk Management. This progress was evident in the identification and tracking of individuals who met triggers and thresholds regarding high-risk behavior, the WRPTs' responses to these events and the documentation of second level reviews (by the Enhanced Trigger Review Committee).
c. ASH has made further progress in the implementation of the joint medical and nursing care protocols and other instruments. This monitor's interviews with some staff members and reviews of the medical and nursing documentation in the charts found evidence of progress in medical and nursing attention to the needs of individuals since the last review.
d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH continue its efforts to standardize across all hospitals the Administrative Directives that impact these services.

e. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. ASH has made significant progress towards this goal, but more progress is needed to achieve substantial compliance with EP requirements. The following is a summary outline of the current status:

i. Mall hours: Several disciplines in the acute service provided adequate numbers of facilitation/therapy hours on average during the review period. However, progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing.

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

**DMH PSR MALL HOURS**

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

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

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

ii. **Progress notes**: In recent months ASH has made progress in ensuring that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. The facility has made similar progress in ensuring that the WRPTs review these notes during the WRPCs and integrate the information in the revisions of the WRPs.

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

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

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

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

4. Staffing

The table below shows the staffing pattern at ASH as of October 1, 2009:

**Atascadero State Hospital Vacancy Totals as of 10/1/09**

| Identified Clinical Positions | Budgeted Positions 09/10 FY | Filled Positions | Vacancies | Vacancy Rate |
|---|---|---|---|---|
| Assistant Coordinator of Nursing Services | 1 | 1 | 0 | 0.00% |
| Assistant Director of Dietetics | 4 | 4 | 0 | 0.00% |
| Audiologist I | 0 | 0 | 0 | 0.00% |
| Chief Dentist, CF | 1 | 1 | 0 | 0.00% |
| Chief Physician & Surgeon, CF | 1 | 1 | 0 | 0.00% |
| Chief Central Program Services | 1 | 1 | 0 | 0.00% |
| Chief of Police Services & Security | 1 | 1 | 0 | 0.00% |
| Clinical Dietician | 12.3 | 9.1 | 3.2 | 26.02% |
| Clinical Laboratory Technologist (Safety) | 2.5 | 2.5 | 0 | 0.00% |
| Clinical Social Worker (Health Facility/S) | 64.4 | 51 | 13.4 | 20.81% |

| Atascadero State Hospital Vacancy Totals as of 10/1/09 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions 09/10 FY** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Communications Supervisor | 1 | 1 | 0 | 0.00% |
| Communications Operator | 10 | 9 | 1 | 10.00% |
| Coordinator of Nursing Services | 1 | 0 | 1 | 100.00% |
| Coordinator of Volunteer Services | 0 | 0 | 0 | 0.00% |
| Dental Assistant D/MH & DS | 3 | 3 | 0 | 0.00% |
| Dentist, D/MH & DS | 3 | 3 | 0 | 0.00% |
| Dietetic Technician (Safety) | 5.6 | 4.6 | 1 | 17.86% |
| E.E.G. Technician (Psych Tech) | 1 | 1 | 0 | 0.00% |
| Food Service Technician I | 56.5 | 49.5 | 7 | 12.39% |
| Food Service Technician II | 34 | 30 | 4 | 11.76% |
| Hospital Police Officers | 111 | 105 | 6 | 5.41% |
| Hospital Police Sergeant | 15 | 14 | 1 | 6.67% |
| Hospital Police Lieutenant | 4 | 4 | 0 | 0.00% |
| Hospital Worker | 0 | 0 | 0 | 0.00% |
| Health Record Technician | 5.3 | 4 | 1.3 | 24.53% |
| Health Record Technician II (Spec) | 6 | 4 | 2 | 33.33% |
| Health Record Technician II (Supv) | 1 | 0 | 1 | 100.00% |
| Health Record Technician III | 1 | 0 | 1 | 100.00% |
| Health Services Specialist (Safety) | 26 | 28 | -2 | -7.69% |
| Institutional Artist Facilitator | 1 | 0 | 1 | 100.00% |
| Licensed Vocational Nurse (Safety) | 2 | 2 | 0 | 0.00% |
| Medical Technical Assistant | 0 | 0 | 0 | 0.00% |
| Medical Transcriber | 12 | 11 | 1 | 8.33% |

| Atascadero State Hospital Vacancy Totals as of 10/1/09 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions 09/10 FY** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Nurse Instructor | 12 | 12 | 0 | 0.00% |
| Nurse Practitioner (Safety) | 21 | 20 | 1 | 4.76% |
| Nursing Coordinator (Safety) | 9 | 7 | 2 | 22.22% |
| Office Technician | 55 | 52 | 3 | 5.45% |
| Pathologist | 0 | 0 | 0 | 0.00% |
| Pharmacist I, D/MH & DS | 15 | 13.6 | 1.4 | 9.33% |
| Pharmacist II | 0 | 0 | 0 | 0.00% |
| Pharmacy Services manager | 1 | 1 | 0 | 0.00% |
| Pharmacy Technician, D/MH & DS | 15 | 15 | 0 | 0.00% |
| Physician & Surgeon (Safety) | 17 | 16.5 | 0.5 | 2.94% |
| Podiatrist D/MH & DS | 0 | 0 | 0 | 0.00% |
| Pre-licensed Pharmacist | 0 | 0 | 0 | 0.00% |
| Pre-licensed Psychiatric Technician (Safety) | 60 | 60 | 0 | 0.00% |
| Pre-Registered Clinical Dietician | 0 | 0 | 0 | 0.00% |
| Pre-Registered Nurse (D/MD & DS) | 0 | 0 | 0 | 0.00% |
| Program Assistant (Mental Dis-Safety) | 8 | 5 | 3 | 37.50% |
| Program Consultant (Psychology) | 0 | 0 | 0 | 0.00% |
| Program Consultant (Rehab. Therapy) | 0 | 0 | 0 | 0.00% |
| Program Consultant (Social Work) | 0 | 0 | 0 | 0.00% |
| Program Director (Mental Dis. – Safety) | 9 | 8 | 1 | 11.11% |
| Psychiatric Nursing Education Director | 1 | 1 | 0 | 0.00% |
| Psychiatric Technician (Safety) | 564.3 | 550.9 | 13.4 | 2.37% |
| Psychiatric Technician Trainee (Safety) | 49 | 31 | 18 | 36.73% |

| Atascadero State Hospital Vacancy Totals as of 10/1/09 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions 09/10 FY** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Psychiatric Technician Assistant (Safety) | 6 | 5 | 1 | 16.67% |
| Psychiatric Technician Instructor | 1 | 0 | 1 | 100.00% |
| Psychologist-HF, Clinical (Safety) | 61.1 | 48.5 | 12.6 | 20.62% |
| Public Health Nurse I (D/MH &DS) | 0 | 0 | 0 | 0.00% |
| Public Health Nurse II | 3 | 3 | 0 | 0.00% |
| Radiologic Technologist | 0 | 0 | 0 | 0.00% |
| Registered Nurse (Safety) | 287.4 | 279 | 8.4 | 2.92% |
| Rehabilitation Therapist S.F., Art-Safety | 7 | 6.5 | 0.5 | 7.14% |
| Rehabilitation Therapist S.F., Dance-Safety | 0 | 0 | 0 | 0.00% |
| Rehabilitation Therapist S.F., Music-Safety | 14 | 12 | 2 | 14.29% |
| Rehabilitation Therapist S.F., Occup-Safety | 2 | 2 | 0 | 0.00% |
| Rehabilitation Therapist S.F., Rec.-Safety | 31 | 29.8 | 1.2 | 3.87% |
| Senior Psychiatrist (Specialist) | 3 | 2 | 1 | 33.33% |
| Senior Psychiatrist, CF, (Supervisor) | 9 | 4 | 5 | 55.56% |
| Senior Psychologist, HF (Specialist) | 10 | 7 | 3 | 30.00% |
| Senior Psychologist, CF (Supervisor) | 12 | 9 | 3 | 25.00% |
| Senior Psychiatric Technician (Safety) | 85 | 75 | 10 | 11.76% |
| Sr. Radiologic Technologist(Specialist-Safety) | 1 | 1 | 0 | 0.00% |
| Senior Special Investigator I, D/MH & DS | 2 | 2 | 0 | 0.00% |
| Senior Vocational Rehab Counselor | 3 | 2 | 1 | 33.33% |
| Special Investigator I, D/MH & DS | 3 | 0 | 3 | 100.00% |
| Speech Pathologist I D/MH & DS | 0 | 0 | 0 | 0.00% |
| Staff Psychiatrist (Safety) | 66.2 | 34 | 32.2 | 48.64% |

| Atascadero State Hospital Vacancy Totals as of 10/1/09 | | | | |
|---|---|---|---|---|
| **Identified Clinical Positions** | **Budgeted Positions 09/10 FY** | **Filled Positions** | **Vacancies** | **Vacancy Rate** |
| Supervising Registered Nurse (Safety) | 2 | 2 | 0 | 0.00% |
| Teacher-Adult Educ. | 18.7 | 12 | 6.7 | 35.83% |
| Teaching Assistant | 11 | 9 | 2 | 18.18% |
| Unit Supervisor (Safety) | 31 | 25 | 6 | 19.35% |
| Vocational Services Instructor | 4 | 4 | 0 | 0.00% |
| Vocational Rehabilitation Counselor | 0 | 0 | 0 | 0.00% |

Key clinical vacancies include staff and senior psychiatrists, senior psychologists, clinical psychologists, social workers, and dieticians, and senior and trainee psychiatric technicians. Additionally, none of the facility's special investigator positions were filled as of October 1.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

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

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Atascadero State Hospital April 19-23, 2010.
2. The Court Monitor's team is scheduled to tour Patton State Hospital December 7-11, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

| **C. Integrated Therapeutic and Rehabilitation Services Planning** | | |
|---|---|---|
| | Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan. | **Summary of Progress:**<br>1. ASH has achieved substantial compliance with the process of WRP reviews by the WRPTs. This is the central requirement in section C.1.<br>2. ASH has made significant progress in the content of the WRPs, including the following areas:<br>a. Development and implementation of the interdisciplinary case formulation;<br>b. Reviews of the individual's present status, including risk factors and progress towards individualized discharge criteria;<br>c. Development of foci of hospitalization that address the individual's needs;<br>d. Development of objectives and interventions for each focus;<br>e. Revision of foci, objectives and interventions;<br>f. Addressing the needs of individuals diagnosed with cognitive impairments, including cognitive screening upon admission, assignment of individuals to groups that align with their cognitive status and development and implementation of formal and informal cognitive remediation interventions;<br>g. Development and implementation of learning-based objectives and interventions for individuals with seizure disorders;<br>h. Addressing the needs of individuals with substance use disorders, including development and implementation of objectives and interventions that align with the individual's stage of change and presenting process and clinical outcome data that verify progress made; and<br>i. Development and implementation of a process to document the individual's progress in Mall groups and ensure alignment of these groups with WRP objectives.<br>This progress was sufficient to achieve substantial compliance with more than half of the requirements in section C.2.<br>3. The progress in the process and content of Wellness and Recovery |

| | | |
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| | | Planning has been supported by training and mentoring programs that provide the foundation to sustain this progress.<br>4. The quality of Mall group provision has improved significantly. The providers knew the individuals objectives and strengths, were well prepared, and facilitated the groups with great enthusiasm and motivation. |

| 1. Interdisciplinary Teams | | |
|---|---|---|
| C.1 | The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall: | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Charlie Joslin, Clinical Administrator<br>2. Donna Nelson, Director, Standards Compliance Department<br>3. Jon DeMorales, Executive Director<br>4. Karen Dubiel, Assistant to the Clinical Administrator<br><br><u>Reviewed</u>:<br>1. Mall Realignment Workbook, May 2009<br>2. WRP Responsibilities by Discipline, July 14, 2009<br>3. Metro Modules I-V: Handouts and Knowledge Assessments, June 8, 2009<br>4. Predisposing, Precipitating and Perpetuating Factors training material<br>5. Behavioral Incidences and the WRP training material<br>6. The Wellness and Recovery Plan (WRP): Psychologist's Input training material<br>7. AD 422 Morning Motivational Meetings<br>8. ASH WRP Observation Monitoring summary data (March-August 2009)<br>9. ASH Clinical Chart Auditing Form summary data (March-August 2009)<br>10. ASH WRP Team Facilitator Observation Monitoring Form summary data (March-August)<br>11. ASH data regarding staffing ratios on admissions and long-term units (March-August 2009)<br>12. ASH vacancy totals comparison for fiscal years 2007-2009<br><br><u>Observed</u>:<br>1. WRPC (Program III, unit 21) for 14-day review of JAM<br>2. WRPC (Program III, unit 21) for 7-day review of AF<br>3. WRPC (Program III, unit 21B) for 14-day review of JWC |

| | | |
|---|---|---|
| | | 4. WRPC (Program IV, unit 2) for monthly review of AHL<br>5. WRPC (Program IV, unit 6) for 14-day review of AJY<br>6. WRPC (Program IV, unit 16) for quarterly review of CL<br>7. WRPC (Program V, unit 13A) for 14-day review of KW<br>8. WRPC (Program VI, unit 7A) for monthly review of FDT<br>9. WRPC (Program VI, unit 18) for quarterly review of JEC<br>10. WRPC (Program VII, unit 23) for monthly review of BDZ<br>11. WRPC (Program VII, unit 23B) for monthly review of LL<br>12. WRPC (Program VII, unit 30) for quarterly review of RH |
| C.1.a | Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that the current training and mentoring systems address and correct the process deficiencies outlined by this monitor [in this cell in the previous report].<br><br>**Findings:**<br>ASH indicated that the overall structure and function of its training and mentoring systems remained consistent since the previous review. The following summarizes the facility's modifications to these and associated systems during the current review period:<br><br>1. ASH reported that it developed and implemented the Mall Realignment Workbook (May 2009). WRPT members have access to the Workbook through the ASH intranet. The Workbook includes clinical examples and templates for development of foci, objectives and interventions. Additionally, it contains training relevant to the formulation of barriers to discharge.<br>2. The facility indicated that it revised the WRP Responsibilities List (July 14, 2009) to emphasize the roles of each WRPT member in addressing treatment planning related to barriers to discharge.<br>3. ASH reported that it initiated the utilization of "real time" reviews |

| | | |
|---|---|---|
| | | of draft WRPs in August 2009. The Master Trainer and Behavioral Specialists supervised by the Clinical Administrator completed the reviews and provided immediate feedback to the teams on the aspects of the WRPs that did not meet established standards. The prompt feedback facilitated revision of the WRPs.<br>4. The facility reported that it implemented the WaRMSS module related to Mall progress notes in July 2009. This system provides facilitators with automatic prompts to complete notes timely and enables WRPTs to review progress notes electronically.<br>5. ASH indicated that it developed databases to facilitate the tracking and documentation of use of restrictive interventions and aggression.<br>6. ASH revised the Metro Modules (June 8, 2009) to incorporate the following:<br>a. Practice exercises related to engagement of individuals, foci and objectives, interventions and discharge planning;<br>b. Updates to the Intervention and Response, Functional, Risk Factor, Objective, Active Interventions and Stages of Change sections of the WRP Guidelines;<br>c. Addition of templates for incorporating behavioral triggers, refusals of medical appointments and procedures, risk factors, cognitive functioning, BGs and PBS plans and By Choice points into the WRPs;<br>d. Updated examples of format to write objectives;<br>e. Clarification of stages of change (solely for Focus 5);<br>f. Additional examples of strengths;<br>g. Training on writing active interventions; and<br>h. Templates for discharge planning.<br><br>**Recommendation 2, April 2009:**<br>Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. |

| | | |
|---|---|---|
| | | **Findings:**<br>ASH reported that it generally maintained its previous training and mentoring systems. The following is a summary of additional activities during the review period:<br><br>1. ASH reported that the facility conducted weekly mentor meetings in which updates to practice and trainings, including the revised Metro Modules, were presented. Mentors, team leaders, program administrators and program directors participated in the meetings and subsequently trained their team members.<br>2. The WRP master trainer developed and facilitated training focused on formulating discharge planning for 69 team leaders and 43 of 43 (100%) unit social workers in June 2009.<br>3. The WRP master trainer developed and facilitated training focused on Psychology responsibilities in the WRP for 39 of 39 (100%) unit psychologists in July 2009.<br>4. The WRP master trainer developed and facilitated training focused on including behavioral incidences in the WRP for 44 of 44 unit and PBS psychologists (100%) in August 2009.<br>5. The WRP master trainer developed and facilitated training focused on Predisposing, Precipitating and Perpetuating Factors for 96 of 117 (82%) of team leaders, mentors and team recorders in September 2009.<br><br>**Recommendation 3, April 2009:**<br>Ensure that all core WRP staff and their supervisors complete training on the WRP modules and provide data comparing percentage complete during the current and last reporting periods.<br><br>**Findings:**<br>The facility presented the following data on training completion: |

| Overview training | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 98% | 95% |
| PhD | 100% | 97% |
| SW | 99% | 100% |
| RT | 100% | 99% |
| RN sponsors | 99% | 99% |
| PT sponsors | 99% | 99% |

| Engagement | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 97% | 92% |
| PhD | 97% | 98% |
| SW | 93% | 100% |
| RT | 93% | 100% |
| RN sponsors | 74% | 97% |
| PT sponsors | 75% | 97% |

| Foci and Objectives | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 94% | 89% |
| PhD | 98% | 98% |
| SW | 92% | 100% |
| RT | 95% | 100% |
| RN sponsors | 75% | 98% |
| PT sponsors | 75% | 97% |

| Interventions and Mall Integration | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 97% | 93% |
| PhD | 94% | 98% |
| SW | 92% | 100% |
| RT | 94% | 100% |
| RN sponsors | 76% | 97% |
| PT sponsors | 75% | 96% |

| Discharge Planning | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 96% | 93% |
| PhD | 96% | 98% |
| SW | 93% | 100% |
| RT | 95% | 100% |
| RN sponsors | 76% | 98% |
| PT sponsors | 77% | 97% |

| Case Formulation | | |
|---|---|---|
| Discipline | Previous review | Current review |
| MD | 96% | 92% |
| PhD | 97% | 98% |
| SW | 93% | 100% |
| RT | 96% | 100% |
| RN sponsors | 76% | 98% |
| PT sponsors | 75% | 97% |

**Recommendations 4 and 5, April 2009:**

- Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low

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

**Findings:**
Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WPRCs held each month (March – August 2009):

| | | |
|---|---|---|
| 1. | *Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care* | 65% |
| 2. | *Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services* | 74% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 10% | 65% |
| 2. | 56% | 74% |
| Compliance rate in last month of period | | |
| 1. | 23% | 98% |
| 2 | 69% | 96% |

**Recommendation 6, April 2009:**
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.

| | | |
|---|---|---|
| | | **Findings:**<br>See Findings for Recommendations 1 and 2 above.<br><br>**Other findings:**<br>The monitor and his experts attended (in person or by phone) 12 WRPCs. By and large, the meetings verified that the facility has achieved substantial compliance with EP requirements regarding the process of WRP reviews and adequately addressed the deficiencies that were outlined in previous reports.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period.<br>2. Continue to monitor this requirement. |
| C.1.b | Be led by a clinical professional who is involved in the care of the individual. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using WRP Observation and WRP Team Facilitator Observation Monitoring Forms based on samples of 20% and 100%, respectively.<br>• Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 23% of the quarterly and |

annual WRPCs held each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *Each team is led by a clinical professional who is involved in the care of the individual:* | 99% |

Comparative data indicated improvement in compliance from 84% in the previous review period.

The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 71% of the required observations (two WRPC observations per team per month) during the review period:

| | | |
|---|---|---|
| 1. | *The team psychiatrist was present during the WRP conference.* | 94% |
| 2. | *The team facilitator encouraged meaningful participation of all disciplines.* | 97% |
| 3. | *The discussion of the clinical data was substantially incorporated into the Present Status section.* | 94% |
| 4. | *The interventions reviewed were linked to the objectives.* | 85% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 92% | 94% |
| 2. | 94% | 97% |
| 3. | 68% | 94% |
| 4. | 65% | 85% |

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th colspan="3">Compliance rate in last month of period</th></tr>
<tr><td>4.</td><td>69%</td><td>100%</td></tr>
</table>
<br>
Recommendation 3, April 2009:<br>
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>
Findings:<br>
The facility's corrective actions are summarized in C.1.a.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Function in an interdisciplinary fashion.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>
Findings:<br>
Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPCs held each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>2.</td><td>Each team functions in an interdisciplinary fashion.</td><td>98%</td></tr>
</table>
</td>
</tr>
</table>

| | | |
|---|---|---|
| | | Comparative data indicated improvement in compliance from 64% in the previous review period.<br><br>**Recommendation 3, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>The facility's corrective actions are summarized in C.1.a.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.1.d | Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using Clinical Chart Audit form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Clinical Chart Audit, ASH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>1. *Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and* — 65% |

| | | |
|---|---|---|
| | *appropriate psychiatric and medical care.* | |
| 1.a | *The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)* | 57% |
| 1.b | *A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)* | 73% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 9% | 65% |
| Compliance rate in last month of period | | |
| 1. | 23% | 98% |
| 1.a | 34% | 97% |
| 1.b | 49% | 98% |

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

**Findings:**
The facility's corrective actions are summarized in C.1.a.

**Compliance:**
Partial.

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.1.e</td><td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPCs held each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>3.</td><td>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services.</td><td>92%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance from 59% in the previous review period.<br><br>Recommendation 3, April 2009:<br>Provide a summary outline of improvements in practice made as a result of the facility’s review of internal monitoring data.</td></tr>
</table>

| | | |
|---|---|---|
| | | **Findings:**<br>The facility's corrective actions are summarized in C.1.a.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.1.f | 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. | **Current findings on previous recommendation:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>ASH used the DMH Observation Monitoring Form to assess its compliance. The mean compliance rate increased to 93% from 51% during the previous review.<br><br>**Recommendation 3, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>The facility's corrective actions are summarized in C.1.a.<br><br>**Compliance:**<br>Substantial. |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.1.g</td><td>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>
Findings:<br>
Using the DMH WRP Observation Monitoring Form, ASH assessed its compliance based on an average sample of 23% of the quarterly and annual WRPCs held each month during the review period (March-August 2009):
<table>
<tr><td>5.</td><td>The WRPT identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td><td>99%</td></tr>
</table>
Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.<br><br>
Recommendation 3, April 2009:<br>
Provide a summary outline of improvements in practice made as a result of the facility’s review of internal monitoring data.<br><br>
Findings:<br>
The facility’s corrective actions are summarized in C.1.a.
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.1.h</td><td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1, 2 and 3, April 2009:<br>• Ensure vacancies are filled and improve core members' attendance at WRPCs.<br>• Monitor this requirement using process observation based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>ASH presented core WRPT member attendance data based on an average sample of 23% of quarterly and annual WRPCs held during the review period (March-August 2009). The following table is a summary of attendance:<br><br>
<table>
<tr><td></td><td>Previous review period</td><td>Current review period</td></tr>
<tr><td>Individual</td><td>95%</td><td>93%</td></tr>
<tr><td>Psychiatrist</td><td>88%</td><td>94%</td></tr>
<tr><td>Psychologist</td><td>72%</td><td>65%</td></tr>
<tr><td>Social Worker</td><td>73%</td><td>70%</td></tr>
<tr><td>Rehabilitation Therapist</td><td>75%</td><td>75%</td></tr>
<tr><td>Registered Nurse</td><td>92%</td><td>97%</td></tr>
<tr><td>Psychiatric Technician</td><td>68%</td><td>81%</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td></td><td>Compliance:<br>Partial.<br><br>Current recommendation:<br>Continue efforts to increase attendance of WRPT members at WRPCs.</td></tr>
<tr><td>C.1.i</td><td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Ensure compliance with the required ratios on the long-term units.<br>• Provide data regarding case loads on both the admission and long-term units.<br><br>Findings:<br>The facility provided the following data on average case load ratios:
<table>
<tr><td></td><td>Previous review period</td><td>Current review period</td></tr>
<tr><td></td><td colspan="2">Admission Units</td></tr>
<tr><td>MDs</td><td>1:13</td><td>1:12</td></tr>
<tr><td>PhDs</td><td>1:15</td><td>1:18</td></tr>
<tr><td>SWs</td><td>1:13</td><td>1:14</td></tr>
<tr><td>RTs</td><td>1:14</td><td>1:13</td></tr>
<tr><td>RNs</td><td>1:5</td><td>1:6</td></tr>
<tr><td>PTs</td><td>1:4</td><td>1:4</td></tr>
<tr><td></td><td colspan="2">Long-Term Units</td></tr>
<tr><td>MDs</td><td>1:23</td><td>1:21</td></tr>
<tr><td>PhDs</td><td>1:32</td><td>1:42</td></tr>
<tr><td>SWs</td><td>1:30</td><td>1:36</td></tr>
<tr><td>RTs</td><td>1:37</td><td>1:37</td></tr>
<tr><td>RNs</td><td>1:10</td><td>1:10</td></tr>
<tr><td>PTs</td><td>1:5</td><td>1:5</td></tr>
</table></td></tr>
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| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure compliance with the required ratios on the admission and long-term units.<br>2. Provide data regarding case loads on both the admission and long-term units. |
| C.1.j | Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as C.1.a through C.1.f.<br><br>**Findings:**<br>Same as C.1.a through C.1.f.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Same as C.1.a through C.1.f. |

| 2. Integrated Therapeutic and Rehabilitation Service Planning (WRP) | | |
|---|---|---|
| | Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that: | **Methodology**<br><br>Interviewed:<br>1. Brooke Hatcher, RT, Supplemental Activities Coordinator<br>2. Charlie Joslin, Clinical Administrator<br>3. Christine Mathiesen, PhD, C-PAS Director<br>4. Deborah Hewitt, PhD, PBS Team Member<br>5. Debra Crawford, LCSW, Senior Supervising Social Worker<br>6. Ed Bischoff, PhD, DCAT member<br>7. Erin Dengate, Assistant Director of Dietetics<br>8. Karen Dubiel, Assistant to the Clinical Administrator<br>9. Kathy Runge, Occupational Therapist<br>10. Killorin Riddell, PhD, Coordinator of Psychology Specialty Services<br>11. Ladonna Decou, Chief of Rehabilitation<br>12. Makoto Ono, PhD, Psychologist<br>13. Mary Marble, PT, BY CHOICE staff<br>14. Matthew Hennessy, PhD, Mall Director<br>15. Michael Ostash, LCSW, Senior Supervising Social Worker<br>16. Michael Tandy, PhD, PBS Team Member<br>17. Peggy Hoshino, PT, BY CHOICE staff<br>18. Rachelle Rianda, Acting Senior Rehabilitation Therapist<br>19. Rafael Romero, U.S, BY CHOICE Coordinator<br>20. William Hellum, MA, MFT, Substance Abuse Recovery Coordinator<br><br>Reviewed:<br>1. The charts of the following 100 individuals: AC, ADG, ADH, AF, AH, AHC, APL, ARM, ATB, AWD, AWS, BEC, BLB, CAP, CEF, CV, DBL, DH, DLA, DLT, DMM, DPP, DS, DS-2, DS-3, DS-4, DWH, EC, ECF, FFM, GEC, HFH, JAD, JB, JCG, JDC, JEC, JGC, JHG, JJ, JJS, JLP, JM, JM-2, JM-3, JS, JSN, JWC, JWO, KAT, KSH, LA, LCR, LEB, LF, LH, LTB, MAE, MBO, MD, MG, MG-2, MH, MJG, MJL, MK, MM, MT, MWT, NWC, OR, PN, PPD, PSJ, PWM, RAC, RC, RGP, RH, RJB, RJL, |

| | | |
|---|---|---|
| | | RMJ, ROL, ROS, SDG, SFV, SJC, SSS, SW, TAK, TB, TFA, TG, TLC, TMH, TN, VC, VP, WTM and YG<br>2. Course outline and lesson plan for Attention, Concentration and Tracking PSR Mall Group<br>3. Course outline and lesson plan for Finding Solutions PSR Mall Group<br>4. Course outline and lesson plan for Get With It PSR Mall Group<br>5. Course outline and description for Language and Cognitive Services PSR Mall Group<br>6. Course outline and lesson plan for Ready, Set, Go PSR Mall Group<br>7. Course outline and lesson plan for Spongebrain<br>8. Course outline and lesson plan for Sport Stacking Challenge PSR Mall Group<br>9. Course outline and lesson plan for You Got Brain PSR Mall Group<br>10. DMH WRP Observation Monitoring Form<br>11. ASH WRP Observation Monitoring summary data (March-August 2009)<br>12. ASH Clinical Chart Auditing Form summary data (March-August 2009)<br>13. DMH Chart Auditing Form<br>14. DMH Chart Auditing Form instructions<br>15. ASH Chart Auditing Form summary data (March-August 2009)<br>16. ASH Substance Abuse Auditing Form summary data (March-August 2009)<br>17. Data regarding types of medication education groups and individuals enrolled<br>18. Memorandum from Hadley Osran, MD to Robert Knapp, MD, Medical Director regarding Mall group concerns<br>19. Mall schedule<br>20. ASH Mall Restructuring Plan<br>21. Mall Course Provider Survey<br>22. All PBS plans completed and implemented during the last six months<br>23. Monthly fidelity of implementation data for PBS plans<br>24. Quantitative baseline and outcome data on active PBS plans and |

| | | |
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| | | Behavior Guidelines<br>25. List of individuals assessed to need family therapy<br>26. List of individuals who have a diagnosis of a disorder affecting cognitive functioning<br>27. List of Mall curricula<br>28. List of scheduled supplemental activities<br>29. List of scheduled vs canceled appointments<br>30. PSR Mall Facilitator Consultation Checklists<br>31. Psychosocial Enrichment Activity List<br>32. Family Therapy Needs Assessment Survey<br><br><u>Observed</u>:<br>1. WRPC (Program III, unit 21) for 14-day review of JAM<br>2. WRPC (Program III, unit 21) for 7-day review of AF<br>3. WRPC (Program III, unit 21B) for 14-day review of JWC<br>4. WRPC (Program IV, unit 2) for monthly review of AHL<br>5. WRPC (Program IV, unit 6) for 14-day review of AJY<br>6. WRPC (Program IV, unit 16) for quarterly review of CL<br>7. WRPC (Program V, unit 13A) for 14-day review of KW<br>8. WRPC (Program VI, unit 7A) for monthly review of FDT<br>9. WRPC (Program VI, unit 18) for quarterly review of JEC<br>10. WRPC (Program VII, unit 23) for monthly review of BDZ<br>11. WRPC (Program VII, unit 23B) for monthly review of LL<br>12. WRPC (Program VII, unit 30) for quarterly review of RH<br>13. PSR Mall group: Anger Management<br>14. PSR Mall group: Cognitive Restructuring--Sponge Brain<br>15. PSR Mall group: Commitment to Change<br>16. PSR Mall group: Depression Group (Spanish Language)<br>17. PSR Mall group: Mental Health Wellness<br>18. PSR Mall group: Supported Treatment Assisted Recovery (STAR)<br>19. PSR Mall group: Wellness and Recovery Action Planning (WRAP) |

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| C.2.a | Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue current training and mentoring regarding engagement of individuals, including both the WRP modules and TMET trainings.<br><br>**Findings:**<br>ASH reported that the facility continued to provide TMET training during the review period. In addition, ASH reported that during September 2009 it implemented daily Morning Motivational Meetings on each unit. The meeting is intended to provide individuals with information needed to achieve their daily goals and to provide staff the opportunity to assess each individual on the unit to determine what supports he might need to be successful during the day.<br><br>**Recommendation 2, April 2009:**<br>Provide comparative data from previous to current review period related to percentage of staff who have successfully completed TMET trainings.<br><br>**Findings:**<br>ASH indicated that 100% of units were trained in TMET, compared to 40% during the previous review. The facility indicated that it trained 853 staff members in TMET during the previous two review periods, and 277 staff still require training.<br><br>**Recommendations 3 and 4, April 2009:**<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

**Findings:**
Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 23% of the WRPCs held each month during the review period (March-August 2009). The following table summarizes the data:

| | | |
|---|---|---|
| 6. | *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.* | 88% |
| 6.a | *The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.* | 86% |
| 6.b | *When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.* | 83% |
| 6.c | *The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.* | 95% |
| 6.d | *When the individual identifies cultural preferences, the team updates the case formulation and August incorporate them into the individual's WRP objectives and interventions, as relevant.* | 90% |

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

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<tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>47%</td><td>88%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>43%</td><td>95%</td></tr>
<tr><td>6.a</td><td>57%</td><td>100%</td></tr>
<tr><td>6.b</td><td>44%</td><td>83%</td></tr>
<tr><td>6.c</td><td>68%</td><td>96%</td></tr>
<tr><td>6.d</td><td>50%</td><td>100%</td></tr>
</table>
<br>
Recommendation 5, April 2009:<br>
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>
Findings:<br>
The facility's corrective actions are summarized in C.1.a.<br><br>
Compliance:<br>
Partial; improved compared to last review.<br><br>
Current recommendations:<br>
1. Provide a summary outline of changes in WRPT training and mentoring regarding engagement of individuals during the reporting period.<br>
2. Provide comparative data from previous to current review period related to percentage of staff who have successfully completed TMET training.<br>
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
</td>
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<tr>
<td>C.2.b</td>
<td>Therapeutic and rehabilitation service planning provides timely attention to the needs of each</td>
<td>Please see sub-cells for compliance findings.</td>
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| | | |
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| | individual, in particular: | |
| C.2.b.i | initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br><br>**Findings:**<br>ASH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (March-August 2009). Based on an average sample of 23% of the A-WRPs, the facility reported a mean compliance rate of 98%, compared to 90% in the previous review period.<br><br>**Other findings:**<br>A review of the charts of 10 individuals (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB) found compliance in all cases.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.b.ii | master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br><br>**Findings:**<br>Based on an average sample of 23% of the 7-day WRPs, the facility reported a mean compliance rate of 97% with this requirement, compared |

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<td>to 90% in the previous review period.<br><br>Other findings:<br>A review of the charts of 10 individuals (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB) found compliance in all cases.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td>
</tr>
<tr>
<td>C.2.b.iii</td>
<td>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.</td>
<td>Current findings on previous recommendations:<br><br>Recommendations 1, 2 and 3, April 2009:<br>• Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>Findings:<br>The following is a summary of the facility's data:
<table>
<tr><th>WRP Review</th><th>Mean sample size</th><th>Mean compliance rate</th></tr>
<tr><td>14-Day</td><td>23%</td><td>98%</td></tr>
<tr><td>Monthly</td><td>20%</td><td>98%</td></tr>
<tr><td>Quarterly</td><td>21%</td><td>99%</td></tr>
<tr><td>Annual</td><td>22%</td><td>96%</td></tr>
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| | | Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period for the 14-day and monthly reviews, and improved compliance for the quarterly and annual reviews from 81% and 85% respectively in the previous review period.<br><br>**Other findings:**<br>A review of the charts of 10 individuals (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB) found compliance in all cases.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.c | Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services; | **Current findings on previous recommendations:**<br><br>**Recommendations 1, April 2009**<br>Stratify sample based on specific diagnoses to ensure adequate sample size for valid calculations.<br><br>**Findings:**<br>ASH stratified the samples for each of the indicators below.<br><br>**Recommendation 2, April 2009:**<br>Implement adequate corrective actions to address the deficiencies outlined by this monitor [in this cell in the previous report].<br><br>**Findings:**<br>The following summarizes the facility's corrective actions during the current review period:<br><br>1. ASH ensured that a cognitive screen was completed for each |

individual, from which the individual's level of support was identified.

2. Recovery Mall Services increased the frequency of cognitive remediation groups from 18 to 29 hours per week.
3. Starting in May 2009, an ASH neurologist reviewed individuals diagnosed with seizure disorders to establish morphological diagnoses.
4. Nursing Services completed a chart audit for all individuals diagnosed with seizure disorders in order to provide information to the WRPT for treatment planning (August 2009).

**Recommendations 3 and 4, April 2009:**

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

**Findings:**

ASH assessed compliance using the DMH WRP Clinical Chart Auditing Form. The average sample ranged from 23% to 99% of the relevant population for each sub-indicator during the review period (March-August 2009). The facility provide data related to sub-indicators, but not the main indicator:

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| 2. | *Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.* | |
| 2.a | *When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.* | 54% |
| 2.b | *When substance abuse is identified on Axis I, it is* | 91% |

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| | *written in Focus 5, and has at least one objective with an appropriately linked intervention.* | |
| 2.c | *When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.* | 79% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2.a | 19% | 54% |
| 2.b | 60% | 91% |
| 2.c | 42% | 79% |
| Compliance rate in last month of period | | |
| 2.a | 0% | 92% |
| 2.c | 33% | 100% |

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

**Findings:**
Same as findings for Recommendation 2 in C.2.c.

**Other findings:**
This monitor reviewed the charts of several individuals who were diagnosed with a variety of cognitive and seizure disorders. The reviews found evidence of significant progress in the following areas:

1. Documentation of adequate learning-based objectives and interventions to address the needs of most individuals diagnosed with

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| | | dementing illnesses and seizure disorders;<br>2. Decreased use of long-term treatment with anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments;<br>3. Adequate documentation of the present status of most individuals diagnosed with dementing illnesses and seizure disorders;<br>4. Documentation of adequate formal cognitive remediation interventions for most individuals diagnosed with cognitive disorders, including, but not limited to, the following examples:<br>a. Drug-Induced Persisting Dementia (ADH and TLC);<br>b. Dementia Due to Head Trauma (LF);<br>c. Mild Mental Retardation (AWS); and<br>d. Mental Retardation, Severity Unspecified (PWM);<br>5. Documentation of adequate informal cognitive strategies for most individuals diagnosed with cognitive impairments; and<br>6. Documentation of timely neurological consultation to address the needs of individuals who suffered recurrent seizure activity during hospitalization (e.g. ATB).<br><br>The review found a few process deficiencies as follows:<br><br>1. Individuals diagnosed with cognitive impairments (ADH, ATB, AWS, LF, MD, PWM, SW and TLC):<br>a. The present status section of the case formulation did not document the status of an individual diagnosed with Drug-Induced Persisting Dementia (ADH).<br>b. One WRP did not provide adequate clinical formulation to differentiate manifestations of malingering from those of Dementia of the Alzheimer type (MD).<br>c. The psychiatric progress notes did not provide adequate rationale to justify long-term treatment with clonazepam for an individual diagnosed with Mild Mental Retardation (AWS).<br>2. Individuals diagnosed with seizure disorders (ATB, CV, DH, LEB, LF |

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| | | and SW):<br>a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in any of the charts reviewed. (This deficiency is more relevant to requirements in section F.7.)<br>b. A WRP included an objective statement that was vague and not based on appropriate learning outcomes (LEB).<br>c. The linkage between the focus of hospitalization and the objectives and interventions listed for few individuals (ATB and SW) was unclear.<br>d. In one individual who was diagnosed with Borderline Intellectual Functioning, the WRP did not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medication (phenytoin) and to minimize its impact on the individual's behavioral and cognitive status (ATB).<br>e. None of the WRPs reviewed addressed the possible negative impact of treatment with old generation anticonvulsant medications on the individual's life quality.<br><br>Based on these reviews there was evidence of substantial compliance in six charts (ADH, AWS, CV, LF, PWM and TLC) and partial compliance in five (ATB, DH, LEB, MD and SW).<br><br>**Compliance:**<br>Partial, improved compared to the last review.<br><br>**Current recommendations**:<br>1. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>2. Address the process deficiencies outlined by this monitor regarding the care of individuals diagnosed with seizure disorders as part of EP requirements in section F.7.a. |

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| C.2.d | Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall: | **Compliance:**<br>Partial; improved compared to the last review. |
| C.2.d.i | be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue training on the Case Formulation Module to all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor [in this cell in the previous report].<br><br>**Findings:**<br>ASH reported that it developed the "data dashboard", a database designed to facilitate the tracking of use and documentation of restrictive interventions. Additionally, the facility's training activities are described in C.1.a.<br><br>**Recommendations 2, 3 and 4, April 2009:**<br>• Monitor this requirement using the DMH WRP Clinical Chart Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 20% of the quarterly and |

annual WRPs due each month during the review period (March-August 2009):

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| 3. | *The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.* | 87% |
| 3.a | *Diagnostic and/or treatment planning implications derived from assessments and consultations are incorporated into the case formulation, and* | 76% |
| 3.b | *The case formulation indicates interdisciplinary participation and is not written from the point of view of one discipline.* | 98% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 17% | 87% |
| Compliance rate in last month of period | | |
| 3. | 55% | 99% |
| 3.a | 57% | 98% |

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

**Other findings:**
Chart reviews and WRPCs attended by this monitor and his consultants indicated that ASH has maintained progress noted during the last review in the organization and content of the Present Status section of the case

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| | | formulation.<br><br>This monitor reviewed the charts of 15 individuals (CAP, DWH, EC, LA, LCR, MM, MWT, PPD, RAC, RJL, ROS, SSS, TFA, TMH and VC). The review found general evidence of significant progress in both structure and content of information. This progress included adequate correction of the deficiencies that were outlined in the previous report regarding the following areas:<br><br>1. Linkages within the 6-components of the case formulation;<br>2. Linkage between the information in the case formulation and the individual's life goals and strengths as utilized in the objectives and interventions;<br>3. Documentation (in the Present Status section) of the WRPT's discussion of the barriers towards discharge and the individual's progress towards individualized discharge criteria; and<br>4. Documentation (in the Present Status section) of the use of restrictive interventions.<br><br>The review found that the facility has yet to make progress in ensuring that planned modifications to treatment in response to the use of restrictive interventions are documented in the Present Status section.<br><br>The facility is currently in the process of streamlining the content of the case formulation. In order to achieve/maintain substantial compliance, the facility needs to ensure the following:<br><br>1. Unnecessary duplication of historical information in the case formulation and the review and analysis of the use of restrictive interventions is eliminated;<br>2. The analysis of the use of restrictive interventions includes discussion of planned modifications to interventions in order to reduce future risk; and |

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<td>3. The review and discussion of risk factors is limited to those factors that are relevant to the individual's status.<br><br>Current recommendation:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
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<tr>
<td>C.2.d.ii</td>
<td>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</td>
<td>
<table>
<tr><td>4.</td><td>The case formulation includes a review of pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history; and present status.</td><td>69%</td></tr>
<tr><td>4.a</td><td>Clinical outcomes and responses to treatment in the previous three (3) months described in clinical notes are incorporated into the case formulation.</td><td>80%</td></tr>
<tr><td>4.b</td><td>Information recorded in the "interventions and Response" tab in the Present Status for the previous three (3) months (for a quarterly WRP) or for the previous 12 months (for an annual WRP) has been summarized in the Previous Treatment Section of the Case Formulation.</td><td>57%</td></tr>
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Comparative data indicated improvement in compliance since the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>3%</td><td>69%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>11%</td><td>98%</td></tr>
<tr><td>4.a</td><td>48%</td><td>100%</td></tr>
<tr><td>4.b</td><td>15%</td><td>95%</td></tr>
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<tr><td>C.2.d.iii</td><td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td><td>
<table>
<tr><td>5.</td><td>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</td><td>99%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 61% in the previous review period.
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<tr><td>C.2.d.iv</td><td>consider such factors as age, gender, culture, treatment adherence, and medication issues that August affect the outcomes of treatment and rehabilitation interventions;</td><td>
<table>
<tr><td>6.</td><td>Consider such factors as age, gender, culture, treatment adherence, and medication issues that August affect the outcomes of treatment and rehabilitation interventions</td><td>85%</td></tr>
<tr><td>6.a</td><td>All five factors: age, gender, culture, treatment adherence, and medication issues (are included)</td><td>97%</td></tr>
<tr><td>6.b</td><td>(The formulation) addresses how they affect treatment and rehabilitation outcomes</td><td>72%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>22%</td><td>85%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>52%</td><td>100%</td></tr>
<tr><td>6.b</td><td>55%</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>C.2.d.v</td><td>support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR</td><td>
<table>
<tr><td>7.</td><td>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical</td><td>69%</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | | *Manual DSM-IV-TR (or the most current edition) checklists* | |
| | | 7.a | *There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter* | 77% |
| | | 7.b | *There is a completed DSM IV-TR Checklist completed when there is a change of a psychiatric diagnosis.* | 60% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 46% | 69% |
| Compliance rate in last month of period | | |
| 7. | 46% | 96% |
| 7.a | 73% | 96% |
| 7.b | 30% | 96% |

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|---|---|---|---|---|
| C.2.d.vi | enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge. | 8. | *The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.* | 81% |
| | | 8.a | *The present status section addresses the following: Treatment, Rehabilitation and Enrichment* | 91% |
| | | 8.b | *The case formulation documents the individual's* | 85% |

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| | *progress as evidenced by symptom reduction, participation in individual therapy and/or mall groups, and achievement of active treatment objectives* | |
| 8.c | *The case formulation documents a pathway to the discharge setting* | 82% |
| 8.d | *There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section* | 65% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 13% | 81% |
| Compliance rate in last month of period | | |
| 8. | 11% | 98% |
| 8.b | 69% | 98% |
| 8.c | 64% | 98% |
| 8.d | 28% | 95% |

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| C.2.e | The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions); | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

**Findings:**
Using the DMH WRP Chart Auditing Form, ASH assessed compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):

| | | |
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| 4. | *The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff will assist the individual to achieve his or her goals/objectives (interventions).* | 90% |
| 4.a | *There is a focus of hospitalization for each Axis I, II, and III diagnosis* | 93% |
| 4.b | *There is a focus for each discharge criteria* | 95% |
| 4.c | *Each focus has an objective and an intervention* | 92% |
| 4.d | *Each intervention includes the name of the staff responsible for implementation, the group name and the group time/day.* | 95% |
| 4.e | *Each objective includes a staff intervention in the therapeutic milieu.* | 90% |

The facility reported an improvement in mean compliance from 21% in the previous review period.

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

**Findings:**
The facility's corrective actions are summarized in C.1.a.

**Other findings:**
This monitor reviewed the records of 11 individuals receiving

| | | |
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| | | Rehabilitation Therapy and Nutrition Services (including Rehabilitation Therapy and Nutrition PSR Mall groups and direct occupational, physical, and speech therapy treatment) to assess compliance with the requirements of C.2.e. All records were in substantial compliance.<br><br>This monitor also reviewed the records of 12 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (occupational therapy, physical therapy and vocational rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Ten records were in substantial compliance (APL, ARM, DBL, DMM, JAD, JHG, MJL, NWC, RAC and RJB) and two records were not in compliance (JDC and KAT).<br><br>Finally, this monitor reviewed the records of 10 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. Nine records were in substantial compliance (BLB, DPP, GEC, JAD, JJS, JM, JWO, LH and SFV) and one record in partial compliance (BEC).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| C.2.f | Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the | Please see sub-cells for compliance findings. |

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| | interdisciplinary team shall: | |
| C.2.f.i | develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the 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; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH WRP Chart Auditing Form and the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Chart Auditing Form, ASH assessed compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009). One sub-item was removed from this tool to improve alignment with EP requirements. The DMH Substance Abuse Monitoring Form will continue to address the linkage between substance abuse objectives and the individual's stage of change (as in C.2.o). A summary of the facility's data follows:<br><br>5. *The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individual's strengths and addresses the individuals identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.* — 80%<br>5.a *The individual's strengths are used in the interventions.* — 95% |

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| 5.b | *There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.* | 60% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 36% | 80% |
| Compliance rate in last month of period | | |
| 5. | 55% | 93% |
| 5.b | 80% | 86% |

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

**Findings:**
The facility's corrective actions are summarized in C.1.a.

**Other findings:**
A review of the charts of six individuals found substantial compliance in five charts (AWD, AWS, MAE, MH and MT) and partial compliance in one (TB).

**Compliance:**
Partial; improved compared to the last review.

**Current recommendation:**
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and

<table>
<tr><td></td><td></td><td>compared to the last period).</td></tr>
<tr><td>C.2.f.ii</td><td>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Same as in C.2.f.i.<br><br>Findings:<br>Using the DMH WRP Chart Auditing Form, ASH assessed compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>6.</td><td>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</td><td>96%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 58% in the previous review period.<br><br>Other findings:<br>Chart reviews found substantial compliance in all cases (AWD, AWS, MAE, MH, MT and TB).<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.2.f.iii</td><td>write the objectives in behavioral, observable, and/or measurable terms;</td><td>Current findings on previous recommendation:</td></tr>
</table>

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| | | **Recommendation, April 2009:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 78% compared to 39% in the previous review period. The compliance rate for the last month of this period was 97%, compared to 45% in the last month of the previous review period.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in five charts (AWD, AWS, MH, MT and TB) and partial compliance in one (MAE).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| C.2.f.iv | include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 94%, compared to 62% in the previous review period.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in all cases (AWD, AWS, MH, MAE, MT and TB). |

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| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.f.v | ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in C.2.f.i.<br><br>**Findings:**<br>The facility reported a mean compliance rate of 85%, compared to 42% in the previous review period. The compliance rate for the last month of this period was 98%, compared to 51% in the last month of the previous review period.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in five charts (AWD, AWS, MH, MT and TB) and partial compliance in one (MAE).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.f.vi | 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; | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Monitor hours of active treatment (scheduled and attended).<br>• Present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to |

current period and last month of current period).

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

**Findings:**
ASH rolled out the new MAPP II schedule at the beginning of the Mall cycle. ASH experienced MAPP II software errors during this review period, especially in July and August. Staff interview and documentation review found that ASH was unable to enter more than 1000 hours worth of Mall Roster data into MAPPII. Thus the data for these recommendations are not comprehensive and the validity of the available data is suspect. The facility had manually calculated the data for two months of this review period (July and August). The tables below summarize the data:

| | Number of individuals by category | |
|---|---|---|
| | Mean scheduled hours | Mean attended hours |
| N | 1086 | 1086 |
| Hours: | | |
| 0-5 | 127 | 652 |
| 6-10 | 235 | 223 |
| 11-15 | 294 | 114 |
| 16-20 | 430 | 93 |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| Mean scheduled | 14.2 | 11.6 |
| Mean attended | 6.2 | 3.0 |

| Mall Attendance | | |
|---|---|---|
| | Previous period | Current period |
| Mean number of individuals | | |
| 0-5 hours | 623 | 652 |
| 6-10 hours | 300 | 223 |
| 11-15 hours | 147 | 114 |
| 16-20+ hours | 48 | 93 |

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

| Individual | WRP scheduled hours | MAPP scheduled hours | MAPP attended hours |
|---|---|---|---|
| AF | 13 | 12 | 7 |
| AH | 12 | 0 | 0 |
| AWS | 11 | 7 | 2 |
| JGC | 14 | 14 | 2 |
| MBO | 14 | 14 | 10 |
| MG | 15 | 15 | 0 |
| MT | 12 | 12 | 3 |
| RMJ | 12 | 11 | 1 |
| TB | 20 | 19 | 7 |
| WTM | 17 | 21 | 9 |

This monitor is uncertain in the validity of the MAPP II data given in the table above. Thus partial compliance will be maintained until the MAPP II software is fixed and the facility reports valid data.

| | | |
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| | | To improve compliance, ASH has been working collaboratively with DMH to resolve the MAPP II issues. ASH continues with various efforts to motivate individuals to attend their assigned Mall groups, including daily morning motivational meetings on each unit, daily assigned Mall Managers on each unit, improved By Choice process, and Motivational Interviewing and NRT efforts.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Monitor hours of active treatment (scheduled and attended).<br>2. Present data regarding average numbers of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period).<br>3. 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. |
| C.2.f.vii | 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 | This requirement is not applicable to ASH at this time. |
| C.2.f.viii | 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 | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the Mall Alignment Monitoring Form.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and |

| | | |
|---|---|---|
| | 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. | compared to the last period).<br><br>**Findings:**<br>Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on a mean sample of 13% of the census each month for the review period (March-August 2009):<br><br>1. *Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.* — 95%<br><br>Comparative data indicated improvement in compliance from 44% in the previous review period.<br><br>A review of the charts of ten individuals (HFH, JB, JS, KSH, MAE, MG, MK, PN, RMJ and WTM) found substantial compliance in nine charts.<br><br>**Recommendation 3, April 2009:**<br>Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.<br><br>**Findings:**<br>See Other Findings in C.2.g.iv.<br><br>**Compliance:**<br>Substantial. |

| | | |
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| | | **Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.g | Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall: | Please see sub-cells for compliance findings. |
| C.2.g.i | revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as C.2.t.<br><br>**Findings:**<br>See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.<br><br>**Other findings:**<br>Chart reviews found substantial compliance in five charts (AWD, AWS, MAE, MH and MT) and partial compliance in one (TB).<br><br>**Other findings:**<br>This monitor reviewed the records of nine individuals receiving direct occupational, speech and physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance. |

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| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.g.ii | review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors); | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the revised monitoring tool based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Clinical Chart Auditing Form, ASH assessed compliance based on an average sample of 86% of individuals placed in seclusion and/or restraints each month during the review period (March-August 2009).<br><br>12. *Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)* — 47%<br>12.a *The Present Status section reviews each use of Seclusion and/or Restraint, including the circumstances leading to its use, and* — 50%<br>12.b *The objectives and interventions have been modified as a result of the use of Seclusion and/or Restraint, as clinically appropriate.* — 44% |

Comparative data is not available as ASH did not collect data on this indicator during the previous review period.

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

**Findings:**
The facility's corrective actions are summarized in C.1.a and C.2.a.

**Other findings:**
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. The following is an outline of the reviews:

| Individual | Date of seclusion and/or restraint | Date of applicable WRP review |
|---|---|---|
| ADG | 8/11/09 | 8/25/09 |
| DH | 9/11/09 | 10/22/09 |
| DS | 7/30/09 | 9/28/09 |
| DS-2 | 7/29/09 | 8/7/09 |
| JCG | 8/3/09 | 8/20/09 |
| PWM | 8/1/09 | 9/4/09 |

This review focused on the documentation in the Present Status section of case formulation of the following information:

1. The use of restrictive interventions;
2. The circumstances that triggered the use of seclusion and/or restraints;
3. Treatment provided to avert the use of restrictive interventions; and/or
4. Modification of the treatment to decrease future risk.

| | | |
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| | | The review found substantial compliance in one chart (DS) and partial compliance in five (ADG, DH, DS-2, JCG and PWM). Overall, improvement was noted in the documentation of the review of the use of restrictive interventions and the circumstances that triggered this use. However, the facility has yet to improve documentation of the following:<br><br>1. Treatment provided to avert the use of restrictive interventions; and/or<br>2. Modification of the treatment to decrease future risk.<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendation**:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| C.2.g.iii | ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form in this section and DMH Discharge Planning and Community Integration in section E.3 based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 23% of the quarterly and annual WRPCs held each month during the review period (March-August |

2009):

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

The facility reported an improvement in mean compliance from 58% in the previous review period.

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

**Findings:**
The facility's corrective actions are summarized in C.1.a.

**Recommendation 4, April 2009:**
Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.

**Findings:**
The facility did not provide information related to this recommendation.

**Other findings:**
This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation) in the charts of six individuals. The review found substantial compliance in all charts (AWD, AWS, MAE, MH, MT and TB).

<table>
<tr><td></td><td></td><td>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.2.g.iv</td><td>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Monitor this requirement using the DMH WRP Observation Monitoring Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>Using the DMH WRP Observation Monitoring Form, ASH assessed compliance based on an average sample of 23% of the quarterly and annual WRPCs held each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>8.</td><td>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</td><td>96%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 61% in the previous review period.<br><br>Recommendation 3, April 2009:<br>Provide a summary outline of improvements in practice made as a result of the facility’s review of internal monitoring data.</td></tr>
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| | | |
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| | | **Findings:**<br>The facility's corrective actions are summarized in C.1.a.<br><br>**Other findings**:<br>This monitor reviewed the charts of six individuals to assess the following:<br><br>1. The timely completion of the Mall notes;<br>2. The adequacy of information in the Mall notes to inform revisions of the WRPs; and<br>3. The WRPT's review of the notes and integration of this review in the revisions of the WRP.<br><br>The reviews found substantial compliance in five charts (AWD, MAE, MH, MT and TB) and partial compliance in one (AWS).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.h | Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care. | Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations. |
| C.2.i | Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that: | **Compliance:**<br>Partial. |
| C.2.i.i | is based on the individual's assessed needs and is directed toward increasing the individual's | **Current findings on previous recommendations:** |

| | | |
|---|---|---|
| | ability to engage in more independent life functions; | **Recommendation 1, April 2009:**<br>The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.<br><br>**Findings:**<br>Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 13% of WRPs due each month during the review period (March-August 2009):<br><br>2. *Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions* 98%<br><br>Comparative data indicated improvement in compliance from 46% in the previous review period.<br><br>A review of the records of 10 individuals found that all 10 WRPs in the charts integrated relevant information from the discipline-specific assessments to address the individual's needs (HFH, JB, JS, KSH, MAE, MG, MK, PN, RMJ and WTM).<br><br>**Recommendation 2 and 3, April 2009:**<br>• Ensure that group leaders are consistent and enduring for specific groups.<br>• Track and monitor this objective.<br><br>**Findings:**<br>See C.2.s.<br><br>**Other findings:**<br>This monitor reviewed the records of 11 individuals receiving Rehabilitation Therapy and Nutrition Services (including Rehabilitation Therapy and Nutrition PSR Mall groups and direct occupational, physical, |

<table>
<tr><td></td><td></td><td>and speech therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.2.i.ii</td><td>Has documented objectives, measurable outcomes, and standardized methodology</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.<br>• Ensure that each objective is directly linked to a relevant focus of hospitalization.<br><br>Findings:<br>Using the DMH WRP Chart Audit Form, ASH assessed its compliance based on an average sample of 21% of WRPs due each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>7.</td><td>The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.</td><td>78%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>39%</td><td>78%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>45%</td><td>97%</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | | A review of the records of 15 individuals found that all 15 WRPs in the charts contained objectives written in a measurable/observable manner (DS, EC, HFH, JB, JM, JS, KSH, MAE, MG, MK, MWT, PN, RGP, RMJ and WTM).<br><br>A review of the records of eight individuals found that the objectives in all eight WRPs in the charts were directly linked to a relevant focus of hospitalization (AC, DS, EC, ECF, JM, MD, MWT and RGP).<br><br>**Current recommendations**:<br>1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.<br>2. 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 | **Current findings on previous recommendation:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals.<br><br>**Findings:**<br>The facility's self-monitoring data were presented in C.2.f.viii. ASH had closed the Mall from May 11 to 29 for service restructuring. As part of the Mall restructuring effort, ASH conducted a survey of individuals' needs and obtained data to align the Mall groups and schedules with those needs. In July 2009, ASH also rolled out the MAPP II program; implementation issues impacted data entry, Mall rosters, Mall scheduling, provider hours of services, and attendance monitoring.<br><br>A review of the WRPs of 10 individuals found that the services documented in all 10 of the WRPs were aligned with the individual's assessed needs (HFH, JB, JS, KSH, MAE, MG, MK, PN, RMJ and WTM). |

| | | |
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| | | **Recommendations 2 and 3, April 2009:**<br>• Group leaders should be held accountable for following the Mall curricula.<br>• Ensure that the Mall director has the necessary staff to assist with Mall programming and management.<br><br>**Findings:**<br>See C.2.s.<br><br>**Current recommendation**:<br>Provide data indicating that therapies and rehabilitation services provided in the Malls are aligned with individuals' assessed needs. |
| C.2.i.iv | utilizes the individual's strengths, preferences, and interests; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>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.<br><br>**Findings:**<br>See C.2.f.i.<br><br>**Recommendation 2, April 2009:**<br>Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.<br><br>**Findings:**<br>Using the DMH WRP Mall Alignment Monitoring Form, ASH assessed its compliance based on an average sample of 1% of Mall group facilitators each month during the review period (March-August 2009): |

| | | |
|---|---|---|
| | | 15. *The group facilitator utilizes the individual's strengths, preferences, and interests.* — 100%<br><br>Comparative data indicated improvement in compliance from 73% in the previous review period.<br><br>**Other findings:**<br>The Mall Director has developed a roster of individuals within groups, and included in the rosters each individual's objectives and strengths. This monitor's Mall group observations found that all Mall group facilitators had these documents with them and were able to describe an individual's WRP objective and strengths. This element is no longer an issue given that this list is updated on an ongoing basis.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.i.v | focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.<br><br>**Findings:**<br>Observation of three WRPCs found that all three teams functioned in an interdisciplinary fashion, with the core team members presenting the relevant information related to their areas.<br><br>**Recommendations 2 and 3, April 2009:**<br>• Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.<br>• Update the present status to reflect the current status of these |

vulnerabilities.

**Findings:**
Using the DMH Mall Alignment Monitoring Form, ASH assessed its compliance based on observation of an average random sample of 13 WRPs each month during the review period (March-August 2009):

| | | |
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| 3. | *Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.* | 99% |

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

A review of WRPs of 11 individuals found that the individual's vulnerabilities were documented in the case formulation section in all 11 of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (DS, HFH, JB, JS, MAE, MG, MK, MWT, PN, RMJ and WTM).

**Recommendation 4, April 2009:**
Provide groups regarding the purpose of Wellness and Recovery Action Plan (WRAP) to all individuals in order to preempt relapse.

**Findings:**
A review of 10 records found that the individual had been enrolled in the Wellness and Recovery Action Plan group in all 10 cases (HFH, JB, JS, KSH, MAE, MG, MK PN, RMJ and WTM).

**Current recommendation**:
Continue to monitor this requirement.

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| C.2.i.vi | is provided in a manner consistent with each individual's cognitive strengths and limitations; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.<br>• 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.<br><br>**Findings:**<br>Using the DMH WRP Mall Facilitator Observation Monitoring Form, ASH assessed its compliance based on an average sample of 1% of the Mall group facilitators each month during the review period (March-August 2009). The following table summarizes the data:<br><br>16. *Material is presented in a manner consistent with each individual's cognitive strengths and limitations.* 100%<br><br>Comparative data indicated improvement in compliance from 85% in the previous review period.<br><br>Psychologists at ASH conduct cognitive screening on all individuals through the Integrated Assessment: Psychology Section at the time of the individual's admission. When psychologists suspect cognitive challenges, they refer individuals for further assessment by the neuropsychology service. WRPTs use the cognitive screening results to assign individuals to PSR Mall groups.<br><br>A review of the records of 10 individuals found that cognitive screening had been conducted as part of the Integrated Assessment: Psychology Section in eight of the WRPs (JB, KSH, MAE, MG, MK, PN, RMJ and WTM). One individual (HFH) had a recent cognitive screening that was |

| | | |
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| | | still valid and another (JS) had refused the screening and the team continues to work with the individual to complete the screening.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.i.vii | Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process; | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• 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.<br>• Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner.<br>• Use the data from monthly Mall Progress Notes in the WRP review process.<br><br>**Findings:**<br>ASH's progress note module is fully automated. However, staff interview found that MAPP II software glitches affected data accuracy. According to the Mall Director, chart audit data showed 94% compliance. The facility is working with DMH to identify and resolve the computer software error and expects to demonstrate increased compliance with the progress note requirement as the software bugs are fixed and monitoring data becomes available.<br><br>A review of the charts of 10 individuals found that nine contained progress notes and incorporated the information from the progress notes into the Present Status section of the individual's WRP (HFH, JB, JS, KSH, MAE, MK, PN, RMJ and WTM). Progress notes were not found in the chart of one individual (MG). |

| | | |
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| | | **Other findings:**<br>This monitor reviewed the records of eight individuals receiving Rehabilitation Therapy and Nutrition Services (including Rehabilitation Therapy and Nutrition PSR Mall groups and direct occupational, physical, and speech therapy treatment) to assess compliance with the requirements of C.2.i.vii. Five records were in substantial compliance (DLT, PWM, RC, SJC and TG) and three records were in partial compliance (AT, SDG and YG).<br><br>**Current recommendations**:<br>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.<br>2. Use the data from monthly Mall Progress Notes in the WRP review process. |
| C.2.i.viii | is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• All Mall sessions should be 50 minutes in length.<br>• Provide groups as needed by the individuals and written in the individuals' WRPs.<br><br>**Findings:**<br>ASH is meeting the requirement to provide Mall services five days a week, four hours a day (two in the morning and two in the afternoon). ASH has scheduled all Mall groups for 50 minutes in length. Mall rosters and By Choice cards showed that each Mall group session had been conducted for 50 minutes. According to the Mall Director, Mall groups might at times begin later than scheduled due to transition time and other hospital-related activities, but end at the scheduled times after 50 minutes. |

ASH continues to support WRPTs and individuals when new groups are requested or needed. ASH had recently restructured the Mall services prioritizing the individual's needs thereby reducing the requests for new Mall groups. The Mall Director had received six requests during this review period, and he had fulfilled five of the requests. One of the requested groups is needed by only one individual. The Mall Director is working with the individual and his WRPT to determine if there is another group that might serve the same purpose.

The tables below showing the census for the review month (N), categories of hours, and the numbers of hours provided and attended by individuals under the various categories are summaries of the facility's data:

| Hours of Mall Groups Provided | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mar | Apr | May | June | July | Aug | Mean |
| N | 1128 | 1100 | 1108 | 1117 | 1014 | 1025 | 1113 |
| 0 – 5 | 126 | 110 | 121 | 163 | 288 | 184 | 130 |
| 6 - 10 | 236 | 224 | 250 | 264 | 515 | 357 | 244 |
| 11-15 | 334 | 362 | 381 | 372 | 190 | 382 | 362 |
| 16-20+ | 432 | 404 | 356 | 318 | 21 | 102 | 378 |

| Hours of Mall Groups Attended | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mar | Apr | May | June | July | Aug | Mean |
| N | 1128 | 1100 | 1108 | 1117 | 1014 | 1025 | 1082 |
| 0 – 5 | 590 | 557 | 593 | 677 | 874 | 818 | 652 |
| 6 - 10 | 439 | 399 | 313 | 387 | 134 | 167 | 223 |
| 11-15 | 246 | 271 | 282 | 346 | 6 | 40 | 114 |
| 16-20+ | 202 | 222 | 365 | 172 | 0 | 0 | 93 |

According to the Mall Director, the data for July and August in the

| | | |
|---|---|---|
| | | tables above are inaccurate due to MAPP II software errors.<br><br>**Current recommendation:**<br>Continue current practice. |
| C.2.i.ix | is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• 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.<br>• Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.<br><br>**Findings:**<br>ASH did not have any bed-bound individuals during this review period. In the past, ASH has provided PSR Mall-related activities within the individual's capacity and health status. The facility has a standing policy (Nursing Procedure 303.1) to provide appropriate service to bed-bound individuals.<br><br>**Current recommendation:**<br>If the facility has bed-bound individuals, ensure that these individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. |
| C.2.i.x | routinely takes place as scheduled; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, |

physical and functional status.

**Findings:**
ASH has addressed this recommendation through its recent Mall restructuring process. ASH used the cognitive screening data to categorize individuals according to their cognitive levels and structured Mall groups aligned with functioning levels. The WRPTs now have online access to the individual's cognitive status and the Mall courses for various cognitive levels, and use this information to assign individuals to groups. A review of the records of nine individuals (AF, AH, AWD, AWS, JGC, MG-2, MT, TB and WM) found that all nine individuals had been assigned to groups aligned with their cognitive levels.

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

**Findings:**
ASH presented the following data regarding cancellation of Mall groups:

| | 3/09 | 4/09 | 5/09 | 6/09 | 7/09 | 8/09 | Mean |
|---|---|---|---|---|---|---|---|
| Groups scheduled | 5800 | 5537 | 1720 | 5885 | 3728 | 4808 | 4580 |
| Groups cancelled | 257 | 261 | 102 | 494 | 373 | 574 | 344 |
| Cancellation rate | 4% | 5% | 6% | 8% | 10% | 12% | 8% |

The Mall Director indicated that the validity of the July and August data in the table above is suspect due to MAPP II software errors.

The mean cancellation rate per month was 6% in the previous review period.

**Recommendations 3 and 4, April 2009:**

- Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.
- Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

**Findings:**

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

| Discipline | Hours Scheduled/ Week | Hours Provided/ Week* | Percentage of Scheduled Hours Fulfilled |
|---|---|---|---|
| Psychiatry ACUTE (4) | 3 | 2 | 73% |
| Psychiatry L-T (8) | 4 | 3 | 79% |
| Psychology ACUTE (5) | 4 | 3 | 65% |
| Psychology L-T (10) | 6 | 4 | 71% |
| Social Work ACUTE (5) | 5 | 3 | 69% |
| Social Work L-T (10) | 7 | 5 | 74% |
| Rehab Therapy ACUTE (7) | 6 | 4 | 72% |
| Rehab Therapy L-T (15) | 9 | 7 | 75% |
| Nursing Admission (6) | 2 | 1 | 53% |
| Nursing L-T (12) | 2 | 1 | 65% |

| | | |
|---|---|---|
| | | Administration (1) \| 3 \| 2 \| 69%<br>*Hours provided have apparently been rounded to the nearest whole hour.<br><br>**Other findings:**<br>According to the Mall Director, MAPP II software glitches have prevented ASH from accurately identifying providers, their caseloads and hours provided, and from confirming that approved work providers are involved when staff decline provision of assigned Mall groups. Furthermore, according to the Mall Director, an increase in the number of Mall groups offered with a contemporaneous 15% reduction in workforce (due to furlough days) and staff vacancies are factors contributing to Mall cancellations. As every available staff is assigned to cover existing Mall groups, substitutes are difficult to schedule when having to cover staff on vacation or are ill.<br><br>**Current recommendations**:<br>1. Continue to monitor this requirement.<br>2. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.<br>3. Ensure that administrators and support staff facilitate a minimum of one Mall group per week. |
| C.2.i.xi | includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• 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.<br>• Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.<br>• Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. |

**Findings:**
The list of enrichment activities offered was reviewed. ASH has increased the number and hours of activities offered during the evenings and weekends. Documentation review and interview with the Enrichment Activity Coordinator found that individuals have the opportunity to engage in 16 hours of enrichment activities per week. The gym is open daily for one hour at noon; and other enrichment activities are offered for two hours on Monday and Thursday evenings and three hours and thirty minutes on Tuesday and Wednesday evenings.

The facility provided the following data regarding enrichment activities:

| | 3/09 | 4/09 | 5/09 | 6/09 | 7/09 | 8/09 | Mean |
|---|---|---|---|---|---|---|---|
| Hours scheduled | 2344 | 2113 | 2390 | 2205 | 1871 | 2040 | 2161 |
| Hours offered | 2344 | 2113 | 2390 | 2205 | 1871 | 2040 | 2161 |
| Compliance rate | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

As the table above indicates, ASH has provided all group activities as scheduled. The Enrichment Activity Coordinator is developing procedures to ensure that there is uniformity in the methodology and process of how groups are organized and managed.

**Current recommendation:**
Continue current practice.

C.2.i.xii

is consistently reinforced by staff on the therapeutic milieu, including living units.

**Current findings on previous recommendations:**

**Recommendation 1, April 2009:**
All WRPs should have therapeutic milieu interventions clearly specified in

the intervention sections.

**Findings:**
Documentation review and staff interview found that in May 2009, ASH developed the Mall Realignment Workbook that includes a section on "Writing General Milieu Intervention Statements." In July 2009, ASH's WRP Master Trainer developed and provided training to the Psychology Department on Psychologist responsibilities in the WRP.

According to the Mall Director, the MAPP II software program prompts WRPTs to write in milieu therapy interventions for every active intervention. Thus, all active interventions should now have accompanying milieu interventions.

A review of the charts of nine individuals found that all nine contained milieu interventions (AF, AH, AWD, AWS, JGC, MBO, MG, MT and TB). In one, the milieu interventions documented were not aligned with the active interventions or were of poor quality (AF).

**Recommendation 2, April 2009:**
Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

**Findings:**
Using the Therapeutic Milieu Monitoring Form, ASH assessed its compliance based on observations (each unit twice, AM and PM shifts) of an average sample of 94% of the units in the facility. The following table summarizes the facility's data:

| | | |
|---|---|---|
| 1. | *During the 30-min observation, there is more staff in the milieu than in the nursing station.* | 75% |
| 2. | *There is some staff interacting (e.g., engaged in conversation or activity) with individuals.* | 90% |

| | | |
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| 3. | *There is evidence of a unit recognition program.* | 91% |
| 4. | *The posted unit rules reflect recovery language and principles.* | 91% |
| 5. | *The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.* | 96% |
| 6. | *Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.* | 100% |
| 7. | *Staff is observed actively engaged with the individuals.* | 90% |
| 8. | *Staff interacts with individuals in a respectful manner.* | 99% |
| 9. | *Situations involving privacy occurred and they were properly handled.* | 100% |
| 10. | *1If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.* | 92% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 5, 6, and 8-10, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 71% | 75% |
| 2. | 83% | 90% |
| 3. | 76% | 91% |
| 4. | 85% | 91% |
| 7. | 86% | 90% |
| Compliance rate in last month of period | | |
| 1. | 78% | 93% |

<table>
<tr><td></td><td></td><td>This monitor's observations of Mall groups and WRPCs found that Mall facilitators and WRPT members frequently and appropriately reinforced the individuals.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>C.2.j</td><td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Ensure that there is sufficient activity programming to keep individuals active and engaged.<br>• Track and review participation of individuals in scheduled group exercise and recreational activities.<br>• Provide training to Mall facilitators to conduct the activities appropriately.<br><br>Findings:<br>The facility presented the following data:<br><br>
<table>
<tr><td colspan="7">Exercise Groups Offered vs. Needed</td></tr>
<tr><td></td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>July</td><td>Aug</td></tr>
<tr><td>Number of groups offered</td><td>67</td><td>72</td><td>72</td><td>73</td><td>90</td><td>96</td></tr>
<tr><td>Number of groups needed</td><td>74</td><td>78</td><td>74</td><td>75</td><td>76</td><td>76</td></tr>
<tr><td>Offered/needed</td><td>91%</td><td>92%</td><td>97%</td><td>97%</td><td>>100%</td><td>>100%</td></tr>
</table>
<br>Each group was composed of 10 individuals. In the previous review period, the number of groups offered consistently exceeded the number of groups needed. However, the number of groups needed was higher in this period.</td></tr>
</table>

The facility also presented the following data:

| BMI Level | Individuals in each category | Individuals assigned to Exercise Groups | Percentage assigned |
|---|---|---|---|
| 25 - 30 | 377 | 236 | 63% |
| 31 - 35 | 221 | 159 | 72% |
| 36 - 40 | 83 | 70 | 84% |
| >40 | 37 | 33 | 89% |

In the previous review period, ASH reported higher assignment percentages for all but the >40 category. However, the numbers of individuals reported as being in the 25-30 and 31-35 categories have increased by 60% and 33% respectively during this review period. Regardless of data vagaries, the table above indicates that a significant proportion of individuals with high BMIs were not enrolled in exercise groups. It is critical that these individuals are enrolled and motivated to participate in exercise groups along with other lifestyle and dietary modifications necessary to address their weight-related issues.

**Compliance:**
Partial.

**Current recommendations**:
1. Ensure that there is sufficient exercise and recreational programming.
2. Ensure that individuals with weight issues are enrolled in exercise groups.
3. Track and review participation of individuals in scheduled group exercise and recreational activities.
4. Provide training to Mall facilitators to conduct the activities appropriately.

| | | |
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| C.2.k | 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. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Continue with the Family Therapy Needs Assessment Survey.<br>• Ensure that family therapy needs are fulfilled.<br><br>**Findings:**<br>Using the DMH C2k Family Therapy Auditing Form, ASH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:<br><br>1. *Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.* — 100%<br>2. *Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.* — 51%<br>3. *Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.* — 88%<br><br>Comparative data indicated improvement in compliance since the previous review period: |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 74% | 100% |
| 2. | 10% | 51% |
| 3. | 15% | 88% |
| Compliance rate in last month of period | | |
| 1. | 100% | 100% |
| 2. | 33% | 100% |
| 3. | 100% | 100% |

ASH has improved its tracking and monitoring of family therapy assessments and provision of services for those who consent to and participate in family therapy services. Documentation improved during the last month of this review period.

According to the Chief of Social Work, consent to contact families is received from about 75% of the individuals. However, a correct home address is only available for 40%-50% of them, and the return from these is very low. ASH now tries to, where possible, to move individuals to a facility closer to their home if that is preferred by the individuals and their families (subject to vacancy). The Social Work Department is also working to get grant funds from CDCR to enable families to visit their relatives in the facility and to participate in family therapy activities.

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| C.2.l | Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Continue to implement plans of correction to increase compliance with this requirement.<br>• Collaborate with and include Nursing regarding the barriers and plans of correction addressing medical conditions in the WRP.<br>• Ensure that interventions in WRPs are being implemented as directed.<br><br>**Findings:**<br>In March 2009, training was conducted by the WRP Master Trainer regarding Present Status: Intervention and Response Section and, Refusal of Medical Appointments, Tests, Labs and Vaccinations. In May 2009, ASH developed a template for refusals of medical appointments that includes instruction for documentation in the WRP and examples. In June 2009, the WRPTs began using the Task Tracker database to track refusals.<br><br>**Recommendation 4, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Integration of Medical Conditions in WRP Audit, ASH assessed its compliance based on a 18% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (March-August 2009):<br><br>1. *All medical conditions listed on Axis III are included on the Medical Conditions Form.* 89%<br>2. *The WRP includes each medical condition or diagnoses listed on Axis III.* 92%<br>3. *There is an appropriate focus statement for each* 77% |

| | | |
|---|---|---|
| | *medical condition or diagnosis.* | |
| 4. | *There is an appropriate objective for each medical condition or diagnosis.* | 88% |
| 5. | *There are appropriate interventions for each objective.* | 78% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 55% | 89% |
| 2. | 63% | 92% |
| 3. | 32% | 77% |
| 4. | 26% | 88% |
| 5. | 2% | 78% |
| Compliance rate in last month of period | | |
| 1. | 63% | 100% |
| 2. | 71% | 98% |
| 3. | 46% | 84% |
| 4. | 38% | 99% |
| 5. | 4% | 96% |

No barriers to compliance were identified. See findings for Recommendations 1-3 above for plan of action to improve compliance.

A review of the WRPs for 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found there has been improvement in all of the items addressing this area from the last review.

The most noted improvement has been in the alignment between the focus statements, objectives and interventions. However, improvement needs to continue in order to achieve substantial compliance.

ASH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 86% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:

| | | |
|---|---|---|
| 6. | *Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.* | 34% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 4% | 34% |
| Compliance rate in last month of period | | |
| 6. | 14% | 73% |

See findings for Recommendations 1-3 above for plan of action to improve compliance, and see F.8.a.i and F.9.d for review findings.

**Compliance:**
Partial.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| C.2.m | The children and adolescents it serves receive, | |

| | | |
|---|---|---|
| | consistent with generally accepted professional standards of care: | The requirements of Section C.2.m are not applicable because ASH does not serve children or adolescents. |
| C.2.m.i | Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and | |
| C.2.m.ii | reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions. | |
| C.2.n | Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in C.2.o.<br><br>**Findings:**<br>Same as in C.2.o.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations:**<br>Same as in C.2.o. |
| C.2.o | Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Provide data regarding SAS clinical and process outcomes, including data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). Continue to include results of consumer satisfaction surveys. |

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

| Process Outcome | Jan-Mar 2009 | Apr-Jun 2009 | Jul-Sep 2009 |
|---|---|---|---|
| Individuals with Substance Abuse Dx | 801 | 877 | 822 |
| Individuals referred for: | | | |
| o SAS treatment | 261 | 239 | 277 |
| o AA groups | 202 | 159 | 141 |
| o NA groups | 207 | 152 | 122 |
| Individuals screened by SAS | 238 | 230 | 277 |
| Hours of SAS treatment offered per week | 78.5 | 81 | 90.5 |
| SAS sessions scheduled | 906 | 744 | 822 |
| %SAS sessions held | 100% | 100% | 99% |
| Individuals enrolled in SAS treatment | 658 | 460* | 696 |
| Individuals enrolled in AA | 588 | 760 in AA/NA | 636 |
| Individuals enrolled in NA | 593 | | No data given |
| Individuals on wait list | 23 | 18 | 20 |
| Hours of staff training provided | 26 | 8 | 9 |
| Number of staff trained | 50 | 9 | 16 |
| Number of staff monitored for fidelity (re implementation of SAS curriculum) | 0 | 0 | 8 |

*This data does not include data for individuals in the Precontemplation stage due to errors in the MAPP II system.

ASH also evaluated the outcome of the SAR services provided this review period. The table below shows the summary of the data:

| Clinical Outcomes | Jan-Mar 2009 | Apr-Jun 2009 | Jul-Sep 2009 |
|---|---|---|---|
| N=Number enrolled 1st day of quarter | 658 | 460* | 696 |
| Advanced at least one stage of change or sustained in maintenance | 272<br>41% | 273<br>59% | 271<br>39% |
| Refused treatment or regressed at least one stage of change. | 107<br>16% | 45<br>10% | 84<br>12% |
| Did not advance in stage of change | 108<br>16% | 57<br>12% | 230<br>33% |
| Out to Court/Other/ Discharged | 171<br>26% | 85<br>18% | 111<br>16% |
| Pre/Post Test-Increase Mean | 15% | 21% | 16% |

*This data does not include data for individuals in the Precontemplation stage due to errors in the MAPP II system.

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

| Consumer Satisfaction Survey | Jan-Mar 2009 | Apr-Jun 2009 | Jul-Sept 2009 |
|---|---|---|---|
| Learned New Skills | N=160 | N=202 | N=172 |
| • Agree | 93% | 94% | 95% |
| • Disagree | 7% | 6% | 5% |
| Group was helpful | | | |
| • Agree | 92% | 96% | 94% |
| • Disagree | 8% | 4% | 6% |
| Understood Information | | | |
| • Agree | 97% | 97% | 97% |
| • Disagree | 3% | 3% | 3% |

| Group Leader Respectful | | | |
|---|---|---|---|
| • Agree | 98% | 97% | 98% |
| • Disagree | 2% | 3% | 2% |

**Recommendation 2, April 2009:**
Monitor this requirement using the DMH Substance Abuse Auditing Form and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

**Findings:**
Using the DMH Substance Abuse Auditing Form, ASH assessed its compliance with this requirement based on an average sample of 22% of individuals with a current diagnosis of substance abuse (March-August 2009):

| | | |
|---|---|---|
| 1. | *Substance abuse is integrated into the case formulation and discussed in the present status.* | 99% |
| 2. | *There is an appropriate focus statement listed under Focus 5.* | 98% |
| 3. | *There is at least one objective related to the individual's stage of change.* | 95% |
| 4. | *There are interventions that are appropriately linked to the active objective(s).* | 90% |
| 5. | *The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.* | 92% |
| 6. | *The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.* | 39% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 62% | 99% |
| 2. | 92% | 98% |
| 3. | 55% | 95% |
| 4. | 52% | 90% |
| 5. | 66% | 92% |
| 6. | 7% | 39% |

The facility did not provide a month-to-month comparison for the indicator at less than 90%.

**Recommendation 3, April 2009:**
Ensure that SAS are aligned with the principles outlined in the Substance Abuse Treatment Program Plan of Improvement.

**Findings:**
Document review indicates that SAS are provided in accordance with the Plan of Improvement.

**Other findings:**
Chart reviews found substantial compliance in all cases (AWD, AWS, DH, MAE, MH, MT and TB).

**Compliance:**
Substantial.

**Current recommendations**:
1. Continue to provide summary of process and clinical outcome data regarding delivery of substance use services.
2. Continue to monitor this requirement.

| | | |
|---|---|---|
| C.2.p | Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision. | **Current findings on previous recommendation:**<br><br>**Recommendation1, April 2009:**<br>Assess the competency of group facilitators and therapists in providing rehabilitation services.<br><br>**Findings:**<br>Using the DMH Mall Facilitator Monitoring Form, ASH assessed its compliance based on an average sample of 1% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (March-August 2009): |

| | | Previous review period | Current review period |
|---|---|---|---|
| 1. | *Instructional skills* | 97% | 100% |
| 2. | *Course structure* | 80% | 98% |
| 3. | *Instructional techniques* | 98% | 100% |
| 4. | *Learning process* | 93% | 100% |

Using the DMH Mall Facilitator Observation Monitoring Form ASH assessed compliance from observation of a 1% sample of all facilitators during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Session starts and ends within 5 minutes of the designated starting and ending time.* | 98% |
| 2. | *Facilitator greets participants to begin the session.* | 100% |
| 3. | *There is a brief review of work from prior session.* | 100% |
| 4. | *Facilitator introduces the day's topic and goals.* | 100% |
| 5. | *Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.* | 100% |
| 6. | *Facilitator attempts to engage each participant in the session.* | 100% |
| 7. | *Facilitator attempts to keep all participants "on task"* | 100% |

| | | |
|---|---|---|
| | *during the session.* | |
| 8. | *Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.* | 100% |
| 9. | *Facilitator attempts to test the participants understanding.* | 100% |
| 10. | *Facilitator presents information in a manner appropriate to the functioning level of the participants.* | 100% |
| 11. | *The facilitator summarizes the work done in the session.* | 94% |
| 12. | *Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.* | 100% |
| 13. | *The room is arranged in a way that is as conducive to learning as possible.* | 100% |
| 14. | *Lesson plan is available and followed.* | 95% |

Comparative data indicated maintenance of compliance rates greater than 90% since the previous review period for items 2, 5-10, 12 and 13, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 87% | 98% |
| 3. | 76% | 100% |
| 4. | 81% | 100% |
| 11. | 57% | 94% |
| 14. | 52% | 95% |

| | | |
|---|---|---|
| | | **Recommendation 2, April 2009:**<br>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.<br><br>**Findings:**<br>This monitor observed seven Mall groups. Providers in all seven groups were well-prepared with handouts and worksheets and they utilized appropriate instructional strategies and techniques suitable for the lesson. The presentation in all groups was varied and appropriate for the topic presented. The level of language used both in written materials and verbal presentation was appropriate. The facilitators engaged the individuals in all groups. The seating arrangements were conducive for learning in all groups. Only three groups had lesson plans at hand. ASH should continue to develop curricula and lesson plans for all Mall groups offered, and these lesson plans should be written by the disciplines facilitating the groups.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| C.2.q | Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Ensure that all group facilitators complete the substance abuse training curriculum per ASH training curriculum.<br>• Evaluate and report on the quality of services provided on Substance Abuse by the trained facilitators.<br>• Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse |

<table>
<tr>
<td></td>
<td></td>
<td>counseling competency.<br><br>Findings:<br>ASH presented the following data regarding the certification of Substance Abuse facilitators:<br><br>
<table>
<tr><td>Number of Substance Abuse Recovery (SAR) providers/ co-providers</td><td>10</td></tr>
<tr><td>Number of certified SAR providers/co-providers</td><td>7</td></tr>
<tr><td>Percentage of SAR providers/co-providers who are certified</td><td>70%</td></tr>
</table>
<br>Additionally, ASH reported that 52 staff, including the 10 represented above, are certified to serve individuals at the pre-contemplative stage. The facility reported that it has further staff trainings scheduled.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Same as in C.2.o.</td>
</tr>
<tr>
<td>C.2.r</td>
<td>Transportation and staffing issues do not preclude individuals from attending appointments.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue to ensure that all medical appointments of individuals are completed as scheduled.<br><br>Findings:<br>The facility provided the following data on scheduled and cancelled appointments:</td>
</tr>
</table>

| Missed Appointments Monitoring – Medical Services | | | |
|---|---|---|---|
| Month | Appointments | | Reasons for Cancellation |
| | Scheduled | Cancelled | |
| Mar 09 | 177 | -- | 0 staffing<br>0 transportation<br>-- other |
| Apr 09 | 180 | -- | 0 staffing<br>0 transportation<br>-- other |
| May 09 | 211 | -- | 0 staffing<br>0 transportation<br>-- other |
| June 09 | 208 | -- | 0 staffing<br>0 transportation<br>-- other |
| July 09 | 71 | -- | 0 staffing<br>0 transportation<br>-- other |
| Aug 09 | 70 | -- | 0 staffing<br>0 transportation<br>-- other |
| Total | 917 | -- | None due to staffing or transportation |

ASH reported that no appointments were cancelled due to staffing or transportation. However, the facility was not able to extract valid data from the WaRMSS system on the number of cancellations and the "other reasons" for the cancellations. The DMH headquarters IT department is currently working on fixes for this module of the WaRMSS system.

**Compliance:**
Should be substantial given that staffing and transportation reportedly were not barriers to keeping scheduled appointments. However, a

| | | |
|---|---|---|
| | | compliance rating will be deferred until valid data is submitted at the next review.<br><br>**Current recommendation**:<br>Continue to ensure that all medical appointments of individuals are completed as scheduled. |
| C.2.s | Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.<br><br>**Findings:**<br>Using the DMH WRP Clinical Chart Auditing Form, ASH assessed its compliance based on an average sample of 20% of the WRPs due each month during the review period (March-August 2009):<br><br>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.* — 78%<br>10.a *The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.* — 78%<br>10.b *For each Axis I, II and III diagnoses, the* — 78% |

| | | |
|---|---|---|
| | *interventions are related to excesses and deficits associated with each diagnosis.* | |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 10. | 24% | 78% |
| Compliance rate in last month of period | | |
| 10. | 37% | 98% |
| 10.a | 37% | 98% |
| 10.b | 40% | 98% |

A review of the WRPs for nine individuals found that all nine individuals had been assigned to meaningful groups in line with their diagnoses and cognitive levels (AF, AH, AWD, AWS, JGC, MG-2, MT, TB and WTM).

According to the Mall Director the MAPP II program prompts WRPTs to ensure that the individual's schedule is aligned with their Mall groups.

**Recommendation 2, April 2009:**
Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning.

**Findings:**
This monitor observed seven Mall groups. The providers in all seven groups were knowledgeable in the course content and were motivated as evidenced by their preparation and usage of language both in their oral presentation and in the printed material used.

| | | |
|---|---|---|
| | | **Other findings:**<br>ASHs policy is to keep the PSR Mall providers as enduring as possible. According to the Mall Director, non-enduring providers are used only when the enduring providers are ill or are on vacation.<br><br>ASH expects Mall providers to follow the curriculum, and they are monitored by the Mall staff. This monitor observed seven Mall groups (see Methodology for this section); the providers of all seven groups were following their respective curricula and their topics and activities of the day matched the lesson plan of the week. Furthermore, all providers and co-providers were the groups' enduring team leaders. According to the Mall Director, facilitator stability is not an issue.<br><br>**Compliance:**<br>Partial; improved compared to last review.<br><br>**Current recommendations**:<br>1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments.<br>2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. |
| 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, and the individual's progress, or lack thereof; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.<br><br>**Findings:**<br>ASH uses the DMH WRP Clinical Chart Auditing Form as a monitoring tool to evaluate process outcome of treatment and rehabilitation services, and assessed its compliance based on an average sample of 20% of the |

WRPs due each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 11. | *Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)* | 65% |
| 11.a | *Each objective is observable, measurable and behavioral.* | 76% |
| 11.b | *All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.* | 76% |
| 11.c | *There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.* | 39% |
| 11.d | *If the individual has not made progress on an objective in two months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.* | 49% |
| 11.e | *If the individual has met the objective, a new objective and related interventions have been developed and implemented.* | 85% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 11. | 0% | 65% |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 11. | 2% | 90% |
| 11.a | 48% | 98% |
| 11.b | 66% | 97% |
| 11.c | 8% | 62% |
| 11.d | 9% | 97% |
| 11.e | 69% | 94% |

A review of the WRPs for nine individuals found that six WRPs met the elements of this requirement (AF, AWD, JGC, MG-2, MT and TB); two did not (AH and AWS); and one was making progress without a need for modifications and subsequently was discharged (MBO).

**Recommendation 2, April 2009:**
Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

**Findings:**
See C.2.i.iii.

**Compliance:**
Partial.

**Current recommendation**:
Ensure that treatment, rehabilitation and enrichment services are monitored and revised as appropriate in light of the individual's progress, or lack thereof.

| | | |
|---|---|---|
| C.2.u | 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. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups).<br>• Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.<br><br>**Findings:**<br><br>Number of the Wellness and Recovery groups offered during the current and previous two Mall terms<br>Jan-Mar 2009: 278<br>Apr-Jun 2009: 204<br>Jul-Sep 2009: 370<br><br>According to the Mall Director, there were 555 available slots for the Wellness and Recovery groups. Four hundred and seven individuals needed to be enrolled in these groups, and 331 had been enrolled.<br><br>**Other findings:**<br>ASH found it difficult to extract accurate data from the WaRMSS system. According to the Mall Director, the system will not allow corrective actions until October 2009 when the program is expected to be fixed.<br><br>ASH dissolved the Sponsor Groups because the facility needed the staff for the PSR Mall groups, especially the Barriers to Discharge groups. Instead the facility now has a Mall Motivational Meeting every morning to encourage individuals to attend their assigned Mall groups. |

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Provide data regarding each group that addresses this requirement (Introduction to Wellness and Recovery for newly admitted individuals and Sponsor Groups).<br>2. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period. |
| 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 August experience. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Provide data regarding the number of groups scheduled and the percentage that was held compared to the previous review period.<br><br>**Findings:**<br>ASH indicated that data reliability was compromised by errors in the MAPP II database. On average, 287 sessions were scheduled each month. The facility reported that during the review period, 72% of scheduled medication education groups were held, consistent with 73% during the previous review period.<br><br>**Recommendation 2, April 2009:**<br>Based on the implementation of the draft tools designed to assess need for medication education groups, provide data on number of individuals with assessed need, number enrolled in medication education groups, and percentage that successfully completed groups compared to the previous review period.<br><br>**Findings:**<br>The facility presented the following data: |

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th colspan="4">Individuals Needing and Provided Medication Education Groups</th></tr>
<tr><th></th><th>Jan-Mar 2009</th><th>Apr-June 2009</th><th>July-Sep 2009</th></tr>
<tr><td># of individuals needing service</td><td>Not assessed</td><td>Not assessed</td><td>421</td></tr>
<tr><td># of individuals receiving service</td><td>845</td><td>1003</td><td>566</td></tr>
</table>
<br>
The facility reported that the current Mall schedule includes 29 medication education classes: 15 at the independent level of support, 10 at assisted, two at supported, and two in Spanish. The facility's data appear to indicate that a number of individuals are receiving this service although they may not need it.<br><br>
Compliance:<br>
Partial.<br><br>
Current recommendations:<br>
1. Provide data regarding the number of groups scheduled and the percentage that was held compared to the previous review period.<br>
2. Based on the implementation of tools designed to assess need for medication education groups, provide data on number of individuals with assessed need, number enrolled in medication education groups and percentage that successfully completed groups compared to the previous review period.
</td>
</tr>
<tr>
<td>C.2.w</td>
<td>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals.
</td>
</tr>
</table>

**Findings:**
ASH has three certified NRT therapists, each carrying a caseload of five individuals. Twelve individuals participating in NRT during the review period were enrolled during the last six months. The three individuals who were in therapy from the previous review period have been successfully transitioned into other activities.

**Recommendation 2, April 2009:**
Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers.

**Findings:**
During this review period, 21 staff were trained as Motivational Interviewing Trainers and 64 staff were trained as Motivational Interviewing Supervisors and managers. ASH also trained 116 staff in Motivational Interviewing Skills and expects to have trained all the remaining staff by August 2010.

**Recommendation 3, April 2009:**
Provide data regarding the mean number of individuals who were non-adherence to WRP during the review period compared to the last review period.

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

| | September 2008 - March 2009 | March – August 2009 |
|---|---|---|
| N | 1089 | 1028 |
| n | 878 | 969 |

**Recommendation 4, April 2009:**
Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.

**Findings:**
ASH continues to uses various means to motivate individuals to attend their scheduled Mall groups, including NRT. ASH increased the number of NRT participants from six in to 15 during this review period. The tables below present outcome data on the 15 individuals enrolled in NRT during this review period. A number of recently enrolled individuals did not participate long enough to have post-NRT scores (as shown with dashes in the tables above). The outcome data show mixed results for individuals in the NRT.

| Individual | Hope Scale Scores | |
|---|---|---|
| | Pre-NRT | With NRT |
| AJ | 30 | 30 |
| AM | 18 | - |
| BM | 19 | - |
| CH | 22 | - |
| DH | 27 | 22 |
| EF | 16 | - |
| EM | 18 | - |
| FE | 15 | 11 |
| HA | 25 | 26 |
| JL | 19 | - |
| LG | 21 | 23 |
| MW | 11 | - |
| PT | 24 | 28 |

| | | |
|---|---|---|
| RJ | 23 | 23 |
| RS | 30 | - |

| Individual | Mindfulness Attention Awareness Scale Scores | |
|---|---|---|
| | Pre-NRT | With NRT |
| AJ | 4.5 | 4.3 |
| AM | 3.5 | - |
| BM | 4.1 | - |
| CH | 2.7 | - |
| DH | 5.2 | 4.7 |
| EF | 3.2 | - |
| EM | 3.4 | - |
| FE | 3.9 | 4.0 |
| HA | 2.6 | 2.8 |
| JL | 4.1 | - |
| LG | 3.9 | 5.2 |
| MW | 4.0 | - |
| PT | 2.3 | 4.9 |
| RJ | 3.6 | 3.2 |
| RS | 2.2 | - |

| Individual | URICA (Self-Assessment by the Individuals) | |
|---|---|---|
| | Pre-NRT | With NRT |
| LG | 11.2 | 11.5 |
| RJ | 4.4 | 7 |
| DH | 10.1 | 10.2 |

| | | |
|---|---|---|
| JL | 6.8 | - |
| CH | 8.7 | - |
| BM | 9.4 | - |
| AM | 7.7 | - |
| HA | 9.9 | 10.1 |
| EM | 10.8 | - |
| AJ | 9.2 | 11.3 |
| MW | 6.7 | - |
| RS | 11.7 | - |
| FE | 9.1 | 7 |
| PT | 8.2 | 9.1 |
| EF | 8.4 | - |

| Individual | URICA (Staff Assessment) | |
|---|---|---|
| | Pre-NRT | With NRT |
| AJ | 9 | 10 |
| AM | 7.9 | - |
| BM | 8.3 | - |
| CH | 3.1 | - |
| DH | 4 | 9.5 |
| EF | 8 | - |
| EM | 10.9 | - |
| FE | 9.6 | 5.28 |
| HA | 6.2 | 9.2 |
| JL | 5 | - |
| LG | 6.3 | 9.2 |
| MW | 6.7 | - |
| PT | 9.6 | 10.3 |
| RJ | 4.4 | 9.1 |
| RS | 9.7 | - |

| | | |
|---|---|---|
| | | **Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Provide data regarding the number of therapists trained in NRT, number of individuals engaged in NRT and their outcome data for the individuals.<br>2. Provide data regarding the status of implementation of Motivational Interviewing, Therapeutic Milieu Program and Activity Centers.<br>3. Develop a system to identify individuals who are not attending Mall groups and differentiate those who are non-adherent due to a lack of motivation, and provide data on these individuals during the review period compared to the last review period.<br>4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. |

| D. Integrated Assessments | | |
|---|---|---|
| D | Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments. | **Summary of Progress on Psychiatric Assessments and Diagnoses:**<br>1. ASH has achieved substantial compliance with EP requirements regarding the admission medical assessment.<br>2. ASH has made significant progress in meeting EP requirements regarding the admission and integrated psychiatric assessments and psychiatric reassessments.<br>3. ASH has achieved substantial compliance with EP requirements regarding resolution of diagnoses listed as not otherwise specified (NOS) or as rule out (R/O).<br>4. ASH has achieved substantial compliance with EP requirement regarding inter-unit transfer assessments.<br>5. ASH has conducted an adequate study to improve the prediction of violence occurring at the facility.<br>6. ASH has implemented an adequate process of quality profiles for its psychiatry staff, including analysis of individual and group practitioner patterns.<br>7. ASH's Chief of Psychiatry (Jean Dansereau, MD) has continued to provide effective leadership during this review period<br><br>**Summary of Progress on Psychological Assessments:**<br>ASH has achieved substantial compliance in this section.<br><br>**Summary of Progress on Nursing Assessments:**<br>ASH has made remarkable progress since the last review regarding the quality of the Nursing Admission and Integrated Nursing Assessments and has achieved substantial compliance with all requirements of this section. The strategies that the facility has implemented addressing this area have resulted in the development of comprehensive clinical documents as well as in the achievement of substantial compliance in this section. The facility should be commended for implementing a mentoring program for the RNs who conduct admission assessments. |

| | | |
|---|---|---|
| | | **Summary of Progress on Rehabilitation Therapy Assessments:**<br>1. ASH has achieved substantial compliance with all requirements of this section except timeliness.<br>2. Integrated and focused assessments have continued to improve in timeliness and quality.<br><br>**Summary of Progress on Nutrition Assessments:**<br>1. ASH has achieved substantial compliance with all requirements of this section except the requirement related to annual nutrition assessments.<br>2. Admission and higher acuity Nutrition assessments have continued to improve in timeliness and quality.<br><br>**Summary of Progress on Social History Assessments:**<br>ASH has achieved substantial compliance with all requirements of this section.<br><br>**Summary of Progress on Court Assessments:**<br>1. ASH has maintained substantial compliance in this section.<br>2. ASH's Chief of Forensic Services (David Fennell, MD) has continued to provide effective leadership during this review period. |

| 1. Psychiatric Assessments and Diagnoses | | |
|---|---|---|
| | Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and, | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Christine Mathiesen, PsyD, Director of Central Psychological Assessment Services<br>2. Frank Stass, MD, Assistant to the Chief of Psychiatry<br>3. Jean Dansereau, MD, Chief of Psychiatry<br>4. Robert Knapp, MD, Medical Director<br><br><u>Reviewed</u>:<br>1. The charts of the following 47 individuals: AAA, ADG, AHC, AMR, AW, BP, CDB, CEF, CJG, DD, DH, DLA, DM, DRR, DS, DS-2, DS-3, DS-4, EJ, FB, GC, GG, JAD, JLP, JM, JM-2, JM-3, JS, JV, KC, LA, LF, LRH, LTB, MD, MJ, MT, PCC, PTF, PWM, RG, RH, RWU, ST, TB, TE and WWM<br>2. Psychiatric Physician Quality Performance Profile (PPQPP) form and instructions<br>3. ASH Physician Profile examples for hydroxyzine, lorazepam, diphenhydramine, trihexyphenidyl, benztropine and clonazepam<br>4. ASH report of DMH Medication Comparison: Anticholinergics and Benzodiazepines Trend Chart: November 2008 – September 2009<br>5. ASH Admission Psychiatric Assessment Audit summary data (March-August 2009)<br>6. ASH Integrated Psychiatric Assessment Audit summary data (March-August 2009)<br>7. ASH revised template for the Monthly Psychiatric Progress Note, July 1, 2009<br>8. ASH Monthly PPN Audit summary data (March-August 2009)<br>9. Psychiatric Weekly Progress Note template, August 1, 2009<br>10. ASH Weekly Physician Progress Note Audit summary data (March-August 2009)<br>11. ASH Medical Initial Admission Assessment Audit summary data |

| | | |
|---|---|---|
| | | (March-August 2009)<br>12. ASH revised template for the Psychiatric Transfer Note, July 30, 2009<br>13. ASH Physician Inter-Unit Transfer Note Audit summary data (March-August 2009)<br>14. ASH Study, Approaching the Prediction of Violence at a Psychiatric Forensic Hospital, by Killorin Riddell, PhD and Joni Walter, MS |
| D.1.a | Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Resume dictation of the assessments.<br><br>**Findings:**<br>The facility indicated that it resumed dictation of the psychiatric admission assessments on June 1, 2009.<br><br>**Recommendations 2 and 3, April 2009:**<br>• Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing forms based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>ASH used the DMH Admission and Integrated Psychiatric Assessment Auditing Forms to assess compliance for the review period (March-August 2009). The average samples were 95% of admission assessments and 90% of integrated assessments for individuals who have been hospitalized for more than 90 days. The following tables summarize the data: |

| Admission Assessment | | |
|---|---|---|
| 4. | *Admission diagnosis is documented* | 97% |

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

| Integrated Assessment | | |
|---|---|---|
| 2.b | *Statements from the individual are included, if available.* | 100% |
| 2.d | *Includes Diagnosis and medications given at previous facility are included* | 100% |
| 7. | *Includes diagnostic formulation* | 94% |
| 8. | *Includes differential diagnosis* | 99% |
| 9. | *Includes current psychiatric diagnoses* | 96% |

Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period for all indicators other than item 7, which improved from 62% in the previous review period.

ASH also used the Monthly Physician Progress Note Auditing Form to assess compliance with this requirement for the review period. ASH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in efforts to ensure clinical relevance and continue to meet all requirements of the Enhancement Plan. ASH implemented the revised PPN Auditing Form in July 2009. Item 3.c was revised to clarify the requirement for a discussion of unresolved diagnoses. The average sample size was 23% of the monthly notes for individuals who had been hospitalized for more than 90 days. The following table summarizes the data:

| Monthly PPN - Revised | | |
|---|---|---|
| 3.a | *The PPN includes the 5 Axis Diagnoses.* | 97% |

| | | |
|---|---|---|
| | | 3.c — *The PPN includes a discussion of diagnostic questions that still require resolution including deferred, R/O and NOS diagnoses.* — 100%<br><br>**Recommendation 4, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.<br><br>**Findings:**<br>ASH reported that it implemented a review of the draft dictation prior to finalization to ensure the presence of the required elements.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| 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 | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Continue current practice.<br>• Provide comparative data from review period to review period regarding the total number of FTE psychiatric positions filled, including direct care and supervisory positions, and the number of psychiatrists who are currently board-certified.<br><br>**Findings:**<br>The facility's report on the number and type of positions is summarized |

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<td>below:<br><br>
<table>
<tr><td>Psychiatric positions</td><td>Previous Period</td><td>Current Period</td></tr>
<tr><td>Direct care (FTE)</td><td>49.75</td><td>57.00</td></tr>
<tr><td>Supervisory (FTE)</td><td>8.25</td><td>16.35</td></tr>
<tr><td>Board-certified</td><td>47</td><td>51</td></tr>
<tr><td>Board-eligible</td><td>20</td><td>28</td></tr>
</table>
<br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue current practice.</td>
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<tr>
<td>D.1.b.ii</td>
<td>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.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Utilize data from the Psychiatric Physician Quality Profile Program in the processes of reprivileging and performance improvement.<br><br>Findings:<br>ASH reported that it implemented the Psychiatric Physician Quality Performance Profile in September 2009. The facility indicated that the Profile is utilized in the reprivileging process and is sent to the Credentials Committee as part of the reprivileging documentation. ASH reported that the reprivileging process also includes a psychiatry peer review audit that incorporates chart reviews, team meeting observations, and other aggregate data in the areas of psychopharmacology, diagnostic assessment, clinical management, leadership and team management, documentation, psychiatry medical staff obligations, committees and forensics.</td>
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| | | ASH indicated that each psychiatrist reviews his/her Profile with the applicable Senior Psychiatrist three times per year. On a monthly basis, each psychiatrist receives feedback on performance related to the admission and integrated assessments, weekly and monthly PPNs, Stat medications, Tardive Dyskinesia and transfer note audit forms. Analysis of the prescription of anticholinergics, benzodiazepines and intra- and inter-class polypharmacy are also provided on a monthly basis for individual practitioners and in aggregate form.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Continue current practice.<br>2. Provide summary of any corrective actions to address group and/or practitioner trends/patterns. |
| D.1.c | Each State hospital shall ensure that: | Please see sub-cells for compliance findings. |
| D.1.c.i | Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes: | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities.<br><br>**Findings:**<br>ASH indicated that the tool was approved and implemented in May 2009.<br><br>**Recommendations 2 and 3, April 2009:**<br>• Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the |

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<td>examination.<br>• Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>Findings:<br>Using the DMH Admission Medical Assessment Monitoring Form, ASH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 84% of admissions each month during the review period (March-August 2009):<br><br>
<table>
<tr><th colspan="3">Initial Medical Assessment</th></tr>
<tr><td>1.</td><td>Completed within 24 hrs.</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.<br><br>Other findings:<br>A review of the charts of 10 individuals who were admitted during this review period (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB) found compliance in all cases.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor completeness of the admission medical examination within the specified time frame.</td>
</tr>
<tr>
<td>D.1.c.i.1</td>
<td>a review of systems;</td>
<td>100%, compared to 100% in the previous review period.</td>
</tr>
<tr>
<td>D.1.c.i.2</td>
<td>medical history;</td>
<td>100%, compared to 100% in the previous review period.</td>
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| | | |
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| D.1.c.i.3 | physical examination; | 99%, compared to 100% in the previous review period. |
| D.1.c.i.4 | diagnostic impressions; and | The monitoring data presented by the facility was inconsistent and is not presented here. |
| D.1.c.i.5 | management of acute medical conditions | 98%, compared to 100% in the previous review period. |
| D.1.c.ii | within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes: | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Provide training to WRPTs regarding the proper formulation of individuals' strengths. The training should focus on attributes of the individuals that could be utilized in the WRPs.<br><br>**Findings:**<br>ASH reported that psychiatry leadership consulted with the WRP Master Trainer (Dr. Alarcon) to modify the Admission Psychiatric Assessment to formulate strengths appropriate for the WRPTs' use in WRP development.<br><br>**Recommendations 2 and 3, April 2009:**<br>• Monitor this requirement using the DMH Admission Psychiatric Assessment Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH Admission Psychiatric Assessment Audit, ASH assessed compliance based on an average sample of 95% of admissions each month during the review period (March-August 2009). The mean compliance rate of 100% is consistent with the rate reported during the previous review period (99%). |

| | | |
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| | | The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.<br><br>**Recommendation 4, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.<br><br>**Findings:**<br>ASH reported that it implemented a review of the draft dictation prior to finalization to ensure the presence of the required elements.<br><br>**Other findings:**<br>This monitor reviewed the charts of 10 individuals who were admitted during this review period (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB). The review found that the facility has made significant progress in addressing the deficiencies that were outlined by this monitor in the previous reports.<br><br>However, in most of the charts reviewed, the violence risk assessment (VRA) checklist (historical factors) did not provide specific information regarding the nature/severity of previous aggressive behavior and the timeframes of the most recent aggression. Therefore, the current rating of violence risk (low, moderate and severe) did not appear to account for this important variable.<br><br>ASH has initiated the process of revising the violence risk assessment checklist based on results of a study that the facility conducted to predict the occurrence of violence in a forensic psychiatric hospital setting. This study found no relationship between the current risk ratings that were established upon admission and physical aggression occurring subsequently. However, certain items on the VRA checklist |

| | | |
|---|---|---|
| | | were found to be strongly correlated with the occurrence of aggression and plans are underway to incorporate these items in the revised VRA checklist.<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendations**:<br>1. Ensure that the violence risk assessment upon admission provides specific information regarding the nature and severity of previous aggression and the timeframes for the most recent aggression and that the rating of risk accounts for this information.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| D.1.c.ii.1 | psychiatric history, including a review of presenting symptoms; | 2. *Psychiatric history, including review of presenting symptoms* 99%<br><br>The facility reported an improvement in mean compliance from 88% in the previous review period. |
| D.1.c.ii.2 | complete mental status examination; | 96%, compared to 97% in the previous review period. |
| D.1.c.ii.3 | admission diagnoses; | 97%, compared to 96% in the previous review period. |
| D.1.c.ii.4 | completed AIMS; | 100%, compared to 98% in the previous review period. |
| D.1.c.ii.5 | laboratory tests ordered; | 98%, compared to 92% in the previous review period. |
| D.1.c.ii.6 | consultations ordered; and | 99%, compared to 79% in the previous review period. |

<table>
<tr>
<td>D.1.c.ii.7</td>
<td>plan of care.</td>
<td>
<table>
<tr><td>8.</td><td>Plan of care</td><td>90%</td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications with rationale</td><td>97%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medications as applicable, with specific behavioral indicators</td><td>93%</td></tr>
<tr><td>8.c</td><td>Special precautions to address risk factors as indicated</td><td>78%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 41% in the previous review period.
</td>
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<tr>
<td>D.1.c.iii</td>
<td>within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Monitor this requirement using the DMH Integrated Assessment: Psychiatric Section auditing form based on at least a 20% sample.<br>
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>
Findings:<br>
Using the DMH Integrated Assessment Psychiatry Section Audit, ASH assessed compliance based on an average sample of 90% of Integrated Assessments due each month during the review period (March-August 2009). Mean compliance increased to 90% in the current review period from 82% in the previous review period.<br><br>
The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.<br><br>
Recommendation 3, April 2009:<br>
Provide a summary outline of improvements in practice made as a result
</td>
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| | | of review by the facility of internal monitoring data.<br><br>**Findings:**<br>ASH reported that it implemented a review of the draft dictation prior to finalization to ensure the presence of the required elements.<br><br>**Recommendation 4, April 2009:**<br>Ensure that the assessments are free of markings/corrections without appropriate signatures/initials.<br><br>**Findings:**<br>ASH reported that HIMD monitors and audit charts to ensure that charts are free of markings and corrections without appropriate signatures or initials.<br><br>**Other findings:**<br>This monitor reviewed the charts of 10 individuals who were admitted during this review period (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB). The review found that the facility has made significant progress in addressing the deficiencies that were outlined by this monitor in the previous reports. However, the violence risk assessment was limited by the deficiency that was outlined in D.1.c.ii. In addition, a few assessments did not provide specific information regarding significant disturbances in the individual's thought content (JM and JM-2).<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendations**:<br>1. Same as D.1.c.ii, Recommendation 1.<br>2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and |

| | | |
|---|---|---|
| | | compared to the last period). |
| D.1.c.iii.1 | psychiatric history, including a review of present and past history; | 2. *Psychiatric history, including a review of present and past history.* 100%<br><br>The facility reported an improvement in mean compliance from 86% in the previous review period. |
| D.1.c.iii.2 | psychosocial history; | 3. *Psychosocial history is documented.* 100%<br><br>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period. |
| D.1.c.iii.3 | mental status examination; | 4. *Complete mental status examination is documented* 97%<br><br>The facility reported an improvement in mean compliance rate from 75% in the previous review period. |
| D.1.c.iii.4 | strengths; | 100%, compared to 98% in the previous review period. |
| D.1.c.iii.5 | psychiatric risk factors; | 6. *Psychiatric risk factors are documented* 99%<br><br>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period. |
| D.1.c.iii.6 | diagnostic formulation; | 94%, compared to 62% in the previous review period. |

<table>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>99%, compared to 96% in the previous review period.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>96%, consistent with 96% in the previous review period.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td>99%</td></tr>
</table>
The facility reported an improvement in mean compliance from 47% in the previous review period.
</td></tr>
<tr><td>D.1.c.iii.10</td><td>management of identified risks.</td><td>94%, compared to 97% in the previous review period.</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>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;</td><td>
Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Provide documentation of 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 title of each program, the instructors, with their academic affiliation, if applicable and the professionals who have received training.<br><br>
Findings:<br>
ASH provided medical education programs related to a variety of topics for its staff. The following is a summary of medication education programs specific to cognitive and other neuropsychiatric disorders.
<table>
<tr><td>Date</td><td>Title</td><td>Speaker/ affiliations</td><td>Attendees</td></tr>
<tr><td>7/16/09</td><td>Evaluation of Malingering Part II</td><td>C. Mathiesen, PsyD, ABPP</td><td>MD - 1</td></tr>
</table>
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| | | |
|---|---|---|
| 7/30/09 | Neuropsychology of Eating Disorders | Makoto Ono, PhD | MD - 0 |
| 8/6/09 | S & N Chapter 21: The Agnosias | Cindy Duke, PhD | MD - 1 |
| 8/13/09 | Neuropsychological Impairment in Drug Abuse | Charles Broderick, PhD | MD - 1 |
| 8/18/09 | Dementia: Causes and Classifications | Erika Wartena, MD | MD - 16 |
| 8/27/09 | Developmental Delay with Head Trauma | Leslie Bolin, PhD | MD - 1 |

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

**Findings:**
ASH reported the following comparative numbers of NOS, Deferred and Rule Out Diagnoses for individuals who had been hospitalized for more than 60 days:

| Diagnostic category | Previous Period | Current Period |
|---|---|---|
| | Number of individuals in category | |
| Rule Out | 22 | 18 |
| Deferred | 73 | 4 |
| NOS | 103 | 51 |

**Other findings:**
This monitor reviewed the facility's databases regarding individuals who received diagnoses listed as Not Otherwise Specified (NOS) for more than two months. The review found that the facility has decreased the

average number of these individuals by almost 50% since the last review (from 103 to 51). The current average number appears to be clinically appropriate for a facility of this size. The database showed that no individual was currently diagnosed with Impulse Control, NOS; Mental Disorder, NOS; Mood Disorder, NOS; or Dementia NOS for more than two months.

This monitor reviewed the charts of 10 individuals who received diagnoses listed as not otherwise specified (NOS) for more than two months during this review period. The following table outlines the reviews:

| Initials | Diagnosis (NOS) |
|---|---|
| AAA | Cognitive Disorder, NOS |
| AMR | Psychotic Disorder, NOS (recently changed to Schizoaffective Disorder) |
| BP | Cognitive Disorder, NOS |
| DRR | Depressive Disorder, NOS (recently changed to Malingering) |
| GC | Cognitive Disorder, NOS |
| MD | Cognitive Disorder, NOS |
| PCC | Cognitive Disorder, NOS |
| PTF | Psychotic Disorder, NOS (recently changed to Schizoaffective Disorder) |
| RWU | Cognitive Disorder, NOS |
| TE | Depressive Disorder, NOS |

The review found general evidence of significant progress in the justification of the NOS diagnoses, including general evidence that individuals with diagnoses of Cognitive Disorder, NOS have received adequate cognitive screening upon admission (AAA, BP, GC, MD, PCC and RWU) as well as further evaluation by neuropsychological testing as indicated (BP, GC, PCC and RWU).

| | | |
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| | | In order to maintain substantial compliance, the facility needs to ensure consistency of diagnoses between the WRPs and the corresponding psychiatric progress notes.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Continue to provide documentation of 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 title of each program, the instructors with their academic affiliation, if applicable and the professionals who have received training.<br>2. Continue to provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period. |
| D.1.d.ii | The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist); | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in D.1.a and D.1.d.i.<br><br>**Findings:**<br>Same as in D.1.a and D.1.d.i.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendations**:<br>Same as in D.1.a and D.1.d.i. |
| D.1.d.iii | Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in D.1.a and D.1.d.i.<br><br>**Findings:**<br>Same as in D.1.a and D.1.d.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>Same as in D.1.a and D.1.d.i. |
| D.1.d.iv | "no diagnosis" is clinically justified and documented. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review.<br><br>**Findings:**<br>ASH reported that two individuals were diagnosed with "no diagnosis" on Axis I during the review period. The Chief Psychiatrist reviewed the cases and considered the diagnosis appropriate in both. The facility reported that the Integrated Assessment: Psychology Section, DSM-IV-TR Checklist and diagnosis of record were consistent with the "no diagnosis" on Axis I. |

| | | |
|---|---|---|
| | | **Other findings:**<br>Reviews by this monitor found no evidence of "no diagnosis" listed on Axis I.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to provide specific information regarding the number of individuals who have received "no diagnosis" on Axis I, identification numbers of these individuals, any review by the Medical Director/Chief of Psychiatry of justification and results of this review. |
| D.1.e | Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH Weekly Physician Progress Note and DMH Psychiatry Monthly PPN Auditing Forms based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>Using the DMH Weekly Physician Progress Note (PPN) Audit, ASH assessed compliance based on an average sample of 95% of individuals with length of stay less than 60 days during the review period (March-August 2009):<br><br>1. *The reassessments are completed weekly for the first 60 days on the admission units:* 67%<br>1.a *There is a note present every seven days from the date of admission, with the understanding that the* 56% |

| | | |
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| | *Integrated Assessment: Psychiatry Section can serve as the first weekly note.* | |
| 1.b | *The note must contain the subjective complaint, objective findings, assessment and plan of care* | *77%* |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 33% | 67% |
| Compliance rate in last month of period | | |
| 1. | 37% | 65% |
| 1.a | 40% | 42% |
| 1.b | 52% | 87% |

ASH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 99%, compared to 90% in the previous review period.

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

**Findings:**
ASH reported that it identified two barriers to compliance for this indicator:

1. Psychiatrists who covered caseloads for colleagues were inconsistent in completing weekly PPNs; and
2. Psychiatrists on the long-term units did not complete weekly PPNs for

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| | | individuals who were transferred off admission units prior to their sixtieth day of admission.<br><br>The facility indicated that as corrective actions, it revised the template for the Psychiatric Transfer Note (July 30, 2009) to include the number of weekly notes due following transfer and intends to develop an electronic database to track completion of weekly PPNs. ASH reported that it also revised the Weekly Psychiatric Progress Note template on August 1, 2009.<br><br>**Other findings:**<br>This monitor reviewed the charts of 10 individuals who were admitted during this review period (AHC, CEF, DLA, DS-3, DS-4, JLP, JM, JM-2, JM-3 and LTB). The review focused on the timeliness of the weekly and monthly notes. The review found substantial compliance in all cases.<br><br>**Compliance:**<br>Partial regarding the weekly progress notes; substantial regarding the monthly progress notes.<br><br>**Current recommendation**:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| D.1.f | Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following: | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement using the DMH Psychiatry Monthly PPN Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |

| | | |
|---|---|---|
| | | **Findings:**<br>ASH implemented the revised PPN Auditing Form in July 2009 and used the revised form to assess compliance, based on an average sample of 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.<br><br>**Recommendation 3, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>In July 2009, the facility made further refinements to its template for the Monthly Psychiatric Progress Notes to ensure proper attention to the following areas:<br><br>1. Review of AIMS testing score annually or every 90 days if there is current diagnosis of TD, history of TD or positive score (of 3 or more);<br>2. Mini Mental Status Examination annually or every 90 days if there is evidence of cognitive impairment or continuous administration of anticholinergic/benzodiazepine medications for more than 60 days;<br>3. Examples of the implications of the psychiatric status in the assignment of PSR Mall groups and participation in these groups;<br>4. Rationale for the use of new generation antipsychotic medications (NGAs) for individuals with diagnosis or family history of certain metabolic disorders;<br>5. The use of PRN/Stat or adjustments in regular medications to minimize the risk of seclusion/restraints; and<br>6. Key strategies in non-pharmacological treatment interventions. |

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| | | **Other findings:**<br>This monitor reviewed the charts of 15 individuals (AW, CDB, DM, FB, GG, JS, JV, KC, MJ, MT, RG, RH, ST, TB and WWM). The review found that ASH has made significant progress in addressing the deficiencies that were outlined in the previous report, including general evidence of proper implementation of the revised template. In order to achieve substantial compliance with this requirement, the facility needs to ensure more consistent documentation of an individualized risk/benefit analysis regarding the use of high-risk medications.<br><br>This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during the review period (ADG, CJG, DH, DS, DS-2 and PWM). The review focused on the utilization of PRN/Stat medications prior to the use of seclusion and/or restraint (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b.<br><br>The review found improvement in addressing the previously-reported deficiencies in the following areas:<br><br>1. Prescription of PRN medications for specified behavioral indications (in most charts);<br>2. The adjustment of the regular medication regimen based on review of the episodes of behavior that resulted in PRN medication use (in most charts);<br>3. The documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications and adjustment of treatment based on this assessment (CJG); and<br>4. The documentation by nursing of the individual's response to PRN/Stat medication use (in most charts).<br><br>This review found a few deficiencies in the following areas: |

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<td>
1. Timely administration of PRN medications that were appropriately tailored to the symptoms (DH, DS and PMW); and<br>
2. The selection of PRN medications that were appropriately tailored to the individual's diagnosis and the circumstances of the behavior requiring this use (DH, DS and PMW);<br><br>
**Compliance:**<br>
Partial; improved compared to the last review.<br><br>
**Current recommendation**:<br>
Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
</td>
</tr>
<tr>
<td>D.1.f.i</td>
<td>significant developments in the individual's clinical status and of appropriate psychiatric follow up;</td>
<td>
SH implemented the revised PPN Auditing Form in July 2009. The sub-indicators of this item were revised to reorganize the structure of the PPN and further refine the requirements of the assessment of this information. The following tables summarize the data:
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>2.</td><td>Significant developments in the individual's clinical status and of appropriate psychiatric follow-up reassessments are completed monthly on other (than admission) units.</td><td>89%</td></tr>
<tr><td>2.a</td><td>Identifying information including current legal status.</td><td>94%</td></tr>
<tr><td>2.b</td><td>Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.</td><td>96%</td></tr>
<tr><td>2.c</td><td>Interval history is documented for the past 30 days including a summary of psychiatric progress, a</td><td>78%</td></tr>
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| | *summary of the status of medical problems listed in Foci 6 affecting psychiatric status, a summary of relevant labs, consults and other tests obtained in the past month, and current changes in BMI and waist circumference.* | |
| 2.d | *A list of current medications and dosages including any psychiatric PRNs/stats and any changes which occurred during the past month.* | 88% |
| 2.e | *Current Mini Mental Status Examination* | 78% |
| 2.f | *Current Mental Status Examination* | 98% |
| 2.g | *Current AIMS* | 91% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 33% | 89% |
| Compliance rate in last month of period | | |
| 2. | 63% | 96% |
| 2.c | 53% | 91% |
| 2.d | 36% | 96% |
| 2.e | 67% | 95% |

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| D.1.f.ii | Timely and justifiable updates of diagnosis and treatment, as clinically appropriate; | ASH implemented the revised PPN Auditing Form in July 2009. The sub-indicators of this item were revised to emphasize the necessary components for accurate diagnosis and to clarify the requirement for a discussion of unresolved diagnoses. The following table summarizes the data: |

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<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>3.</td><td>Timely and justifiable updates of diagnoses/ treatment as clinically appropriate.</td><td>95%</td></tr>
<tr><td>3.a</td><td>The 5 Axis Diagnosis</td><td>97%</td></tr>
<tr><td>3.b</td><td>The individual's target symptoms are consistent with the diagnosis.</td><td>96%</td></tr>
<tr><td>3.c</td><td>A discussion of diagnostic questions that still require resolution including deferred, r/o and NOS diagnoses.</td><td>100%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 62% in the previous review period.
</td>
</tr>
<tr>
<td>D.1.f.iii</td>
<td>Analyses of risks and benefits of chosen treatment interventions;</td>
<td>
ASH implemented the revised PPN Auditing Form in July 2009. The number of this item changed and the content was modified to increase the specificity of requirements for analyzing the risks and benefits of pharmacological treatment. The following table summarizes the data:
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>5.</td><td>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</td><td>91%</td></tr>
<tr><td>5.a</td><td>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data.</td><td>95%</td></tr>
<tr><td>5.b</td><td>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</td><td>84%</td></tr>
<tr><td>5.c</td><td>Monitored for effectiveness against clearly identified target variables.</td><td>95%</td></tr>
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<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>88%</td></tr>
</table>
<br>The facility reported an improvement in mean compliance from 50% in the previous review period.
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</tr>
<tr>
<td>D.1.f.iv</td>
<td>Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;</td>
<td>
ASH implemented the revised PPN Auditing Form in July 2009. The number of this item changed and the content of the sub-items was modified to increase the focus on high risk behaviors. The following table summarizes the data:
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>4.</td><td>Assessment of, and attention to, high-risk behaviors (assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks</td><td>76%</td></tr>
<tr><td>4.a</td><td>The individual's high risk behaviors</td><td>82%</td></tr>
<tr><td>4.b</td><td>The frequency of high risk behaviors during the past month</td><td>81%</td></tr>
<tr><td>4.c</td><td>Precautions and treatments instituted or planned to minimize those risks</td><td>79%</td></tr>
<tr><td>4.d</td><td>The effectiveness of precautions taken</td><td>68%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance since the previous review period:
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<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>68%</td><td>76%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>66%</td><td>93%</td></tr>
<tr><td>4.a</td><td>69%</td><td>94%</td></tr>
<tr><td>4.b</td><td>71%</td><td>93%</td></tr>
<tr><td>4.c</td><td>66%</td><td>93%</td></tr>
<tr><td>4.d</td><td>N/A</td><td>93%</td></tr>
</table>
</td></tr>
<tr><td>D.1.f.v</td><td>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;</td><td>ASH implemented the revised PPN Auditing Form in July 2009. The number of this item changed and the content was modified to decrease redundancy with other audit tools and increase alignment with the EP requirement. The following table summarizes the data:
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>88%</td></tr>
</table>
ASH indicated that the implementation of the Physician Profile is intended to increase compliance with this indicator.</td></tr>
<tr><td>D.1.f.vi</td><td>Timely review of the use of “pro re nata” or “as-needed” (“PRN”) and “Stat” (i.e., emergency psychoactive) medications and adjustment of</td><td>ASH implemented the revised PPN Auditing Form in July 2009. The number of this item changed and the sub-items were removed to increase focus on the EP requirement. The following table summarizes the data:</td></tr>
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<table>
<tr>
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<td>regular treatment, as indicated, based on such use; and</td>
<td>
<table>
<tr><td colspan="3">Revised</td></tr>
<tr><td>6.</td><td>Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</td><td>71%</td></tr>
</table>
<br>
The facility reported a mean compliance rate of 71%, compared to 33% during the previous review period. The compliance rate for the last month of the current period was 71%, compared to 24% during the last month of the previous review period.<br><br>
ASH reported that it implemented a standardized Stat form in August 2009 that delineates the required documentation elements for Stat medications. The form is aligned with nursing documentation for administration of Stat medications. The facility indicated that it intends to develop a "real time" tracking system for Stat medications to increase monitoring of timeliness.
</td>
</tr>
<tr>
<td>D.1.f.vii</td>
<td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</td>
<td>
ASH implemented the revised PPN Auditing Form in July 2009. The number of this item changed and the sub-items were modified to increase the expectation for clinical specificity within the PPN. The following table summarizes the data:<br><br>
<table>
<tr><td>7.</td><td>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive support plans prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for</td><td>100%</td></tr>
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| | *psychopharmacological treatments, and document evidence of integration of treatments.* | |
| 7.a | *Behavioral guidelines/PBS plans, if applicable including the key strategies being employed.* | 100% |
| 7.b | *Other therapies such as individual therapy* | 100% |

The facility reported an improvement in mean compliance from 23% in the previous review period.

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| D.1.g | When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 4, April 2009:**<br>• Provide ongoing feedback and mentoring to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.<br>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>The facility indicated that it revised the template for the Psychiatric Transfer Note on July 30, 2009. The revised template standardized the transfer notes to ensure that the required elements are included in the note.<br><br>**Recommendations 2 and 3, April 2009:**<br>• Monitor this requirement using the DMH Physician Inter-Unit Transfer Note Auditing Form based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>ASH used the DMH Physician Inter-Unit Transfer Note Audit to assess |

compliance. The average sample was 20% of the individuals who experienced inter-unit transfer per month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *Psychiatric course of hospitalization,* | 75% |
| 2. | *Medical course of hospitalization,* | 76% |
| 3. | *Current target symptoms,* | 86% |
| 4. | *Psychiatric risk assessment,* | 86% |
| 5. | *Current barriers to discharge,* | 75% |
| 6. | *Anticipated benefits of transfer.* | 90% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 40% | 75% |
| 2. | 41% | 76% |
| 3. | 74% | 86% |
| 4. | 59% | 86% |
| 5. | 48% | 75% |
| 6. | 79% | 90% |
| Compliance rate in last month of period | | |
| 1. | 43% | 100% |
| 2. | 57% | 100% |
| 3. | 71% | 100% |
| 4. | 64% | 98% |
| 5. | 64% | 100% |
| 6. | 93% | 100% |

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| | | **Recommendation 5, April 2009:**<br>Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accordance with PBS principles.<br><br>**Findings:**<br>ASH reported that there were no individuals with inter-unit transfers for behavioral reasons that did not have or were not considered for behavioral interventions during the review period.<br><br>**Other findings:**<br>A review of the charts of six individuals who experienced inter-unit transfers during the last two months of this review period found substantial compliance in five charts (DD, JAD, LA, LF and LRH) and noncompliance in one (EJ). These findings indicate that in recent months, the facility has implemented adequate corrective actions to address this requirement.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| 2. Psychological Assessments | | |
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| | | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Deborah Hewitt, PhD, Psychologist<br>2. Diane Imrem, PsyD, Chief of Psychology<br>3. Ed Bischoff, PhD, Psychologist<br>4. Killorin Riddell, PhD, Coordinator of Psychology Specialist Services<br>5. Michael Tandy, PhD, Psychologist<br>6. Teresa George, PhD, Senior Psychologist Supervisor<br><br><u>Reviewed</u>:<br>1. The charts of the following 55 individuals: AC, AE, AR, AT, BC, BO, CM, DLA, DS, EC, EDF, EDG, EN, FA, GJ, GM, GR, HH, HN, HS, JAZ, JD, JB, JD, JF, JLP, JM-1, JM-2, JM-3, JP, JS, JT, JW, KA, KTB, LB, MC, MD, MHC, MT, MV, RF, RG, RGP, RH, RM, RP, SC, SE, SMS, SS, SW, TC, TN and VK<br>2. Focused Psychological Assessments<br>3. Functional Assessments completed in the last six months<br>4. Integrated Assessments: Psychology Section<br>5. List of individuals 23 years and under<br>6. List of individuals whose preferred/primary language is other than English<br>7. List of individuals with diagnostic uncertainties (No Diagnosis, NOS, Rule-out, and Deferred)<br>8. List of neuropsychological referrals<br>9. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission<br>10. Neuropsychological Assessments completed in the last six months<br>11. PBS Plans developed and implemented in the last six months<br>12. Structural Assessments completed in the last six months |

| | | |
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| | | Observed:<br>1. WRPC (Program III, unit 21B) for 14-day review of JWC<br>2. WRPC (Program VI, unit 7A) for quarterly review of JEC<br>3. WRPC (Program VII, unit 30) for quarterly review of RH<br>4. PSR Mall group: Anger Management<br>5. PSR Mall group: Cognitive Restructuring--Sponge Brain<br>6. PSR Mall group: Commitment to Change<br>7. PSR Mall group: Depression Group (Spanish Language)<br>8. PSR Mall group: Mental Health Wellness<br>9. PSR Mall group: Supported Treatment Assisted Recovery (STAR)<br>10. PSR Mall group: Wellness and Recovery Action Planning (WRAP) |
| D.2.a | Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Finalize and get the necessary approvals for the DCAT manual.<br><br>**Findings:**<br>ASH has included the DCAT manual as an addendum to the PBS Manual since many DCAT activities are aligned with the PBS process and procedures. In addition, DCAT staff participates in all PBS staff training and accreditation procedures.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.2.b | Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Ensure that all individuals admitted to the facility have their |

| | | |
|---|---|---|
| | been performed within one year of admission and is available to the interdisciplinary team. | 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.<br>• 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<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (March-August 2009):<br><br>1. *Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.* — 100%<br><br>Comparative data indicated improvement in compliance from 70% in the previous review period.<br><br>This monitor reviewed charts of 14 individuals under 23 years of age. Two individuals (BN and TS) possessed a GED or a high school diploma or were recently evaluated and did not require further assessments. Assessments for six individuals (JP, MC, MV, MV, RH and VK) were completed in a timely fashion. The remaining six individuals (GJ, GR, JB, JF, JS and TN) were discharged prior to 30 days or refused to participate in the assessments. |

<table>
<tr><td></td><td></td><td>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.2.c</td><td>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Ensure that all psychologist positions are filled.<br><br>Findings:<br>The following table summarizes ASH's psychology staffing pattern as of August 2009:<br><br>
<table>
<tr><td></td><td>Filled positions</td><td>Vacant positions</td></tr>
<tr><td>Unit psychologist</td><td>22</td><td>4</td></tr>
<tr><td>Senior psychologist</td><td>3</td><td>0</td></tr>
<tr><td>Neuropsychologist</td><td>4</td><td>0</td></tr>
</table>
<br>Since the previous tour, the facility has reduced the number of vacant unit and senior psychologist positions from 15 and four positions respectively.<br><br>Other findings:<br>The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:<br><br>
<table>
<tr><td>1.a</td><td>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</td><td>68</td></tr>
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<table>
<tr><td>1.b</td><td>Number of psychologists who meet the hospital's credentialing and privileging requirements</td><td>68</td></tr>
<tr><td>2.a</td><td>Number of psychologists observed while undertaking psychological assessments</td><td>21</td></tr>
<tr><td>2.b</td><td>Number observed to be verifiably competent in assessment procedures</td><td>21</td></tr>
</table>
<br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Ensure that all psychologist positions are filled.
</td>
</tr>
<tr>
<td>D.2.d</td>
<td>Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:</td>
<td>Compliance:<br>
Substantial.</td>
</tr>
<tr>
<td>D.2.d.i</td>
<td>expressly state the clinical question(s) for the assessment;</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Ensure that the statements of the reasons for referral are concise and clear.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):<br><br>
<table>
<tr><td>3.</td><td>Expressly state the clinical question(s) for the assessment.</td><td>100%</td></tr>
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| | | |
|---|---|---|
| | | Comparative data indicated improvement in compliance from 88% in the previous review period.<br><br>A review of the Focused Psychology Assessments for five individuals found that all five contained clear and concise statements with a rationale for the referral (AE, BO, JAZ, JM-1 and JT).<br><br>**Recommendation 2, April 2009:**<br>Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH.<br><br>**Findings:**<br>All five Focused Psychology Assessments reviewed (AE, BO, JAZ, JM-1 and JT) showed continuity among the sections, from clinical questions to conclusions and recommendations.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.d.ii | include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009): |

<table>
<tr>
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<table>
<tr><td>4.</td><td>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance from 82% in the previous review period.<br><br>
A review of the Focused Psychology Assessments for five individuals found that all five addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP (AE, BO, JAZ, JM-1 and JT).<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.2.d.iii</td>
<td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):<br><br>
<table>
<tr><td>5.</td><td>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</td><td>100%</td></tr>
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| | | |
|---|---|---|
| | | Comparative data indicated improvement in compliance from 83% in the previous review period.<br><br>A review of the Focused Psychology Assessments for five individuals found that all five indicated if the individual would benefit from individual and/or group therapy (AE, BO, JAZ, JM-1 and JT).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.d.iv | be based on current, accurate, and complete data; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that all psychological assessments are based on current, accurate, and complete data.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):<br><br>6. *Be based on current, accurate, and complete data.* 99%<br><br>Comparative data indicated improvement in compliance from 76% in the previous review period.<br><br>A review of the Focused Psychology Assessments for five individuals found that all five included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AE, BO, JAZ, JM-1 and JT). |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.2.d.v</td><td>determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.<br><br>Findings:<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):<br><br>
<table>
<tr><td>7.</td><td>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</td><td>100%</td></tr>
</table>
<br>Comparative data indicated improvement in compliance from 81% in the previous review period.<br><br>A review of the Focused Psychology Assessments for five individuals found that all five indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (AE, BO, JAZ, JM-1 and JT).<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.2.d.vi</td><td>include the implications of the findings for interventions;</td><td>Current findings on previous recommendation:</td></tr>
</table>

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<td>
Recommendation, April 2009:<br>
Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):<br><br>
<table>
<tr><td>8.</td><td>Include the implications of the findings for interventions</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance from 91% in the previous review period.<br><br>
A review of the Focused Psychology Assessments for five individuals found that all five contained documentation of the implications of the findings for PSR and other interventions (AE, BO, JAZ, JM-1 and JT).<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.2.d.vii</td>
<td>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Ensure that all focused psychological assessments meet this requirement.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):
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<table>
<tr><td>9.</td><td>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance from 80% in the previous review period.<br><br>
A review of the Focused Psychology Assessments for five individuals found that all five contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AE, BO, JAZ, JM-1 and JT).<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.2.d.<br>viii</td>
<td>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• 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.<br>
• Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.<br><br>
Findings:<br>
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Focused Psychological Assessments due each month for the review period (March-August 2009):
</td>
</tr>
</table>

| | | |
|---|---|---|
| | | <table><tr><td>10.</td><td>*Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*</td><td>100%</td></tr></table><br>Comparative data indicated maintenance of compliance greater than 90% since the previous review period.<br><br>A review of the Focused Psychology Assessments for five individuals found that all five had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (AE, BO, JAZ, JM-1 and JT).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.e | Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above. | ASH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan and where indicated, conducted re-assessments.<br><br>**Compliance:**<br>Substantial. |
| D.2.f | Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a | **Compliance:**<br>Substantial. |

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

**Current findings on previous recommendations:**

**Recommendation 1, April 2009:**
Ensure that integrated psychological assessments are conducted in a timely manner as required.

**Findings:**
Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (March-August 2009):

<table>
<tr><td>12.</td><td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td><td>89%</td></tr>
</table>

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

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>12.</td><td>33%</td><td>89%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>12.</td><td>48%</td><td>100%</td></tr>
</table>

A review of the IAPs for 23 individuals found that all 23 were conducted

</td></tr>
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| | | |
|---|---|---|
| | | in a timely manner (AC, AR, CM, DLA, DS, EC, EDF, EDG, FA, GM, JD, JLP, JM-2, JM-3, JP, JW, KTB, LB, MD, MT, RGP, RM, and RP). GM is a readmission and an addendum was completed in a timely manner.<br><br>**Recommendation 2, April 2009:**<br>Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.<br><br>**Findings:**<br>Documentation review and interview of the Chief of Psychology found that ASH is short one admission unit psychologist. The facility uses a roamer to conduct the assessments in the one unit.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.f.i.1 | address the nature of the individual's impairments to inform the psychiatric diagnosis; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 98% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (March-August 2009):<br><br>13. *Address the nature of the individual's impairments to inform the psychiatric diagnosis* 99%<br><br>Comparative data indicated improvement in compliance from 75% in the previous review period. |

| | | |
|---|---|---|
| | | A review of the IAPs for eight individuals found that all eight documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (AR, JD, JM-1, JM-2, JP, LB, MT and RP).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.f.i.2 | provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item.<br>• Ensure accurate evaluation of psychological functioning that informs WRPTs of individuals' rehabilitation service needs.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 98% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (March-August 2009):<br><br>14. *Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.* 99%<br><br>Comparative data indicated improvement in compliance from 75% in the previous review period.<br><br>A review of the IAPs for eight individuals found that all eight provided an accurate and valid evaluation of the individual's psychological functioning, |

| | | |
|---|---|---|
| | | and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (AR, JD, JM-1, JM-2, JP, LB, MT and RP).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.f.ii | if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue with the current procedure.<br><br>**Findings:**<br>ASH continues to follow the policy of conducting structural and functional assessments for all referrals prior to developing and implementing positive behavior support plans. All plans reviewed had been developed and implemented using data derived through the structural and functional assessments.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.2.f.iii | additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>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.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of Differential |

Diagnoses, 98% of Rule-outs, 100% of Deferred Diagnoses, 99% of "No diagnosis", and 100% of the Not Otherwise Specified diagnoses from the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (March-August 2009). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:

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

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 16. *Differential diagnosis* | 22% | 100% |
| 17. *Rule-out* | 46% | 100% |
| 18. *Deferred* | 46% | 100% |
| 19. *No diagnosis* | 83% | 100% |
| 20. *NOS diagnosis* | 50% | 100% |

This monitor reviewed the charts of nine individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all nine of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (BC, JM-1, KA, RF, RG, SC, SE, SW and TC).

| | | |
|---|---|---|
| | | **Other findings:**<br>ASH uses a database to ensure that all diagnostic uncertainties are tracked and monitored for clarification within a 60 day timeline.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.2.g | For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Ensure that examiners consider cultural aspects when choosing assessment instruments for individuals whose preferred language is not English.<br>• Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.<br><br>**Findings:**<br>Using the DMH Psychology Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the review period (March-August 2009):<br><br>21.a — *Number of individuals who needed assessment during the evaluation period whose primary language was not English* — 19<br>21.b — *Of those in 21.a, number of individuals who were assessed in their primary language* — 19<br>22.a — *Of those in 21.a, number of individuals who could not be assessed* — 9<br>22.b — *Of those in 22.a, number of individuals who had plans developed to meet their assessment needs* — 9<br>23. — *Of those in 22.b, number of individuals* — 9 |

| | | |
|---|---|---|
| | | *whose plans for assessment were implemented* |

A review of the charts of 12 individuals (AT, EN, GM, GR, HH, HN, HS, JP, JS, MHC, SMS and SS) found that assessments for all 12 individuals were conducted in the individuals' primary/preferred languages.

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement.

| 3. Nursing Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. Concha Silva, RN<br>2. Donna Hunt, RN, HSS<br>3. Marlene Espitia, RN, Assistant Director of Standards Compliance<br>4. Rosie Morrison, RN, HSS<br><br>Reviewed:<br>1. ASH's progress report and data<br>2. ASH's training rosters<br>3. Medical records for the following 40 individuals: AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK |
| D.3.a | Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum: | **Compliance:**<br>Substantial. |
| D.3.a.i | a description of presenting conditions; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Provide training to Admission RNs and nursing mentors that focuses on the clinical relevance of questions contained in the admission and integrated nursing assessments.<br><br>**Findings:**<br>Since February 2009, ASH has required that all new RNs receive eight hours of hands-on training regarding Admission and Integrated Assessments. In addition, ASH implemented a mentoring program in May |

2009 in which 30 RNs were taken out of the staffing numbers so that they could provided concentrated mentoring regarding the following areas:

- Assessments
- Communication skills
- Focus 6
- Provision of care
- Restraint/seclusion and PRN/Stat documentation
- RN monthly/PT weekly documentation
- WRP input
- Medication side effect monitoring

**Recommendation 2, April 2009:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 95% mean sample of admissions each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *A description of presenting conditions* | 90% |

Comparative data indicated improvement in compliance from 62% in the previous review period.

A review of Nursing Admission Assessments for 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that ASH has made significant improvement in the content and the quality of both the initial and integrated admission assessments, especially in the area of the description of the presenting conditions. ASH's efforts in

implementing strategies since the last review regarding the nursing admission/integrated assessments have resulted in a considerable increase in the clinically relevant content of the assessments. The improvement in the specific information included in the other areas of the assessments had a significant impact on the narrative section addressing the presenting conditions, in that much of the clinical information was addressed in the narrative. In addition, most of the goals that were included in the admission assessments were more in alignment with the information contained in the assessment. There was also significant improvement in the assessments for individuals who were not fully cooperative with the admission process. These assessments were noted to include more individual-specific observations that included elements such as eye contact, posture and nonverbal reactions to questions asked than previous assessments reviewed. ASH needs to continue producing the quality admission/integrated assessments that were seen during this review.

Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH also assessed its compliance based on a 93% mean sample of admissions each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.* | 82% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 69% | 82% |

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.</td><td>65%</td><td>98%</td></tr>
</table>
<br>
A review of Integrated Nursing Assessments for 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that the quality of these assessments has significantly increased in basically all areas, but especially in the section addressing presenting conditions. This reviewer found that 39 out of 40 integrated assessments were in compliance.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.3.a.ii</td>
<td>current prescribed medications;</td>
<td>
<u>Admission Assessments</u><br><br>
<table>
<tr><td>2.</td><td>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</td><td>97%</td></tr>
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Comparative data indicated improvement in compliance from 82% in the previous review period.
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<td>
<u>Integrated Assessments</u>
<table>
<tr><td>2.</td><td>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</td><td>98%</td></tr>
</table>
Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.
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<tr>
<td>D.3.a.iii</td>
<td>vital signs;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>3.</td><td>Vital signs</td><td>98%</td></tr>
</table>
Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.
<br><br>
<u>Integrated Assessments</u>
<table>
<tr><td>3.</td><td>Vital signs</td><td>95%</td></tr>
</table>
Comparative data indicated that ASH maintained compliance at or greater than 90% from the previous review period.
</td>
</tr>
<tr>
<td>D.3.a.iv</td>
<td>allergies;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td>4.</td><td>Allergies</td><td>98%</td></tr>
</table>
C Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.
</td>
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</table>

<table>
<tr><td></td><td></td><td>Integrated Assessments<br><table><tr><td>4.</td><td>Allergies</td><td>97%</td></tr></table><br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.</td></tr>
<tr><td>D.3.a.v</td><td>pain;</td><td>Admission Assessments<br><table><tr><td>5.</td><td>Pain</td><td>95%</td></tr></table><br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>Integrated Assessments<br><table><tr><td>5.</td><td>Pain</td><td>90%</td></tr></table><br>Comparative data indicated improvement in compliance from 88% in the previous review period.</td></tr>
<tr><td>D.3.a.vi</td><td>use of assistive devices;</td><td>Admission Assessments<br><table><tr><td>6.</td><td>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</td><td>93%</td></tr></table><br>Comparative data indicated improvement in compliance from 85% in the previous review period.<br><br>Integrated Assessments<br><table><tr><td>6.</td><td>The update assistive devices use or need section is</td><td>96%</td></tr></table></td></tr>
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| | | | | |
|---|---|---|---|---|
| | | | *complete, or the "no problems noted" box is checked.* | |

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

| | | | | |
|---|---|---|---|---|
| D.3.a.vii | activities of daily living; | Admission Assessments | | |
| | | 7. | *Activities of daily living* | 98% |

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

Integrated Assessments

| | | |
|---|---|---|
| 7. | *Activities of daily living* | 96% |

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

| | | | | |
|---|---|---|---|---|
| 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 | Admission Assessments | | |
| | | 8. | *The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.* | 100% |

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

Integrated Assessments

| | | |
|---|---|---|
| 8. | *The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.* | 99% |

| | | |
|---|---|---|
| | | Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period. |
| D.3.a.ix | conditions needing immediate nursing interventions. | <u>Admission Assessments</u><br><br>9. *Conditions needing immediate nursing interventions* 95%<br><br>Comparative data indicated improvement in compliance from 82% in the previous review period.<br><br><u>Integrated Assessments</u><br><br>9. *Conditions needing immediate nursing interventions* 97%<br><br>Comparative data indicated improvement in compliance from 84% in the previous review period. |
| D.3.b | Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>ASH's Nursing Department's Policy and Procedures and practices demonstrate that they are consistently using the Wellness and Recovery Model for Nursing.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| | | |
|---|---|---|
| D.3.c | Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Atascadero State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• See D.3.a.i.<br>• Ensure that nursing staff follows the instructions regarding Nursing Admission/ Integrated Assessments to ensure that the clinical relevance of the questions is included.<br><br>**Findings:**<br>See D.3.a.1, Findings for Recommendation 1.<br><br>**Recommendation 3, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>ASH's training and licensing rosters verified that 100% of the RNs conducting assessments received competency training regarding nursing assessments and all nurses were currently licensed. In addition, mentoring related to Nursing Assessments continues for all RNs.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>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: | **Compliance:**<br>Substantial. |
| D.3.d.i | Initial nursing assessments are completed within 24 hours of the individual's admission; | **Current findings on previous recommendation:** |

<table>
<tr>
<td></td>
<td></td>
<td>
Recommendation, April 2009:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Nursing Admission Assessment Monitoring Audit, ASH assessed its compliance based on a 95% mean sample of admissions each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>10.</td><td>Initial nursing assessments are completed within 24 hours of the individual's admission.</td><td>99%</td></tr>
</table>
<br>
Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>
A review of Nursing Admission Assessments for 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that all were timely completed.<br><br>
Current recommendation:<br>
Continue current practices.
</td>
</tr>
<tr>
<td>D.3.d.ii</td>
<td>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Nursing Integrated Assessment Monitoring Audit, ASH assessed its compliance based on a 93% mean sample of admissions each month during the review period (March-August 2009):
</td>
</tr>
</table>

| | | |
|---|---|---|
| | | 10. *Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.* — 88%<br>10.a *The Integrated Nursing Assessment is completed prior to the 7 day WRP, and* — 81%<br>10.b *An RN was present and signed the 7 day WRP.* — 94%<br><br>Comparative data indicated improvement in compliance since the previous review period:<br><br>Previous period / Current period<br>Mean compliance rate<br>10. 54% 88%<br>Compliance rate in last month of period<br>10. 65% 92%<br>10.a 84% 86%<br>10.b 71% 98%<br><br>A review of Integrated Nursing Assessments for 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that 39 were completed timely.<br><br>**Current recommendation**:<br>Continue current practices. |
| D.3.d.iii | 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 | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement. |

| | | |
|---|---|---|
| | a quarterly review and the 12th monthly review shall be the annual review. | **Findings:**<br>Using the DMH Observation Monitoring Audit, ASH assessed its compliance based on a mean sample of 23% of WRPCs observed each month during the review period (March-August 2009):<br><br>3. *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.* — 92%<br><br>Comparative data indicated improvement in compliance from 59% in the previous review period.<br><br>A review of the charts of 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that all had an RN and PT in attendance at the WRP.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |

| 4. Rehabilitation Therapy Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. Kathy Runge, Occupational Therapist<br>2. Ladonna Decou, Chief of Rehabilitation<br>3. Rachelle Rianda, Acting Senior Rehabilitation Therapist<br><br>Reviewed:<br>1. DMH Rehabilitation Therapy IA-RTS audit data for March-August 2009<br>2. Focused assessment audit data for March-August 2009 for Occupational Therapy, Physical Therapy, Speech Therapy and Vocational Rehabilitation<br>3. List of individuals who had IA-RTS assessments from March-August 2009<br>4. Records of the following 15 individuals who had IA-RTS assessments from March-August 2009: CEF, DMM, GEG, HHH, HLM, HW, JDC, JHG, MJL, NWC, PWM, RCM, RJB, RW and SMP<br>5. List of individuals with Occupational Therapy assessments in March-August 2009<br>6. Record for the following five individuals with Occupational Therapy assessments in March-August 2009: CS, DBL, FFM, TG and VP<br>7. List of individuals with Physical Therapy assessments in March-August 2009<br>8. Records for the following seven individuals with Physical Therapy assessments in March-August 2009: AJB, CJG, GM, KAT, KM, RAC and SSS<br>9. List of individuals with Speech Therapy assessments in March-August 2009<br>10. Records for the following six individuals with Speech Therapy assessments in March-August 2009: ARM, BLB, DS, GEC, HVA and SDG |

| | | |
|---|---|---|
| | | 11. List of individuals with Vocational Rehabilitation assessments in March-August 2009<br>12. Records for the following seven individuals who had Vocational Rehabilitation assessments from March-August 2009: ACJ, APL, DRT, GN, JO, MA and RA<br>13. List of individuals with CIPRTA assessments in March-August 2009<br>14. Records for the following four individuals with CIPRTA assessments in March-August 2009: DPP, JAD, RJB and WST |
| D.4.a | Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Use standardized assessments (e.g., Careerscope, CASAS) to supplement the findings of the Vocational Rehabilitation focused assessments as clinically indicated.<br><br>**Findings:**<br>In April 2009, ASH began utilizing the CASAS to supplement the findings on identified individuals in need of Vocational focused assessments. Standardized assessments should be selected and utilized to supplement findings of VRAT focused assessments on an individualized basis as clinically indicated.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| D.4.b | Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care: | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that each individual served receives an Integrated Rehabilitation |

Therapy assessment (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.

**Findings:**
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 97% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2009 (total of 557 out of 574):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 96% |

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

A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with timeliness found 14 records in compliance (CEF, DMM, GEG, HHH, HLM, HW, JDC, JHG, MJL, PWM, RCM, RJB, RW and SMP) and one record not in compliance (NWC).

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2009 (total of 16):

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

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

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2009 (total of 62):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 72% |
| 1.a | *The assessment was completed within 14 days of referral, and* | 43% |
| 1.b | *Filed in the medical record.* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 48% | 72% |
| Compliance rate in last month of period | | |
| 1.a | 75% | 94% |
| 1.b | 75% | 100% |

The facility reported that the previous Physical Therapy contract was a

barrier to compliance as it did not include a 14-day timeliness requirement for assessments. On 7/27/09, a new contract was approved which addresses the EP requirements including the 14-day timeframe for assessments. The current contract includes provision for 40 hours of PT services, which is an increase from the previous contract.

A review of the records of six individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found three records in compliance (AJB, CJG and RAC) and three records not in compliance (GM, KM and SSS).

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2009 (total of 32):

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

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

A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found five records in compliance (ARM, BLB, DS, HVA and SDG) and one record not in compliance (GEC).

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 46% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2009 (total of 102 out

of 222):

| | | |
|---|---|---|
| 1. | *Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:* | 81% |
| 1.a | *The assessment was completed within 30 days of referral, and* | 61% |
| 1.b | *Filed in the medical record.* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 97% | 81% |
| Compliance rate in last month of period | | |
| 1.a | 97% | 57% |
| 1.b | 100% | 100% |

The facility attributed less than substantial compliance to inadequate numbers of staff responsible for completing Vocational Therapy focused assessments due to transfer and medical leave. In an effort to improve compliance, the facility has trained additional staff to competency on performing the VRAT assessment (see D.4.c).

A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found four records in compliance (ACJ, APL, GN and RA) and three records not in compliance (DRT, JO and MA).

Using the DMH Comprehensive Integrated Physical Rehabilitation

<table>
<tr>
<td></td>
<td></td>
<td>Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2009 (total of four):<br><br>
<table>
<tr><td>1.</td><td>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</td><td>100%</td></tr>
</table>
<br>Comparable data were not available from the previous review period, as the CIPRTA was implemented in February 2009.<br><br>A review of the records of four individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.<br><br>Compliance:<br>Partial.<br><br>Current recommendation:<br>Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.4.b.i</td>
<td>Is accurate and comprehensive as to the individual's functional abilities;</td>
<td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.<br>• Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.<br><br>Findings:<br>Using the DMH Integrated Assessment Rehabilitation Therapy Section</td>
</tr>
</table>

Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 97% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2009 (total of 556 out of 574):

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

Comparative data indicated improvement in compliance from 87% in the previous review period.

A review of the records of 15 individuals to assess compliance of IA-RTS assessments with D.4.b.i criteria found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2009 (total of 22):

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

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

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

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

month for the review period March-August 2009 (total of 62):

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

Comparative data indicated improvement in compliance from 64% in the previous review period.

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

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2009 (total of 32):

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

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

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

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 49% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2009 (total of 108 out of 222):

| | | |
|---|---|---|
| | | 2. *Is accurate and comprehensive as to the individuals functional abilities;* 100%<br><br>Comparative data indicated improvement in compliance from 86% in the previous review period.<br><br>A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.<br><br>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period March-August 2009 (total of four):<br><br>2. *Is accurate and comprehensive as to the individuals functional abilities;* 100%<br><br>Comparative data were not available from the previous review period, as the CIPRTA was implemented in February 2009.<br><br>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.4.b.ii | Identifies the individual's current functional status and the skills and supports needed to | **Current findings on previous recommendations:** |

| | | |
|---|---|---|
| | facilitate transfer to the next level of care; and | **Recommendation 1, April 2009:**<br>Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.<br><br>**Findings:**<br>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 97% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2009 (total of 557 out of 574):<br><br>3. *Identifies the individual's current functional status, and* — 99%<br>4. *The skills and supports needed to facilitate transfer to the next level of care* — 99%<br><br>Comparative data indicated improvement in compliance from 72% and 80% respectively in the previous review period.<br><br>A review of the records of 15 individuals to assess compliance of IA-RTS assessments with D.4.b.ii criteria found all records in substantial compliance.<br><br>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2009 (total of 16):<br><br>3. *Identifies the individual's current functional status, and* — 100%<br>4. *The skills and supports needed to facilitate transfer* — 100% |

| | | |
|---|---|---|
| | *to the next level of care* | |

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

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2009 (total of 62):

| | | |
|---|---|---|
| 3. | *Identifies the individual's current functional status, and* | 100% |
| 4. | *The skills and supports needed to facilitate transfer to the next level of care* | 90% |

Comparative data indicated maintenance of compliance greater than 90% for item 3 and improvement in compliance from 86% in the previous review period for item 4.

A review of the records of seven individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found six records in substantial compliance (AJB, CJG, GM, KM, RAC and SSS) and one record in partial compliance (KAT).

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2009 (total of 31):

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

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

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

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.ii criteria based on an average sample of 49% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2009 (total of 108 out of 222):

| | | |
|---|---|---|
| 3. | *Identifies the individual's current functional status, and* | 94% |
| 4. | *The skills and supports needed to facilitate transfer to the next level of care* | 79% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for item 3 and a decline in compliance for item 4:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 99% | 79% |
| Compliance rate in last month of period | | |
| 4. | 100% | 64% |

The facility reported that less than substantial compliance was due to staff being recently trained on the VRAT assessment tool; the facility plans to use proactive mentoring with newly trained staff to improve compliance with item 4.

A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found six records in substantial compliance (APL, DRT, GN, JO, MA and RA) and one record in partial compliance (ACJ).

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

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

Comparative data were not available from the previous review period, as the CIPRTA was implemented in February 2009.

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

**Recommendation 2, April 2009:**
Ensure adequate auditing and training in response to auditing results occurs in regards to D.4.b.ii criteria for focused assessments, and ensure that data is reliable and valid.

<table>
<tr><td></td><td></td><td>Findings:<br>Facility self assessment data and data collected during the week of the review appear to be generally consistent.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.4.b.iii</td><td>Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.<br><br>Findings:<br>Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 97% of Integrated Rehabilitation Therapy Assessments due each month for the review period March-August 2009 (total of 556 out of 574):<br><br>
<table>
<tr><td>5.</td><td>Identifies the individual's life goals,</td><td>99%</td></tr>
<tr><td>6.</td><td>Strengths, and:</td><td>99%</td></tr>
<tr><td>7.</td><td>Motivation for engaging in wellness activities</td><td>98%</td></tr>
</table>
<br>Comparative data indicated maintenance of compliance greater than 90% from the previous review period for all three items (item 7 was reported incorrectly as 87% in the previous report; it should have been reported as 97%).</td></tr>
</table>

A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period March-August 2009 (total of 16):

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

Comparative data indicated maintenance of compliance greater than 90% for items 5 and 6 and improvement in compliance from 0% in the previous review period for item 7.

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

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period March-August 2009 (total of 62):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 97% |
| 6. | *Strengths, and:* | 96% |
| 7. | *Motivation for engaging in wellness activities* | 97% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 85% | 97% |
| 6. | 84% | 96% |
| 7. | 86% | 97% |

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

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period March-August 2009 (total of 31):

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

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for all three items.

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

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, ASH assessed its compliance with D.4.b.iii criteria based on an average sample of 49% of Vocational Rehabilitation Focused Assessments due each month for the review period March-August 2009 (total of 108 out of 222):

| | | |
|---|---|---|
| 5. | *Identifies the individual's life goals,* | 100% |
| 6. | *Strengths, and:* | 98% |
| 7. | *Motivation for engaging in wellness activities* | 96% |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for all three items.

A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.

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

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

Comparative data were not available from the previous review period, as the CIPRTA was implemented in February 2009.

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

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| D.4.c | Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible.<br><br>**Findings:**<br>During the review period, three out of three new RT clinicians were trained to competency on the IA-RTS; two RT staff were trained to competency on the VRAT; and 11 Vocational Services staff were trained to competency on the VRAT.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue current practice. |
| D.4.d | Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above. | All conversion assessments were completed as of the April 2009 tour of ASH. |

| 5. Nutrition Assessments | | |
|---|---|---|
| D.5 | Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following: | **Methodology:**<br><br>Interviewed:<br>1. Dawn Hartman, Assistant Director of Dietetics<br>2. Erin Dengate, Assistant Director of Dietetics<br><br>Reviewed:<br>1. Nutrition Care Monitoring audit data for March 2009-August 2009 for each assessment type<br>2. Lists of individuals with Nutrition Care Assessments due from March 2009-August 2009 for each assessment type<br>3. Records for the following three individuals with type D.5.a assessments from March 2009-August 2009: GHW, JJS and WPB<br>4. Records for the following two individuals with type D.5.b assessments from March 2009-August 2009: DPP and RAA<br>5. Records for the following seven individuals with type D.5.d assessments from March 2009-August 2009: BJS, DJD, DWB, JM, JRH, JWL and SMP<br>6. Records for the following four individuals with type D.5.e assessments from March 2009-August 2009: CEF, EKW, LDP and MLN<br>7. Records for the following four individuals with type D.5.f assessments from March 2009-August 2009: BEC, HJB, JMC and KWJ<br>8. Records for the following five individuals with type D.5.g assessments from March 2009-August 2009: JJK, MG, RJK, RPO and SFV<br>9. Records for the following five individuals with type D.5.i assessments from March 2009-August 2009: BLB, DVW, JAD, JWO and OR<br>10. Records for the following six individuals with type D.5.j.i assessments from March 2009-August 2009: BTR, GEC, JRC, RW, TE and WL<br>11. Records for the following seven individuals with type D.5.j.ii assessments from March 2009-August 2009: AF, CDB, EWS, JR, LH, |

| | | |
|---|---|---|
| | | MM and MM-2 |
| D.5.a | For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period March-August 2009 (total of five): |

| | | |
|---|---|---|
| 1. | *Assessment is completed on time per policy* | 100% |
| 2. | *All required subjective concerns are addressed* | 100% |
| 3. | *All pertinent objective nutrition information is accurately addressed* | 100% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 100% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 100% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 100% |
| 7. | *Nutrition education is documented* | 100% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 100% |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 100% |
| 11. | *Recommendations are appropriate and complete* | 100% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |

| | | |
|---|---|---|
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance of 90% or greater from the previous review period for items 3, 4, 7, 8, 12, 13, and 15-18 and improvement in compliance for the remaining items (items 9 and 14 were not applicable in either period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 50% | 100% |
| 2. | 80% | 100% |
| 5. | 80% | 100% |
| 6. | 80% | 100% |
| 10. | 40% | 100% |
| 11. | 60% | 100% |

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

**Recommendation 2, April 2009:**
Recruit and retain Dietitians to fill current vacancies to ensure that there is an adequate number of staff to complete assessments.

<table>
<tr><td></td><td></td><td>Findings:<br>The facility reported that one full-time dietitian was hired but one full-time position was lost during the reporting period. There continue to be 4.5 dietitian vacancies, which have compromised the timeliness of lower-acuity assessments.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.5.b</td><td>For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.b assessments due each month for the review period March-August 2009 (total of two):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>100%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>100%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>100%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
</table></td></tr>
</table>

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

Comparative data indicated maintenance of compliance greater than 90% for items 1-5, 7, 8, 10, 12, and 15-17, and improvement in compliance from the previous review period for the remaining items (items 9 and 14 were not applicable in either period and item 13 was 100% in the previous period and not applicable in the current period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 50% | 100% |
| 11. | 50% | 100% |
| 18. | 50% | 100% |

<table>
<tr><td></td><td></td><td>A review of the records of two individuals to assess compliance with Nutrition type D.5.b criteria found both records in substantial compliance.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.5.c</td><td>For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td><td>Not applicable. ASH does not have a skilled nursing facility unit.</td></tr>
<tr><td>D.5.d</td><td>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.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d assessments due each month for the review period March-August 2009 (total of 122):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>91%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>99%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>98%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>99%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and</td><td>87%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| | *objective data* | |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 98% |
| 7. | *Nutrition education is documented* | 98% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 99% |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 81% |
| 11. | *Recommendations are appropriate and complete* | 98% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 97% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2-4, 8, 12, 13, and 15-18 and improvement in the remaining items (items 9 and 14 were not applicable in either period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 76% | 91% |
| 5. | 81% | 87% |

<table>
<tr>
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<table>
<tr><td>6.</td><td>80%</td><td>98%</td></tr>
<tr><td>7.</td><td>88%</td><td>98%</td></tr>
<tr><td>10.</td><td>79%</td><td>81%</td></tr>
<tr><td>11.</td><td>62%</td><td>98%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>5.</td><td>87%</td><td>100%</td></tr>
<tr><td>10.</td><td>73%</td><td>96%</td></tr>
</table>
<br>
The facility reported that although compliance for items 5 and 10 was less than 90%, data for the last three months in the review period were above 90% compliance for item 5 and data in the last two months were above 90% compliance for item 10, thus showing an upward trend in compliance for these items.<br><br>
A review of the records of seven individuals to assess compliance with Nutrition type D.5.d criteria found all seven records in substantial compliance.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.5.e</td>
<td>For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue current efforts to achieve compliance.<br><br>
Findings:<br>
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e assessments due each month for the review period March-August 2009
</td>
</tr>
</table>

(total of 12):

| | | |
|---|---|---|
| 1. | *Assessment is completed on time per policy* | 83% |
| 2. | *All required subjective concerns are addressed* | 100% |
| 3. | *All pertinent objective nutrition information is accurately addressed* | 100% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 100% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 100% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 100% |
| 7. | *Nutrition education is documented* | 96% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 100% |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 96% |
| 11. | *Recommendations are appropriate and complete* | 92% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance greater than 90%

<table>
<tr>
<td></td>
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<td>from the previous review period for items 2, 7, 8, and 12-18 and improvement in the remaining items (item 9 was not applicable in either period):
<table>
<tr><th></th><th>Previous period</th><th>Current period</th></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>40%</td><td>83%</td></tr>
<tr><td>3.</td><td>80%</td><td>100%</td></tr>
<tr><td>4.</td><td>80%</td><td>100%</td></tr>
<tr><td>5.</td><td>60%</td><td>100%</td></tr>
<tr><td>6.</td><td>40%</td><td>100%</td></tr>
<tr><td>10.</td><td>60%</td><td>96%</td></tr>
<tr><td>11.</td><td>40%</td><td>92%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.</td><td>0%</td><td>100%</td></tr>
</table>
The facility reported that timeliness was below 90% due to RD vacancies and resultant high caseloads.<br><br>A review of the records of four individuals to assess compliance with Nutrition type D.5.e criteria found three records in substantial compliance (CEF, EKW and MLN) and one record in partial compliance (LDP).<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue current efforts to achieve compliance.</td>
</tr>
<tr>
<td>D.5.f</td>
<td>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive</td>
<td>Current findings on previous recommendation:</td>
</tr>
</table>

| | | |
|---|---|---|
| | Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission. | **Recommendation, April 2009:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f assessments due each month for the review period March-August 2009 (total of 37): |

| | | |
|---|---|---|
| 1. | *Assessment is completed on time per policy* | 84% |
| 2. | *All required subjective concerns are addressed* | 100% |
| 3. | *All pertinent objective nutrition information is accurately addressed* | 98% |
| 4. | *Estimated daily needs for nutrients specified are appropriate* | 100% |
| 5. | *Assessment utilizes findings from subjective and objective data* | 86% |
| 6. | *Nutrition diagnosis is correctly formulated, prioritized and validated* | 96% |
| 7. | *Nutrition education is documented* | 92% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 100% |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 86% |
| 11. | *Recommendations are appropriate and complete* | 94% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |

| | | |
|---|---|---|
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2-4, 6, 8, 12, 13, and 15-17 and overall improvement in the remaining items (items 9 and 14 were not applicable in either period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 79% | 84% |
| 5. | 71% | 86% |
| 7. | 78% | 92% |
| 10. | 86% | 86% |
| 11. | 50% | 94% |
| 18. | 86% | 100% |
| Compliance rate in last month of period | | |
| 1. | 50% | 50% |
| 5. | 50% | 100% |
| 10. | 100% | 100% |

The facility reported that timeliness was below 90% due to RD vacancies and resultant high caseloads. Items 5 and 10 were below substantial compliance for the full review period but were above substantial compliance during the last two months of the period.

A review of the records of four individuals to assess compliance with

<table>
<tr><td></td><td></td><td>Nutrition type D.5.f criteria found all four records in substantial compliance.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.5.g</td><td>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 24% of Nutrition Type D.5.g assessments due each month for the review period March-August 2009 (total of 83 out of 351):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>89%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>100%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>99%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>93%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>98%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>99%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</td><td>100%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| | *identified* | |
| 9. | *Progress is monitored, measured, and evaluated* | N/A |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 88% |
| 11. | *Recommendations are appropriate and complete* | 98% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 100% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | N/A |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2-4, 6-8, 12, 13, and 15-18 and improvement in the remaining items (items 9 and 14 were not applicable in either period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 88% | 89% |
| 5. | 81% | 93% |
| 10. | 71% | 88% |
| 11. | 61% | 98% |
| Compliance rate in last month of period | | |
| 1. | 88% | 100% |
| 10. | 71% | 100% |

| | | |
|---|---|---|
| | | The facility reported that timeliness was below 90% due to RD vacancies and resultant high caseloads. Items 1 and 10 were below substantial compliance for the full review period but were above substantial compliance during the last two months of the period.<br><br>A review of the records of five individuals to assess compliance with Nutrition type D.5.g criteria found all five records in substantial compliance.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.5.h | Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 34% of Nutrition assessments (all types) due each month of the review period March-August 2009 (529 out of 1574). The facility reports that a weighted mean of 99% of Nutrition admission assessments had evidence of a correctly assigned NST level.<br><br>A review of the records of 43 individuals found that all 43 had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h. |

| | | |
|---|---|---|
| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.5.i | The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.i assessments due each month for the review period March-August 2009 (total of 128 out of 552):<br><br>1. *Assessment is completed on time per policy* — 57%<br>2. *All required subjective concerns are addressed* — 100%<br>3. *All pertinent objective nutrition information is accurately addressed* — 96%<br>4. *Estimated daily needs for nutrients specified are appropriate* — 92%<br>5. *Assessment utilizes findings from subjective and objective data* — 100%<br>6. *Nutrition diagnosis is correctly formulated, prioritized and validated* — 93%<br>7. *Nutrition education is documented* — 97%<br>8. *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* — 99%<br>9. *Progress is monitored, measured, and evaluated* — 99%<br>10. *Nutrition goals are individualized, relate to the* — 93% |

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

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2, 5, 8, 9, and 12-18 and overall improvement in the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 59% | 57% |
| 3. | 78% | 96% |
| 4. | 65% | 92% |
| 6. | 88% | 93% |
| 7. | 86% | 97% |
| 10. | 78% | 93% |
| 11. | 65% | 97% |
| Compliance rate in last month of period | | |
| 1. | 62% | 61% |

The facility reported that item 1 was in less than substantial compliance due to staff vacancies, high caseloads, and the prioritization of higher-

<table>
<tr><td></td><td></td><td>acuity admission assessments over lower-acuity updates.<br><br>A review of the records of five individuals to assess compliance with Nutrition type D.5.i criteria found four records in substantial compliance (BLB, DWV, JAD and OR) and one record in partial compliance (JWO).<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.5.j.i</td><td>Individuals will be reassessed when there is a significant change in condition.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current efforts to achieve compliance.<br><br>Findings:<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of29% of Nutrition Type D.5.j.i assessments due each month for the review period March-August 2009 (total of 72 out of 247):<br><br>
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>83%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>100%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>97%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>95%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>95%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>99%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| 7. | *Nutrition education is documented* | 97% |
| 8. | *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* | 97% |
| 9. | *Progress is monitored, measured, and evaluated* | 95% |
| 10. | *Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable* | 85% |
| 11. | *Recommendations are appropriate and complete* | 97% |
| 12. | *NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment* | 97% |
| 13. | *Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present* | 100% |
| 14. | *Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support* | N/A |
| 15. | *Assessment utilizes approved abbreviations* | 100% |
| 16. | *Assessment is concise* | 100% |
| 17. | *Assessment is legible* | 100% |
| 18. | *Each page of the assessment is signed* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 2, 5, 8, 9, and 12-18 and overall improvement in the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 83% | 83% |
| 3. | 75% | 97% |
| 4. | 87% | 95% |
| 6. | 79% | 99% |
| 7. | 80% | 97% |
| 10. | 75% | 85% |

| | | |
|---|---|---|
| | | 11. 62% 97%<br>Compliance rate in last month of period<br>1. 91% 92%<br>10. 82% 100%<br><br>Item 1 was below substantial compliance due to staff vacancies and to an August 2009 increase in referrals for overdue assessments that were generated in response to a CMS audit. Item 10 was in substantial compliance for the last two months of the review period.<br><br>A review of the records of six individuals to assess compliance with Nutrition type D.5.j.i criteria found five records in substantial compliance (BTR, GEC, RW, TE and WL) and one record in partial compliance (JRC).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.5.j.ii | Every individual will be assessed annually. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current efforts to achieve compliance.<br><br>**Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 27% of Nutrition Type D.5.j.ii assessments due each month for the review period March-August 2009 (total of 68 out of 248):<br><br>1. *Assessment is completed on time per policy* 18% |

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

Comparative data indicated maintenance of compliance at or above 90% from the previous review period for items 2, 4, 8, and 15-18, and mixed changes in the remaining items (item 14 was not applicable in either period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 32% | 18% |
| 3. | 83% | 100% |
| 5. | 70% | 100% |
| 6. | 72% | 100% |
| 7. | 86% | 90% |
| 9. | 71% | 100% |
| 10. | 67% | 100% |
| 11. | 55% | 100% |
| 12. | 88% | 100% |
| 13. | 63% | 100% |
| Compliance rate in last month of period | | |
| 1. | 22% | 0% |

The facility reported that item 1 was in less than substantial compliance due to staff vacancies, high caseloads, and the prioritizing of higher-acuity admission assessments over lower-acuity annual assessments.

A review of the records of seven individuals to assess compliance with Nutrition type D.5.j.ii criteria found four records in substantial compliance (AF, EWS, JR and LH) and three records in partial compliance (CDB, MM and MM-2).

**Compliance:**
Partial.

**Current recommendation:**
Continue current efforts to achieve compliance.

| 6. Social History Assessments | | |
|---|---|---|
| | Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care: | **Methodology:**<br><br>Interviewed:<br>1. Debra Crawford, LCSW, Acting Supervising Social Worker<br>2. Janet Bouffard, LCSW, Chief of Social Work<br>3. Michael Ostash, LCSW, Acting Supervising Social Worker<br><br>Reviewed:<br>1. The charts of the following 22 individuals: AC, AJL, BC, CM, DA, DLA, DS, EC, ECF, EDG, FA, JLP, JM-1, JM-2, JM-3, JW, LR, LTB, MD, RGP, RM, and TJC<br>2. ASH's Social History Progress Report (March to August 2009)<br>3. 30-Day Social History Assessments<br>4. Integrated Assessments: Social Work Section<br><br>Observed:<br>1. WRPC (Program III, unit 21B) for 14-day review of JWC<br>2. WRPC (Program VI, unit 7A) for quarterly review of JEC<br>3. WRPC (Program VII, unit 30) for quarterly review of RH<br>4. PSR Mall group: Anger Management<br>5. PSR Mall group: Cognitive Restructuring--Sponge Brain<br>6. PSR Mall group: Commitment to Change<br>7. PSR Mall group: Depression Group (Spanish Language)<br>8. PSR Mall group: Mental Health Wellness<br>9. PSR Mall group: Supported Treatment Assisted Recovery (STAR)<br>10. PSR Mall group: Wellness and Recovery Action Planning (WRAP) |
| D.6.a | Is, to the extent reasonably possible, accurate, current and comprehensive; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments. |

**Findings:**
Using the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 48% of the Integrated Assessments: Social Work Sections due each month during the review period (March-August 2009):

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

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 77% | 100% |
| 2. | 79% | 100% |
| 3. | 66% | 100% |

This monitor reviewed the charts of six individuals to evaluate the Integrated Assessments: Social Work Section. All six assessments were current and comprehensive (CM, DA, DS, EC, JM-1 and LR).

Using the DMH Social History Assessment Monitoring Form, ASH assessed its compliance based on an average sample of 22% of the 30-Day Psychosocial Assessments due each month during the review period (March-August 2009):

<table>
<tr>
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<table>
<tr><td>1.</td><td>Is, to the extent reasonably possible, accurate</td><td>98%</td></tr>
<tr><td>2.</td><td>Current, and</td><td>99%</td></tr>
<tr><td>3.</td><td>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</td><td>97%</td></tr>
</table>
<br>
Comparative data indicated improvement in compliance since the previous review period:
<br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>1.</td><td>72%</td><td>98%</td></tr>
<tr><td>2.</td><td>57%</td><td>97%</td></tr>
<tr><td>3.</td><td>71%</td><td>99%</td></tr>
</table>
<br>
This monitor reviewed the charts of nine individuals to evaluate the 30-Day Social Work Assessments. Eight assessments were timely and comprehensive (AC, AJL, CM, DA, DS, EC, LR and TJC) and one was untimely (JM-1).<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.6.b</td>
<td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Ensure that social workers identify and address the inconsistencies in current assessments.
</td>
</tr>
</table>

<table>
<tr>
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<td>
<ul><li>Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.</li></ul>
<br>
Findings:<br>
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of the 30-Day Psychosocial Assessments due each month during the review period (March-August 2009):
<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>100%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>100%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>100%</td></tr>
</table>
Comparative data indicated maintenance of compliance rates greater than 90% from the previous review period for all three items.<br>
<br>
This monitor reviewed the charts of six individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies. All six assessments identified and resolved factual inconsistencies (AC, CM, DA, DS, EC and LR).<br>
<br>
Compliance:<br>
Substantial.<br>
<br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
</tr>
<tr>
<td>D.6.c</td>
<td>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</td>
<td>
Current findings on previous recommendations:<br>
<br>
Recommendation 1, April 2009:<br>
Ensure that all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC.
</td>
</tr>
</table>

**Findings:**
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 48% of Integrated Assessments: Social Work Sections due each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 7. | *Is included in the 7-day integrated assessment* | 99% |

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

This monitor reviewed 20 charts to evaluate timeliness of the Social Work Integrated Assessments. Nineteen assessments were timely (AC, BC, CM, DA, DS, EC, ECF, EDG, FA, JLP, JM-1, JM-2, JM-3, JW, LR, LTB, MD, RGP and RM) and one of them was not (DLA).

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

**Findings:**
Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of 30-Day Psychosocial Assessments due each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 8. | *Fully documented by the 30th day of the individual's admission.* | 98% |

Comparative data indicated improvement in compliance from 66% in the previous review period.

| | | |
|---|---|---|
| | | This monitor reviewed 22 charts to evaluate timeliness of the 30-day Social Work Assessments. Eighteen assessments were timely (AC, AJL, BC, CM, DA, DLA, DS, ECF, FA, JLP, JM-2, JM-3, JW, LR, LTB, MD, RGP and TJC) and four were untimely (EC, EDG, JM-1 and RM). .<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.6.d | Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.<br><br>**Findings:**<br>Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 48% of Integrated Assessments: Social Work Sections due each month during the review period (March-August 2009):<br><br>10. *Educational status* 100%<br><br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>This monitor reviewed six charts to evaluate documentation of the individual's educational status in the Integrated Assessment: Psychology Section. All six assessments included information on the individual's educational status (AC, CM, DA, DS, EC and LR). |

| | | |
|---|---|---|
| | | Using the DMH Social History Assessments Monitoring Form, ASH assessed its compliance based on an average sample of 22% of 30-Day Psychosocial Assessments due each month during the review period (March-August 2009):<br><br>10. *Educational status* 99%<br><br>Comparative data indicated maintenance of a compliance rate greater than 90% from the previous review period.<br><br>This monitor reviewed seven charts to evaluate documentation of the individual's educational status in the 30-day Social Work Assessment. Six of the assessments included information on the individual's educational status (BC, CM, DA, DS, EC and LR) and one did not (AC).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| 7. Court Assessments | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. David Fennell, MD, Chief of Forensic Psychiatry<br>2. Jennifer Brush, Forensic Services Manager<br>3. Robert Knapp, MD, Medical Director<br><br>Reviewed:<br>1. Charts of six individuals (AH, CE, JB, JN, MAC and SAG) who were admitted under PC 1026<br>2. Charts of six individuals (AR, CCS, DE, JDB, JTP and TVP) who were admitted under PC 1370<br>3. ASH PC 1026 Report Auditing summary data (March-August 2009)<br>4. ASH PC 1370 Report Auditing summary data (March-August 2009)<br>5. Minutes of the Forensic Review Panel meetings on March 4, April 1, May 7, June 2 and August 4, 2009. |
| D.7.a | Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated: | **Compliance:**<br>Substantial. |
| D.7.a.i | clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense); | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and corrective actions, as indicated. |

| | | |
|---|---|---|
| | | • Continue to ensure that symptoms contributing to the offense and persisting during hospitalization are specified regarding their nature, course and setting within which they occur<br><br>**Findings:**<br>ASH used the DMH Court Report PC 1026 Monitoring Form to assess its compliance. The facility reviewed 100% of the court reports written during the review period (March-August 2009). The mean compliance rate was 100%, consistent with 100% in the previous review period.<br><br>The mean compliance rates for the requirements in D.7.a.ii through D.7.a.xi are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate.<br><br>**Other findings:**<br>A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (AH, CE, JB, JN, MAC and SAG).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| 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; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated.<br><br>**Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period. |

| | | |
|---|---|---|
| | | **Other findings:**<br>A review of the charts of six individuals admitted under PC 1026 found substantial compliance in all cases (AH, CE, JB, JN, MAC and SAG).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.a.iii | understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Same as above.<br>• Continue to ensure proper formulation of the precursors of dangerous behavior, including psychosocial triggers<br><br>**Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>A review of the charts of six individuals admitted under PC 1026 found substantial compliance in five charts (AH, CE, JB, JN and SAG) and partial compliance in one (MAC).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.a.iv | acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated. |

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**Findings:**
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>14.</td><td>Individual's acceptance of mental illness</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's understanding of the need for treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Individual's adherence to treatment</td><td>100%</td></tr>
</table>

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

**Other findings:**
This monitor found substantial compliance in all charts reviewed (AH, CE, JB, JN, MAC and SAG).

**Current recommendation**:
Continue to monitor this requirement.

</td>
</tr>
<tr>
<td>D.7.a.v</td>
<td>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;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Same as above.

**Findings:**
The facility reported the following mean compliance rates for each indicator regarding this requirement:

<table>
<tr><td>17.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>100%</td></tr>
<tr><td>18.</td><td>Individual's recognition of precursors and warning signs and symptoms (that August mediate) future dangerous acts</td><td>100%</td></tr>
</table>

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</tr>
</table>

| | | |
|---|---|---|
| | | Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AH, CE, JB, JN, MAC and SAG).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.a.vi | willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above); | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above.<br><br>**Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>Chart reviews by this monitor found compliance in all charts to which this requirement was applicable (AH, CE, JN and SAG).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.a.vii | previous community releases, if the individual has had previous CONREP revocations; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above. |

| | | |
|---|---|---|
| | | **Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>Chart reviews by this monitor found compliance in all charts to which this requirement was applicable (JB, JN, MAC and SAG).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.7.a. viii | social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above.<br><br>**Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>Chart reviews by this monitor found compliance in all cases (AH, CE, JB, JN, MAC and SAG).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| D.7.a.ix | relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above. |

| | | |
|---|---|---|
| | | **Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>Chart reviews by this monitor found compliance in all cases (AH, CE, JB, JN, MAC and SAG).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.b | Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following: | **Compliance:**<br>Substantial. |
| D.7.b.i | relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement based on a 100% sample and provide data analysis that evaluates any decrease in compliance and identifies corrective actions, as indicated. |

| | | |
|---|---|---|
| | | **Findings:**<br>ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance. The facility reviewed 100% of the court reports written during the review period (March-August 2009). The mean compliance rate was 100%, consistent with 100% in the previous review period.<br><br>The mean compliance rates for the requirements in D.7.b.ii through D.7.b.iv are reported for each corresponding cell below. The indicators are listed if they represent sub-criteria of the requirement. Comparative data are listed, as appropriate.<br><br>**Other findings:**<br>A review of the charts of six individuals admitted under PC 1370 found substantial compliance in all cases (AR, CCS, DE, JDB, JTP and TVP).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| D.7.b.ii | clinical description of the individual at the time of admission to the hospital; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above.<br><br>**Findings:**<br>ASH reported a mean compliance rate of 100%, consistent with 99% in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AR, CCS, DE, JDB, JTP and TVP). |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>D.7.b.iii</td><td>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</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Same as above.<br><br>Findings:<br>ASH reported the following mean compliance rates for each indicator regarding this requirement:<br><br>
<table>
<tr><td>13.</td><td>Clinical description of the individual at the time of admission</td><td>100%</td></tr>
<tr><td>14.</td><td>Description of any progress or lack of progress</td><td>100%</td></tr>
<tr><td>15.</td><td>Individual's response to treatment</td><td>100%</td></tr>
<tr><td>16.</td><td>Current relevant mental status</td><td>100%</td></tr>
<tr><td>17.</td><td>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</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that the facility maintained compliance at or above 90% from the previous review period.<br><br>Other findings:<br>This monitor found compliance in all charts reviewed (AR, CCS, DE, JDB, JTP and TVP).<br><br>Current recommendation:<br>Same as above.</td></tr>
</table>

| | | |
|---|---|---|
| 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. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as above.<br><br>**Findings:**<br>ASH reported a mean compliance rate of 99%, consistent with 100% in the previous review period.<br><br>**Other findings:**<br>This monitor found substantial compliance in all charts reviewed (AR, CCS, DE, JDB, JTP and TVP).<br><br>**Current recommendation**:<br>Same as above. |
| D.7.c | Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that August warrant modifications in their forensic status and/or level of restriction | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Continue current practice.<br>• Provide information regarding any relevant training to FRP members and WRPTs, including the provider, frequency and the content of training.<br><br>**Findings:**<br>ASH reported that the forensics service has initiated consultation and liaison services with the WRPTs. The purpose of the consultation is to train WRPT members on the legal criteria for continued commitment pursuant to Penal Code Section 1026. The facility also reported that the consultation included training on the current case law concerning the inclusion of antisocial personality disorder as a qualifying mental disorder for the purpose of extension of the NGRI commitment pursuant to Section 1026.5 of the Penal Code. Additionally, ASH |

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| | | indicated that forensic staff met with WRPTs on August 4, 2009 to facilitate integration of the assessment of competency into the overall WRP.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Provide information regarding changes in relevant training to FRP members and WRPTs. |

| E. Discharge Planning and Community Integration | | |
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| | | **Summary of Progress:**<br>1. ASH has made significant improvements on discharging individuals referred for discharge.<br>2. ASH has attained substantial compliance with most EP requirements in this section. |
| E | Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs. | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Debra Crawford, LCSW, Acting Supervising Social Worker<br>2. Janet Bouffard, LCSW, Chief of Social Work<br>3. Michael Ostash, LCSW, Acting Supervising Social Worker<br><br><u>Reviewed</u>:<br>1. The records of the following 26 individuals: AD, DH, DS, EC, GNS, GS, HWT, JEC, JHG, JM, JWC, LI, MG-1, MG-2, MK, MLV, MO, MT, MTG, MWT, NL, PN, RGP, RH, RP, and WM<br>2. List of individuals assessed to need family therapy<br>3. List of individuals who have met discharge criteria in the last six months<br>4. List of individuals who have met discharge criteria in the last six months and are still hospitalized<br><br><u>Observed</u>:<br>1. WRPC (Program III, unit 21B) for 14-day review of JWC<br>2. WRPC (Program VI, unit 7A) for quarterly review of JEC<br>3. WRPC (Program VII, unit 30) for quarterly review of RH |
| E.1 | Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning | Please see sub-cells for compliance findings. |

<table>
<tr><td></td><td>conferences, the particular considerations for each individual bearing on discharge, including:</td><td></td></tr>
<tr><td>E.1.a</td><td>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</td><td>

**Current findings on previous recommendations:**

**Recommendations 1-3, April 2009:**

- Ensure that the individual's strengths and preferences are utilized to achieve discharge goals.
- These should be linked to the interventions that impact the individual's discharge criteria
- The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

**Findings:**

ASH had conducted a number of activities to improve compliance, including mentoring and training for WRPTs, real-time feedback to WRPTs and Discharge Planning and Community Integration training for WPR Social Work staff. In addition, the WRP Master Trainer developed and implemented the Clinical Chart Checklist to assist WRPTs with WRPC preparation.

Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2009):

<table>
<tr><td>1.</td><td>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</td><td>98%</td></tr>
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Comparative data indicated improvement in compliance from 75% in the previous review period.

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| | | A review of the records of ten individuals found that nine of the WRPs in the charts had utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AD, DH, GNS, GS, MG-1, MK, MO, MT and PN). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining one (MG-2).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.1.b | the individual's level of psychosocial functioning; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that the level of psychosocial functioning (functional status) is included in the individual's Present Status section of the case formulation section of the WRP.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>2. *The individual's level of psychosocial functioning* 95%<br><br>Comparative data indicated improvement in compliance from 57% in the previous review period.<br><br>A review of the records of eight individuals found that all eight of the WRPs in the charts included the individual's psychosocial functioning in |

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| | | the Present Status section (AD, GNS, GS, MG-1, MG-2, MO, MT and PN).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.1.c | any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1 and 2, April 2009:**<br>• Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.<br>• Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>3. *Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.* 91%<br><br>Comparative data indicated improvement in compliance from 46% in the previous review period.<br><br>A review of the records of eight individuals found that six of the WRPs in the charts contained documentation that discharge barriers and their progress were discussed with the individual (AD, GS, MG-1, MO, PN and |

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| | | WM), and two did not (MG-2 and MT).<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.<br>2. 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. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.<br>• Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.<br>• Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>4. *The skills and supports necessary to live in the setting in which the individual will be placed.* 93%<br><br>Comparative data indicated improvement in compliance from 59% in the previous review period. |

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| | | A review of the records of ten individuals found that all ten of the WRPs in the charts documented the skills training and supports the individual needed to overcome barriers to discharge and successfully transition to the identified setting (AD, GNS, GS, MG-1, MG-2, MLV, MO, MT, PN and WM).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.2 | 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. | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Ensure that the individual is an active participant in the discharge planning process.<br>• Ensure that the individual understands all of the discharge requirements before leaving the WRPC.<br>• Prioritize objectives and interventions related to the discharge processes.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>12. *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* — 96% |

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| | | | *extent possible, given the individual's level of functioning and legal status.* | |

Comparative data indicated improvement in compliance from 82% in the previous review period.

A review of the records of five individuals found that all five of the WRPs in the charts contained documentation indicating that the individual was an active participant in the discharge process (JHG, MK, MLV, MTG and WM).

This monitor observed three WRPCs (JEC, JWC and RH). In all three cases, the WRPT discussed the individual's progress and current barriers to discharge. Only one individual (RH) participated in the discussion on his discharge issues. JWC did not contribute to the discussion, and JEC did not participate in the conference, instead leaving the room 30 seconds after joining the conference.

A review of the records of nine individuals found that six of the WRPs in the charts prioritized objectives and interventions related to the discharge processes with each discharge criteria having appropriate foci, objectives, and relevant PSR Mall services (DS, EC, JHG, MLV, MTG and RP). The remaining three (HWT, JM and RGP) failed to address each and every discharge criteria with appropriate foci, objectives, and relevant PSR Mall services.

**Compliance:**
Partial.

**Current recommendations**:
1. Ensure that the individual is an active participant in the discharge planning process.
2. Ensure that the individual understands all of the discharge

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| | | requirements before leaving the WRPC.<br>3. Prioritize objectives and interventions related to the discharge processes. |
| E.3 | Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes: | Please see sub-cells for compliance findings. |
| E.3.a | measurable interventions regarding these discharge considerations; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>*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:*<br>6. *Measurable interventions regarding these discharge considerations* — 93% |

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| | | Comparative data indicated improvement in compliance from 59% in the previous review period.<br><br>A review of the WRPs of 12 individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all 12 (AD, DS, EC, GS, JHG, MG-1, MG-2, MO, MT, MWT, PN and RGP).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.3.b | the staff responsible for implementing the interventions; and | **Current findings on previous recommendations:**<br><br>**Recommendations and 2, April 2009:**<br>• Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.<br>• Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group or intervention.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>7. *The interventions specify the name(s) of specific staff responsible for implementing each one* — 98%<br><br>Comparative data indicated improvement in compliance from 82% in the previous review period. |

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| | | A review of the records of 12 individuals found that all 12 of the WRPs in the charts identified the staff member responsible for the interventions (AD, DS, EC, GS, JM, MG-1, MG-2, MO, MT, MWT, PN and RGP); and documentation review and Mall group observations found that the staff listed in the WRP is the one involved in facilitating the activity or group.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.3.c | The time frames for completion of the interventions. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>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.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>*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:*<br>8. *The time frames for completion of interventions* 99% |

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| | | Comparative data indicated improvement in compliance from 89% in the previous review period.<br><br>A review of the records of 12 individuals found that all 12 of the WRPs in the charts clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AD, DS, EC, GS, JM, MG-1, MG-2, MO, MT, MWT, PN and RGP).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.4 | Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that: | **Compliance:**<br>Substantial. |
| E.4.a | individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Reduce the overall number of individuals still hospitalized after referral for discharge has been made.<br>• Identify and resolve system factors that act as barriers to timely discharge.<br><br>**Findings:**<br>ASH has done an exemplary job of clearing all its list of long-standing referrals for discharge. The facility's data showed that currently it takes an average of 62 days from the day of discharge readiness to actual placement. As of September 18, 2009, only 12 discharge-ready individuals (referred for discharge since March 2009) are still |

hospitalized. The table below showing the individuals waiting for placement, their discharge readiness date, their placement availability, and their barriers to placement is a summary of the data.

| Initials | Discharge Readiness | Placement Availability | Barriers to placement |
|---|---|---|---|
| MA | 3/13/09 | Court to approve | DA is contesting COT |
| DH | 3/17/09 | CONREP accepted 8/17/09 | Waiting for court to approve |
| AR | 3/09 | Referral rescinded 4/23/09 | Recent referral 8/09 Waiting for placement interview |
| ES | 5/5/09 | CONREP accepted 8/7/09 | Waiting for court to approve |
| MO | 7/13/09 | | Waiting for placement interview |
| JG | 7/23/09 | | Waiting for placement interview |
| DW | 7/28/09 | | Waiting for placement interview |
| GR | 8/18/09 | | Waiting for placement interview |
| AP | 8/20/09 | | Waiting for placement interview |
| JN | 8/20/09 | | Waiting for placement interview |
| LC | 8/25/09 | | Waiting for placement interview |
| AW | 8/25/09 | | Waiting for placement interview |

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| | | **Recommendation 3, April 2009:**<br>Write all discharge criteria in behavioral terms.<br><br>**Findings:**<br>See E.3.a.<br><br>**Current recommendation**:<br>Continue current practice. |
| E.4.b | Individuals receive adequate assistance in transitioning to the new setting. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Develop and implement a monitoring and tracking system to address the key elements of this requirement.<br>• Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting.<br><br>**Findings:**<br>Using the DMH Discharge Planning and Community Integration Auditing Form, ASH assessed its compliance based on an average sample of 90% of the quarterly and annual WRPs due each month during the review period (March-August 2009):<br><br>| | *Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:* | |<br>| 10. | *Individuals receive adequate assistance in transitioning to the new setting. (E4b)* | 100% |<br><br>Comparative data indicated improvement in compliance from 32% in the previous review period. |

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| | | A review of the records of nine individuals found that all nine of the WRPs in the charts contained documentation of the assistance needed by the individual in the new setting (AD, GS, LI, MG-1, MG-2, MO, MT, NL and PN). The documented assistance given to individuals when transitioning to a new setting included family education, arrangement for community services, and contacting parole officers to make referral and plan for Social Security.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| E.5 | For all children and adolescents it serves, each State hospital shall: | The requirements of cell E.5 and sub-cells are not applicable to ASH as it does not serve children and 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 | |
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| | **Summary of Progress on Psychiatric Services:**<br>1. ASH has made significant progress in decreasing the unjustified long-term use of anticholinergics and benzodiazepines.<br>2. ASH has improved its practice regarding the justification of polypharmacy use.<br>3. ASH has made further progress in the laboratory monitoring of individuals receiving new generation antipsychotic agents (NGAs).<br>4. ASH has achieved substantial compliance with EP requirements regarding the reporting and analysis of adverse drug reactions (ADRs).<br>5. ASH has achieved substantial compliance with EP requirements regarding the processes of drug utilization evaluation (DUE).<br>6. ASH has made significant progress regarding the process of reporting medication variances.<br>7. ASH has achieved substantial compliance with EP requirements regarding the clinical monitoring of individuals diagnosed with tardive dyskinesia (TD).<br><br>**Summary of Progress on Psychological Services:**<br>1. ASH has achieved substantial compliance with all requirements of this section, with the exception of the requirement related to PBS team staffing.<br>2. The PSSC has made significant improvements in adhering to the Risk Management Policies (SO 262) by reviewing trigger thresholds and following up with assessments and where appropriate interventions.<br>3. Behavior guidelines at ASH now follow the same format and procedures as the PBS plans<br>4. Neuropsychology Services has significantly reduced the time from referral to completion of assessments, even as the number of referrals has increased, and has increased the number of cognitive remediation groups offered. |

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| | **Summary of Progress on Nursing Services:**<br>1. ASH continues to make steady progress regarding the documentation of PRN and Stat medications.<br>2. ASH has implemented a number of systems to critically evaluate the barriers and discrepancies regarding medication administration. A medication room staff survey has yielded recommendations addressing problematic issues that were noted on the surveys.<br>3. There was much improvement noted during this review in documentation regarding change of status. Mentoring in this area needs to continue to bring this requirement into substantial compliance.<br><br>**Summary of Progress on Rehabilitation Therapy Services:**<br>1. Significant improvement has been noted in the integration of information related to RT objectives, interventions, and progress in treatment into the WRP.<br>2. The POST department has developed several PSR Mall groups related to physical rehabilitation that are pending implementation.<br><br>**Summary of Progress on Nutrition Services:**<br>1. ASH has achieved substantial compliance with all requirements of this section.<br>2. Significant improvement has been noted in the integration of information related to Nutrition objectives, interventions, and progress in treatment into the WRP.<br><br>**Summary of Progress on Pharmacy Services:**<br>1. ASH has maintained substantial compliance with EP requirements in this section.<br>2. ASH's Chief of Pharmacy (Dr. Ron O'Brien) has continued to provide effective leadership during this review period. |

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| | **Summary of Progress on General Medical Services:**<br>ASH has achieved substantial compliance with EP requirements regarding the provision of general medical care (not including seizure management).<br><br>**Summary of Progress on Infection Control:**<br>1. ASH has achieved substantial compliance in all areas of the Enhancement Plan regarding Infection Control.<br>2. ASH has done a significant amount of work implementing a number of hospital-wide interventions to aggressively address issues surrounding the H1N1 virus.<br><br>**Summary of Progress on Dental Services**<br>1. The Dental Department has achieved substantial compliance in most of the areas of the Enhancement Plan with the exception of dental refusals. However, based on ASH's plan of correction, the facility should reach substantial compliance in this area by the next review period.<br>2. Throughout this process, ASH's Dental Department has remained passionate and committed to the individuals they serve. |

| 1. Psychiatric Services | | |
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| | | **Methodology:**<br><br>Interviewed:<br>1. Frank Stass, MD, Assistant to the Chief of Psychiatry<br>2. Jean Dansereau, MD, Chief of Psychiatry<br>3. Robert Knapp, MD, Medical Director<br>4. Stephanie Chavez, Associate Mental Health Specialist<br>5. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee<br><br>Reviewed:<br>1. Charts of the following 39 individuals: AAA, AFG, AJP, AWS, BO, BSH, DJM, DT, GC, GP, JAE, JCP, JEP, JJC, JJG, JO, JPW, JSH, JW, LG, MB, MBM, MH, MM, MP, MSB, OR, PPD, PWM, RDA, RWK, SA, SCL, SDJ, TJP, TSK, VUL, WCB and WM<br>2. ASH Admission Psychiatric Assessment Audit summary data (March-August 2009)<br>3. ASH Integrated Assessment: Psychiatry Section Audit summary data (March-August 2009)<br>4. ASH Monthly PPN Audit summary data (March-August 2009)<br>5. ASH PRN and Stat monitoring summary data (March-August 2009)<br>6. Stat/NOW PPN form, September 2009<br>7. ASH New Generation Antipsychotic Medications Monitoring summary data (March-August 2009)<br>8. ASH Tardive Dyskinesia Database<br>9. ASH TD Monitoring summary data (March-August 2009)<br>10. Last ten ADRs for this reporting period<br>11. ASH aggregated data regarding ADRs (March-August 2009)<br>12. Intensive case analyses (ICAs) completed during this review period<br>13. Physician's Order form, July 2009<br>14. Last ten MVRs for this reporting period<br>15. ASH aggregated data regarding medication variances (March-August |

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| | | 2009)<br>16. Nursing Procedure 309.0: Control Drugs, June 24, 2009<br>17. Pharmacy Policy 107: Controlled Medications, May 10, 2009<br>18. Accountability Sheets and Controlled Medication on Unit Form and Instructions<br>19. Pharmacy and Therapeutics Committee Minutes during the review period<br>20. Drug utilization evaluations completed by ASH during this review period |
| F.1.a | Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are: | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines.<br><br>**Findings:**<br>During this review period, the DMH's Psychopharmacology Advisory Committee (PAC), led by ASH's psychopharmacology consultant (Dr. Cummings), has made further revisions, updates and additions to the DMH Psychotropic Medication Policy. This monitor reviewed the changes and found that they comported with current literature and generally accepted standards. However, ASH did not receive the finalized version of these changes during this review period.<br><br>Under the leadership of the facility's Chief of the Pharmacy and Therapeutics (P&T) Committee (Dr. Mohaupt), ASH updated its medication protocols as follows:<br><br>1. ASH protocol regarding the use of ziprasidone was revised to require that oral ziprasidone be dosed near meal times due to increased absorption by up to two-fold. |

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| | | 2. The facility limited the use of Zyprexa Zydis (olanzapine orally disintegrating tablets) and Risperdal M-Tab (risperidone orally disintegrating tablets) for cost savings. The facility reported that these dosage forms will be allowed on admission units for up to 14 days without prior approval and that use on long-term units or beyond 14 days on admission units will require approval from the Medication Review Committee (MRC) using a non-formulary request form.<br>3. The facility provided an adequate guideline to taper off benzodiazepines after routine use of a week or more and to individualize the tapers.<br>4. Depakote liquid was placed on restricted formulary. This was approved after discussion of the unit dosing challenges with the liquid formulation.<br>5. Due to their potential for drug abuse, the facility developed a guideline to require that the following medications will always be ordered as crushed: bupropion, quetiapine and benzodiazepines.<br><br>**Recommendations 2-4, April 2009:**<br>• Monitor this requirement using the DMH Admission Psychiatric Assessment, DMH Integrated Assessment: Psychiatric Section and Monthly Physician Progress Note auditing form based on at least a 20% sample and ensure validity of data.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br>• Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>ASH used the DMH Admission Psychiatric Assessment and Integrated Assessment: Psychiatry Section Forms to assess compliance during the review period (March-August 2009), based on average samples of 95% and 90% respectively. |

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| | | ASH also used the Monthly Psychiatric Progress Note Auditing Form to assess compliance with this requirement. ASH revised the Monthly Physician Progress Note Template and Auditing Form during this review period in efforts to ensure clinical relevance and to continue to meet all requirements of the Enhancement Plan. Specific modifications are noted in each cell as applicable. The sample size was 23% of the monthly notes for individuals who had been hospitalized for more than 90 days.<br><br>Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below<br><br>**Compliance:**<br>Partial; improved compared to the last review. Substantial compliance is contingent on timely communications between the facilities and DMH's PAC.<br><br>**Current recommendations**:<br>1. Continue to update (as necessary) individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary and provide specific summary outline of these updates.<br>2. Implement corrective actions to ensure timely communications between the PAC and all facilities.<br>3. Continue to monitor this requirement. |
| F.1.a.i | specifically matched to current, clinically justified diagnoses or clinical symptoms; | |

| **Admission Psychiatric Assessment** | | |
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| 8. | *Plan of care includes:* | 89% |
| 8.a | *Regular psychotropic medications, with rationale.* | 97% |
| 8.b | *PRN and/or Stat medication as applicable, with specific behavioral indications* | 93% |
| 8.c | *Special precautions to address risk factors, as indicated.* | 78% |

The facility reported an improvement in mean compliance from 41% during the previous review period. ASH did not provide comparative data on compliance rates from the last month of the previous review period to the last month of the current review period.

| **Integrated Psychiatric Assessment** | | |
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| 7. | *Diagnostic formulation is documented* | 94% |
| 10. | *Psychopharmacology treatment plan includes:* | 99% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 62% | 94% |
| 10. | 47% | 99% |

ASH implemented the revised PPN Auditing Form in July 2009. These items' numbers were changed and these items were revised to more closely align with the EP requirement.

| **Monthly PPN Revised** | | |
|---|---|---|
| 2.b | *Subjective complaints and symptoms are documented or there is documentation substantiating the reason that subjective complaints/concerns are not available.* | 96% |
| 3. | *Timely and justifiable updates of diagnosis and treatment, as clinically indicated.* | 97% |

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

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.b</td><td>75%</td><td>96%</td></tr>
<tr><td>3.</td><td>62%</td><td>97%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>ASH implemented the revised PPN Auditing Form in July 2009. The item number changed and the wording was simplified to reduce confusion.<br><br>
<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>5.b</td><td>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</td><td>84%</td></tr>
</table>
<br>The facility reported a mean compliance rate of 57% during the previous review period. The rate for the last month of this review period was 97% compared to 53% during the last month of the previous review period.<br><br>ASH reported that it implemented the revised Monthly PPN template during the review period to increase compliance with this item.</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>ASH implemented the revised PPN Auditing Form in July 2009. This item number changed and the wording was revised to facilitate the discussion of target symptoms within the context of treatment.<br><br>
<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>5.c</td><td>Monitored for effectiveness against clearly identified target variables</td><td>95%</td></tr>
</table>
<br>The facility reported a mean compliance rate of 78% in the previous review period.</td></tr>
</table>

<table>
<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>ASH implemented the revised PPN Auditing Form in July 2009. This item number changed and the item was revised for clarity.
<table>
<tr><th colspan="3">Monthly PPN Revised</th></tr>
<tr><td>2.g</td><td>Current AIMS</td><td>91%</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</td><td>88%</td></tr>
</table>
Comparative data indicated improvement in compliance since the previous review period:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.g</td><td>86%</td><td>91%</td></tr>
<tr><td>5.d</td><td>N/A</td><td>88</td></tr>
</table></td></tr>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>ASH implemented the revised PPN Auditing Form in July 2009. These items' numbers were changed and the items were revised for clarity.
<table>
<tr><th colspan="3">Monthly PPN Revised</th></tr>
<tr><td>5.a</td><td>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</td><td>95%</td></tr>
<tr><td>5.d</td><td>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines,</td><td>88%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| | | anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications. |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5.a | 78% | 95% |
| 5.d | N/A | 88% |

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

ASH implemented the revised PPN Auditing Form in July 2009. This item number was changed and items were consolidated to reduce redundancy.

| **Monthly PPN Revised** | | |
|---|---|---|
| 5.d | *Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.* | 88% |

F.1.a.viii

Properly documented.

| | | |
|---|---|---|
| Admission Psychiatric Assessment | 8.a, 8.b and 8.c | 89% |
| Integrated Assessment (Psychiatry) | 7 and 10 | 97% |
| Monthly PPN | 2b, 2c, 2d, 2h2, 6a1, 6a2, 6b, and 6c | 88% |

Comparative data indicated improvement in compliance since the previous

<table>
<tr><td></td><td></td><td>review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>Admission Psychiatric Assessment</td><td>63%</td><td>89%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>49%</td><td>97%</td></tr>
<tr><td>Monthly PPN</td><td>74%</td><td>88%</td></tr>
</table>
</td></tr>
<tr><td>F.1.b</td><td>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.</td><td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Monitor this requirement using the DMH Monthly Physician Progress Note auditing form and the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses based on at least a 20% sample.<br>
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>
Findings:<br>
ASH used the standardized DMH Monthly PPN tool (revised in July 2009) to assess compliance, based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (March-August 2009). The number of this item was revised and the sub-items removed. The following table summarizes the data:<br><br>
<table>
<tr><td colspan="3">Monthly PPN Revised</td></tr>
<tr><td>6.</td><td>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</td><td>71%</td></tr>
</table>
<br>
The facility reported a mean compliance rate of 33% during the previous
</td></tr>
</table>

review period. The compliance rate for the last month of this review period was 76% compared to 24% during the last month of the previous review period.

The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 20% and 17% of PRN and Stat medications given per month, respectively.

| **Nursing Services PRN** | | |
|---|---|---|
| 1. | *Safe administration of PRN medication.* | 91% |
| 3. | *Documentation of the circumstances requiring PRN medication.* | 86% |
| 5. | *Documentation of the individual's response to PRN medication.* | 87% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 81% | 91% |
| 3. | 48% | 86% |
| 5. | 57% | 87% |
| Compliance rate in last month of period | | |
| 3. | 84% | 95% |
| 5. | 78% | 95% |

| **Nursing Services Stat** | | |
|---|---|---|
| 2. | *Safe administration of Stat medication.* | 79% |
| 4. | *Documentation of the circumstances requiring Stat medication.* | 81% |

| | | |
|---|---|---|
| 6. | *Documentation of the individual's response to Stat medication.* | 85% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 40% | 79% |
| 4. | 37% | 81% |
| 6. | 44% | 85% |
| Compliance rate in last month of period | | |
| 2. | 55% | 91% |
| 4. | 84% | 87% |
| 6. | 77% | 93% |

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

**Findings:**
ASH reported that it implemented a standardized Stat form in August 2009 that delineates the required documentation elements for Stat medications. The form is aligned with nursing documentation for administration of Stat medications. The facility indicated that it intends to develop a "real time" tracking system for Stat medications to increase monitoring of timeliness.

**Compliance:**
Partial; improved compared to the last review. Substantial compliance is dependent on compliance with D.1.f.

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| F.1.c | Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 3, April 2009:**<br>• Monitor this requirement using the Benzodiazepine, Anticholinergic and Polypharmacy Audit Forms based on at least a 20% sample.<br>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>During this review period, this monitor reviewed the revised DMH Monthly PPN Audit Form and found it to be sufficient to provide self-assessment data while simplifying and consolidating the processes of monitoring for the use of benzodiazepines, anticholinergics and polypharmacy.<br><br>ASH used the standardized DMH Monthly PPN Audit Form to assess compliance (March-August 2009). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates: |

| **PPN - Revised** | | |
|---|---|---|
| 5.d. | *Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:* | |
| 5.d.i | *Benzodiazepines* | 88% |

| | | |
|---|---|---|
| 5.d.ii | *Anticholinergics* | 88% |
| 5.d.iii | *Polypharmacy* | 82% |

Additionally, ASH reported the following comparative data:

| | Indicators | Previous Period | Current Period |
|---|---|---|---|
| 1. | *Total number of individuals receiving benzodiazepines for 60 days or more* | 157 | 119 |
| 2. | *Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more* | 142 | 108 |
| 3. | *Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more* | 130 | 95 |
| 4. | *Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)* | 28 | 22 |
| 5. | *Total number receiving anticholinergics for 60 days or more* | 299 | 155 |
| 6. | *Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above* | 57 | 30 |
| 7. | *Total number with intra-class polypharmacy* | 374 | 405 |
| 8. | *Total number with inter-class polypharmacy* | 256 | 240 |

| | | |
|---|---|---|
| | | **Recommendation 2, April 2009:**<br>Provide a summary outline of improvements in practice made as a result of review by the facility of internal monitoring data.<br><br>**Findings:**<br>See D.1.b.ii for a summary of ASH's implementation of the Physician Performance Profile. The facility indicated that implementation of the Profile is intended to increase compliance with this indicator.<br><br>**Other findings:**<br>This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:<br><br>1. Benzodiazepines in the presence of diagnoses of substance use disorders and/or cognitive disorders;<br>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;<br>3. Anticholinergic medications for elderly individuals; and<br>4. Various forms of polypharmacy.<br><br>The reviews found that the facility has made significant progress in decreasing the overall use of anticholinergic and benzodiazepine medications from November 2008 to September 2009 (a 66% percent decrease was noted). In addition, ASH made significant progress during this review period in decreasing the unjustified use of these medications for individuals who are diagnosed with substance use and/or cognitive disorders.<br><br>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following tables outline chart reviews by this monitor (diagnoses are listed only of they represented high risk conditions): |

**Benzodiazepine use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| BO | Clonazepam | Polysubstance Dependence and Borderline Intellectual Functioning |
| GP | Lorazepam | Dementia Due To General Medical Condition with Behavioral Disturbance |
| JCD | Lorazepam | Polysubstance Dependence |
| JEP | Lorazepam | Alcohol Abuse and Borderline Intellectual Functioning |
| JJC | Lorazepam | Alcohol Dependence and Cannabis Abuse |
| MB | Clonazepam | Cognitive Disorder NOS |
| MBM | Lorazepam | Polysubstance Dependence |
| PPD | Clonazepam | Polysubstance Dependence |
| RWK | Clonazepam | Alcohol Dependence |
| WM | Clonazepam | Sedative, Hypnotic or Anxiolytic Dependence |

This review found substantial compliance in four charts (GP, JJC, MB and WM), partial compliance in five (JCD, JEP, MBM, PPD and RWK) and noncompliance in one (BO).

**Anticholinergic use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| AAA | Benztropine | Cognitive Disorder NOS |
| GC | Benztropine | Mild Mental Retardation and Cognitive Disorder NOS |
| JEP | Benztropine | Borderline Intellectual Functioning |
| JPW | Diphenhydramine | Borderline Intellectual Functioning |

| | | |
|---|---|---|
| MH | Trihexyphenidyl | Dementia Due to General Medical Condition with Behavioral Disturbance |
| MM | Benztropine (and clonazepam) | Borderline Intellectual Functioning |
| RDA | Diphenhydramine | Borderline Intellectual Functioning |

At the time of this review, no individual at the facility age 65 or above was receiving anticholinergic treatment (except for one individual who was newly admitted while receiving this treatment).

This review found substantial compliance in four charts (AAA, JEP, JPW and MH), partial compliance in one (RDA) and noncompliance in two (GC and MM).

**Polypharmacy use**

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| AWS | Risperidone (Consta), risperidone (by mouth), olanzapine, divalproex, clonazepam and lithium. | Polysubstance Dependence and Mild Mental Retardation |
| GP | Fluphenazine decanoate, fluphenazine (by mouth), risperidone and divalproex | |
| MP | Olanzapine, quetiapine, mirtazapine, buspirone and propranolol | |
| OR | Clozapine, clonazepam, divalproex, lithium, propranolol and benztropine | Polysubstance Dependence |
| PWM | Olanzapine, perphenazine, fluvoxamine, lithium and benztropine | Borderline Intellectual Functioning |

| | | |
|---|---|---|
| SCL | Olanzapine, haloperidol, fluoxetine and divalproex. | |
| SDJ | Risperidone, ziprasidone, clonazepam, divalproex and benztropine | |
| VUL | Olanzapine, ziprasidone, mirtazapine, benztropine and duloxetine | R/O Diabetes Mellitus |
| WM | Olanzapine, divalproex, sertraline, clonazepam and benztropine | Sedative, Hypnotic or Anxiolytic Dependence And other Substance Abuse |

This review found substantial compliance in five charts (GP, MP, PWM, SCL and VUL) and partial compliance in four (AWS, OR, SDJ and WM).

**Compliance:**
Partial; improved compared to the last review.

**Current recommendations**:
1. Continue to monitor this requirement.
2. Provide aggregated data (and data comparisons across review periods) regarding the mean total number of individuals receiving the following:
   a. Benzodiazepines for 60 days or more;
   b. Benzodiazepines in the presence of any diagnosis of substance use disorder;
   c. Benzodiazepines in the presence of any diagnosis of cognitive impairment;
   d. Anticholinergics for 60 days or more days;
   e. Anticholinergics in the presence of any diagnosis of cognitive impairments and/or tardive dyskinesia;

<table>
<tr><td></td><td></td><td>f. Anticholinergics for individuals aged 65 or above;<br>g. Intra-class polypharmacy; and<br>h. Inter-class polypharmacy.</td></tr>
<tr><td>F.1.d</td><td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td><td>

**Current findings on previous recommendations:**

**Recommendations 1 and 2, April 2009:**

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

**Findings:**

During this review period, DMH simplified the current self-auditing tool to focus the monitoring process on areas in need of improvement. Using the ASH New Generation Antipsychotic Medications Auditing Form, ASH assessed its compliance based on an average sample of 25% of individuals receiving these medications during the review period (March-August 2009):

<table>
<tr><td></td><td>If prescribed any medication except aripiprazole, justification is documented in the PPN for individuals with diagnosis of:</td><td></td></tr>
<tr><td>5.</td><td>Dyslipidemia</td><td>43%</td></tr>
<tr><td>6.</td><td>Diabetes Mellitus</td><td>65%</td></tr>
<tr><td>7.</td><td>Obesity</td><td>58%</td></tr>
</table>

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

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 17% | 43% |
| 6. | 21% | 65% |
| 7. | 25% | 58% |
| Compliance rate in last month of period | | |
| 5. | 20% | 57% |
| 6. | 50% | 57% |
| 7. | 20% | 52% |

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

**Findings:**
The following summarizes the facility's corrective actions during the review period:

1. Implementation of the revised Monthly PPN Template (July 2009), which included prompts to document justification of NGA use in individuals with metabolic disorders;
2. Development of examples of appropriate documentation of justification of NGA use in individuals with metabolic disorders (October 12, 2009);
3. Completion of DUEs related to prescription of NGAs for individuals with metabolic disorders; and
4. Implementation of "real time" audits with immediate corrections of deficiencies.

**Other findings:**
This monitor reviewed the charts of 11 individuals who received new-generation antipsychotic agents and were diagnosed with a variety of

metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the diagnosed metabolic disorder(s):

| Individual | Medication(s) | Diagnosis |
|---|---|---|
| AFG | Olanzapine | Diabetes Mellitus |
| BSH | Olanzapine | Diabetes Mellitus, Obesity, Hyperlipidemia and Hypertension |
| DJM | Risperidone and aripiprazole | Diabetes Mellitus and Obesity |
| DT | Quetiapine | Diabetes Mellitus and Hyperlipidemia |
| JAE | Risperidone, quetiapine and perphenazine | Diabetes Mellitus |
| JJG | Clozapine | Diabetes Mellitus and Obesity |
| JSH | Clozapine | Obesity |
| JW | Quetiapine | Hyperlipidemia |
| MM | Olanzapine | Diabetes Mellitus and Hyperlipidemia |
| SA | Clozapine | Diabetes Mellitus, Hyperlipidemia and Obesity |
| TSK | Risperidone | Diabetes Mellitus, Obesity and Hypertension |

The review found that ASH has made significant progress in addressing the deficiencies that were outlined by this monitor in previous reports, including the following areas:

1. Laboratory monitoring for the risks of endocrine and pancreatic dysfunction;
2. Laboratory monitoring for the metabolic risks associated with clozapine therapy;
3. Psychiatric documentation of the actual (individualized) risks of treatment; and

| | | |
|---|---|---|
| | | 4. Psychiatric documentation of a risk/benefit analysis (in some recent psychiatric progress notes).<br><br>The review found that the facility's practice is on the verge of substantial compliance with this requirement. In order to reach compliance, the following deficiency must be corrected:<br><br>The psychiatric progress notes did not include an adequate risk/benefit analysis to justify continued treatment with olanzapine (AFG and MM) or risperidone (TSK) for some individuals who were suffering from diabetes mellitus, serious obesity and or dyslipidemia and experiencing progressive weight gain on this treatment.<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendation**:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| F.1.e | Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Develop and implement a policy and procedure to ensure that:<br>a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD;<br>b. TD is recognized as one of the foci of hospitalization and appropriate objectives and interventions are identified for treatment and/or rehabilitation;<br>c. The individuals receive appropriate periodic screening; and<br>d. The individuals receive care at a specialized TD clinic. |

**Findings:**
The facility's current AD 516.7 contains the above elements. The facility indicated that minor changes were made to ensure consistency in language during the review period, but there were no modifications to process.

**Recommendations 2 and 3, April 2009:**

- Monitor this requirement using the DMH Tardive Dyskinesia Monitoring Form based on at least a 100% sample and identify the target population for all indicators.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

**Findings:**
During this review period, DMH revised the TD Auditing Form in order to streamline the auditing indicators. Using the new DMH Movement Disorders tool, ASH assessed its compliance based on average samples ranging from 23% to 95% of individuals relevant to each indicator during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *A baseline assessment shall be performed for each individual at admission.* | 100% |
| 2. | *Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.* | 91% |
| 3. | *Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.* | 91% |
| 4. | *Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there is documentation of rationale for continuation.* | 97% |
| 5. | *A neurology consultation / TD Clinic evaluation was* | 68% |

| | | |
|---|---|---|
| | *completed as indicated.* | |
| 6. | *Diagnosis of TD is listed on Axis I and/or III (for current diagnosis).* | 95% |
| 7. | *Tardive Dyskinesia is included in Focus 6 of the WRP.* | 84% |
| 8. | *The WRP reflect objectives and interventions for Tardive Dyskinesia.* | 84% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 98% | 100% |
| 2. | 61% | 91% |
| 3. | 59% | 91% |
| 4. | 72% | 97% |
| 5. | 76% | 68% |
| 6. | 66% | 95% |
| 7. | 59% | 84% |
| 8. | 59% | 84% |
| Compliance rate in last month of period | | |
| 1. | 100% | 100% |
| 2. | 85% | 96% |
| 3. | 74% | 96% |
| 4. | 85% | 85% |
| 5. | 83% | 100% |
| 6. | 65% | 100% |
| 7. | 71% | 100% |
| 8. | 71% | 100% |

| | | |
|---|---|---|
| | | **Recommendation 4, April 2009:**<br>Provide a summary outline of any improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>**Findings:**<br>No specific information was provided and none is required at this stage (see Other Findings below).<br><br>**Other findings:**<br>This monitor reviewed the charts of six individuals who were diagnosed with tardive dyskinesia (AJP, JO, LG, MSB, TJP and WCB) and reviewed the facility's database regarding this diagnosis. Based on these reviews, there was evidence that ASH has made significant progress as follows:<br><br>1. The facility has improved its system of identifying individuals with diagnosis or history of TD (the database identified 42 individuals compared to 32 during the last review);<br>2. The admission AIMS tests were completed in all the charts reviewed. This review was limited to individuals who were admitted during the past year;<br>3. AIMS tests were completed on a quarterly basis during this review period in all charts;<br>4. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in most of the charts reviewed;<br>5. With one exception, the objectives related to TD utilized appropriate learning outcomes for most individuals;<br>6. None of the individuals diagnosed with TD (in the charts reviewed) received unnecessary long-term treatment with anticholinergic agents during this review period; and<br>7. The psychiatric progress notes provided adequate tracking of the movement disorder in all charts. |

| | | |
|---|---|---|
| | | Fewer deficiencies were identified compared to the last review. The following is an outline:<br><br>1. In one individual, the objective related to lowering the severity of TD movements was unattainable for the individual (MSB).<br>2. The WRP of one individual did not include focus, objectives or interventions to address this condition (JO). However, the psychiatric progress note indicated that the TD movements had recently dissipated.<br>3. There was no focus, objective or interventions specified in the WRP of one individual (TJP).<br><br>Overall, the review found substantial compliance in four charts (AJP, JO, LG and WCB) and partial compliance in two (MSB and TJP).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.1.f | Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR"). | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Increase reporting of ADRs.<br>• Present summary data to address the following:<br>a. Number of ADRs reported during the review period compared with the number during the previous period;<br>b. Classification of ADRs by outcome category compared with the number during the previous period;<br>c. Clinical information regarding each ADR that was classified as severe and the outcome to the individual involved;<br>d. Information regarding any intensive case analysis done for each |

reaction that was classified as severe; and

e. Outline of intensive case analysis including description of ADR, recommendations and actions taken.

**Findings:**
The following summarizes the facility's data:

| | Previous period | Current period |
|---|---|---|
| Total ADRs | 35 | 69 |
| Classification of Probability of ADRs | | |
| Doubtful | 1 | 4 |
| Possible | 18 | 38 |
| Probable | 15 | 24 |
| Definite | 1 | 3 |
| Classification of Severity of ADRS | | |
| Mild | 8 | 15 |
| Moderate | 22 | 40 |
| Severe | 5 | 14 |

ASH conducted intensive case analyses (ICAs) on 14 severe ADRs. The ICAs were based on appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. Based on the facility's report, none of these ADRs resulted in permanent sequelae to the individual involved.

**Recommendation 3, April 2009:**
Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.

**Findings:**
A summary of the facility's analysis follows:

| | | |
|---|---|---|
| | | 1. The most common ADRs included sedation, hypotension, dizziness (lightheadedness or vertigo) or nausea/ vomiting. ASH concluded that these symptoms may occur as a result of rapid titration and that the populations at greatest risk are the elderly, relatively medication-naïve and those with co-morbid conditions.<br>2. The medications with most frequent ADRs are divalproex, risperidone, quetiapine and olanzapine. ASH indicated that these are the most frequently prescribed medications.<br><br>In terms of corrective actions, ASH reported the following:<br><br>1. Any individual with an ADR from clozapine will be referred to the Clozaril clinic for an appointment.<br>2. Triggered by a recommendation during an ICA, the facility has added the category of "Sensitivity" to "Allergy" on the physician order, monthly progress note and WRP. This category is intended to capture reactions that do not meet the definition of "allergy" but are relevant to future pharmacological treatment planning.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Continue review and analysis of ADRs and present summary of aggregated data to address the following:<br>a. The number of ADRs reported each month during the review period compared with the number reported during the previous period;<br>b. Classification of probability and severity of ADRs;<br>c. Any negative outcomes for individuals who were involved in serious reactions;<br>d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and |

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| | | e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).<br>2. Continue to provide analysis of patterns and trends, with corrective/educational actions related to ADRs. |
| F.1.g | Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.<br><br>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue 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.<br><br>**Findings:**<br>ASH reported that it completed DUEs on paliperidone, risperidone, anticholinergics, benzodiazepines, tardive dyskinesia and olanzapine during this review period.<br><br>**Recommendation 2, April 2009:**<br>Conduct a DUE on individuals who are prescribed NGAs and are suffering from metabolic disorders and ensure that corrective actions include interventions to reduce risk for these individuals.<br><br>**Findings:**<br>ASH reported that the above DUE was proposed to and approved by the Quality Council. The facility indicated that it is currently in the process of developing a database to facilitate this review. ASH indicated that it intends to complete this project on December 1, 2009.<br><br>**Recommendation 3, April 2009:**<br>Ensure proper aggregation and analysis of DUE data to determine |

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| | | practitioner and group patterns and trends.<br><br>**Findings:**<br>The Physician Performance Profile implemented during the review period facilitates the identification of practitioner and group patterns and trends.<br><br>**Other findings:**<br>Review by this monitor found that the facility's DUEs employed appropriate methodologies and comported with generally accepted standards in this process.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken. |
| F.1.h | Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Present data to address the following:<br>a. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;<br>b. Number of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual;<br>c. Clinical information regarding each variance (category E or above) and the outcome to the individual involved;<br>d. Information regarding any intensive case analysis done for each reaction that was classified as category E or above; and<br>e. Outline of ICAs, including description of variance, recommendations and actions taken. |

**Findings:**
ASH reported the following data regarding MVRs:

| Number of Medication Variances | Previous Period | Current Period |
|---|---|---|
| Prescribing | | 50 |
| Transcribing | | 263 |
| Ordering/Procurement | | 14 |
| Dispensing | | 29 |
| Administration | | 368 |
| Drug Security | | 204 |
| Documentation | | 1391 |
| **Total variances** | 2129 | 2319 |

*ASH reported that small discrepancies between the MVR data represented here and MVR data in the Key Indicator report is related to the timing of data collection cut-offs for each report.

| Total Critical Breakdown Points | Current Period |
|---|---|
| Total Critical Breakdown Points | 2083 |
| Potential MVRs | 1728 |
| Actual MVRs | 355 |
| # Prescribing | 30 |
| # Transcribing | 222 |
| # Order/Procure | 5 |
| # Dispensing | 17 |
| # Administration | 264 |
| # Drug Security | 197 |
| # Documentation | 1348 |
| Outcome A | 125 |

| | |
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| Outcome B | 1603 |
| Outcome C | 338 |
| Outcome D | 17 |
| Outcome E | 0 |
| Outcome F | 0 |
| Outcome G | 0 |
| Outcome H | 0 |
| Outcome I | 0 |

**Recommendation 2, April 2009:**
Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.

**Findings:**
A summary of the facility's analysis and corrective actions follows:

1. Following a drug security variance involving the replacement of narcotic medication with non-narcotic medication, ASH reported that it increased the monitoring of drug security. The facility concluded that the increased monitoring led to further discovery of drug security variances, explaining the trend for this variance.
2. ASH reported that it revised its Nursing Procedure 309.0: Control Drugs (June 24, 2009) and Pharmacy Policy 107: Controlled Medications (May 10, 2009) and implemented the Accountability Sheets and Controlled Medication on Unit Form and Instructions in response to the aforementioned drug security medication variance.
3. ASH indicated that it completed a medication room survey from which the Quality Assurance Team generated several recommendations that were being considered at the time of this review.
4. The facility removed clozapine from the night pharmacy following an incidence of titration deviating from protocol and an incidence of administration of clozapine prior to registration.

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| | | **Other findings:**<br>Reviews by this monitor found that the facility's data were internally consistent and adequately covered the range of variance categories and critical breakdown points. The facility also conducted adequate analyses and corrective actions related to three types of variance events during this review period (an incident involving lost narcotics, two clozapine-related variances and two insulin-related events). However, all analyses were triggered by actual variances. In order to achieve substantial compliance, the facility should assess trends and patterns and institute corrective actions related to both actual and potential variances based on regular, systemic and timely reviews of the data.<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendations**:<br>1. Present data to address the following:<br>a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period,<br>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period,<br>c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc),<br>d. Number of critical breakdown points by outcome,<br>e. Clinical information regarding each variance (category E or above) and the outcome to the individual involved,<br>f. Information regarding any intensive case analysis done for each reaction that was classified as category E or above, and<br>g. Outline of ICAs, including description of variance, recommendations and actions taken. |

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| | | 2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs. |
| F.1.i | Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial; improved compared to last review.<br><br>**Current recommendations**:<br>Same as in F.1.a through F.1.h. |
| F.1.j | Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.b and F.1.i.<br><br>**Findings:**<br>Same as in F.1.b and F.1.i.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in F.1.b and F.1.i. |
| F.1.k | Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and | **Current findings on previous recommendation:** |

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| | the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care. | **Recommendation, April 2009:**<br>Same as in F.1.b and F.1.i.<br><br>**Findings:**<br>Same as in F.1.b and F.1.i.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>Same as in F.1.b and F.1.i. |
| F.1.l | Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Compliance:**<br>Partial; improved compared to last review.<br><br>**Current recommendations**:<br>Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. |
| F.1.m | Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for: | **Compliance:**<br>Partial; improved compared to the last review. |
| F.1.m.i | all individuals prescribed continuous anticholinergic treatment for more than two | **Current findings on previous recommendations:** |

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| | months; | **Recommendations 1 and 2, April 2009:**<br>• Same as in F.1.c.<br>• Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Findings:**<br>Same as in F.1.c, D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.<br><br>**Current recommendation**:<br>Same as in F.1.c, D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. |
| F.1.m.ii | all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment; | **Current findings on previous recommendation:**<br><br>**Recommendation, September 2008:**<br>Same as above.<br><br>**Findings:**<br>Same as above.<br><br>**Current recommendations**:<br>Same as above. |
| F.1.m.iii | all individuals prescribed benzodiazepines as a scheduled modality for more than two months; | **Current findings on previous recommendation:**<br><br>**Recommendation, September 2008:**<br>Same as above.<br><br>**Findings:**<br>Same as above.<br><br>**Current recommendations**:<br>Same as above. |

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| F.1.m.iv | all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and | **Current findings on previous recommendation:**<br><br>**Recommendation, September 2008:**<br>Same as above.<br><br>**Findings:**<br>Same as above.<br><br>**Current recommendations**:<br>Same as above. |
| F.1.m.v | all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as F.1.e.<br><br>**Findings:**<br>Same as F.1.e.<br><br>**Current recommendations**:<br>Same as F.1.e. |
| F.1.m.vi | all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.d. and F.1.g.<br><br>**Findings:**<br>Same as in F.1.d. and F.1.g.<br><br>**Current recommendations**:<br>Same as in F.1.d. and F.1.g. |

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| F.1.n | Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in C.2.o and F.1.c.<br><br>**Findings:**<br>Same as in C.2.o and F.1.c.<br><br>**Compliance:**<br>Partial; improved compared to last review.<br><br>**Current recommendations**:<br>Same as in C.2.o and F.1.c. |
| F.1.o | Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction August be provided either onsite or through attendance at conferences elsewhere. | This requirement applies exclusively to Metropolitan State Hospital. |

| 2. Psychological Services | | |
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| | Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and: | **Methodology:**<br><br>Interviewed:<br>1. Brooke Hatcher, RT, Supplemental Activity Coordinator<br>2. Charlie Joslin, Clinical Administrator<br>3. Christine Mathiesen, PsyD, C-PAS Director<br>4. Diane Imrem, PsyD, Chief of Psychology<br>5. Donna Nelson, Standards Compliance Director<br>6. John De Morales, Executive Director<br>7. Karen Dubiel, Hospital Administrative Resident<br>8. Killorin Riddell, PhD, Coordinator Psychology Specialty Services<br>9. Matt Hennessy, PhD, Mall Director<br>10. Theresa M. George, PhD, Senior Psychologist Supervisor<br><br>Reviewed:<br>1. Charts of the following 55 individuals: AA, AB, AE, AF, AG, AM, AR, AS, BB, BG, BM, CG, CV, DC, DLA, DS, EC, ECF, EE, ES, HA, HWT, JB, JC, JeB, JuB, JEC, JHG, JLP, JM, JS, JWC, KR, MA, MAR, MG, MLV, MM, MTG, OR, RC, RD, RGP, RH, RP, RR, SA, SB, SM, TB, TG, TQ, WT, ZE and ZS<br>2. Fidelity data on Positive Behavior Support Plans<br>3. List of individuals in need of neuropsychological services<br>4. List of individuals who have a diagnosis of a disorder affecting cognitive functioning<br>5. List of individuals who have utilized higher than threshold levels of seclusion, restraint and/or PRN or Stat medication for maladaptive behaviors<br>6. Positive Behavior Support plan outcome data and analysis<br>7. Positive Behavior Support plans developed and implemented in the last six months<br>8. Psychiatry Progress Notes<br>9. Psychology Progress Notes |

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| | | 10. Staff training records of PBS plans<br>11. Structural and functional assessments for PBS plans developed and implemented in the last six months<br><br><u>Observed</u>:<br>1. WRPC (Program III, unit 21B) for 14-day review of JWC<br>2. WRPC (Program VI, unit 7A) for quarterly review of JEC<br>3. WRPC (Program VII, unit 30) for quarterly review of RH<br>4. PSR Mall group: Cognitive Restructuring--Sponge Brain<br>5. PSR Mall group: Commitment to Change<br>6. PSR Mall group: Wellness and Recovery Action Planning (WRAP)<br>7. PSR Mall group: Supported Treatment Assisted Recovery (STAR)<br>8. PSR Mall group: Depression Group (Spanish Language)<br>9. PSR Mall group: Anger Management<br>10. PSR Mall group: Mental Health Wellness |
| F.2.a | Each State hospital shall ensure that it has positive behavior support teams (with one team for each 300 individuals, consisting of one clinical psychologist, one registered nurse, two psychiatric technicians (one of whom may be a behavior specialist), and one data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas: | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Maintain the required number of PBS teams to meet the 1:300 ratio as stated in the EP.<br><br>**Findings:**<br>ASH has three PBS teams, sufficient to meet the 1:300 ratio based on the average census for the review period. However, none of the teams have all the required members. One team lacks a Psychiatric Technician and one team lacks a Clinical Psychologist. Both these team members had been transferred from their respective teams to the units. The third team lacks a Behavior Data Specialist.<br><br>**Other findings:**<br>Training data (training topics, schedules, and sign-in sheets) indicated that ASH continued to provide training to its PBS teams to keep them |

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| | | updated on developments in the field. During this review period, training was provided in behavioral assessment, WRP, graphing, Motivational Interviewing, and the PBS Manual.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Maintain the required number of PBS teams to meet the 1:300 ratio as stated in the EP. |
| F.2.a.i | the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1-5, April 2009:**<br>• Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles.<br>• Conduct treatment implementation fidelity checks regularly.<br>• Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual.<br>• 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.<br>• 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).<br><br>**Findings:**<br>The table below showing the number of direct care staff at ASH (N), the number of direct care staff receiving an average of two hours of PBS training (cumulative across months) each month of this review period (n), |

and the percentage of staff trained (%C) is a summary of the facility's data:

| 2009 | Mar | Apr | May | June | July | Aug | Mean |
|---|---|---|---|---|---|---|---|
| N | 1128 | 1129 | 1135 | 1130 | 1130 | 1146 | 1133 |
| n | 1101 | 1127 | 1143 | 1160 | 1181 | 1208 | 1153 |
| %S | 98 | 100 | 100 | 100 | 100 | 100 | 100 |
| % C | 98 | 100 | 100 | 100 | 100 | 100 | 100 |

The table below showing the number of new staff hired during this review period (N), the number of new staff receiving an average of six hours of PBS training (n), and the percentage of new employees trained (%C) is a summary of the facility's data:

| 2009 | Mar | Apr | May | June | July | Aug | Mean |
|---|---|---|---|---|---|---|---|
| N | 27 | 20 | 23 | 46 | 29 | 17 | 27 |
| n | 27 | 20 | 23 | 46 | 29 | 17 | 27 |
| %S | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| % C | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Documentation review (training protocols, staff training post-tests, and sign-in-sheets) verified the facility's data.

Documentation review (PSSC meeting minutes, PBS plans, Structural and functional assessments, fidelity checks, staff training protocols and sign-in-sheets) found that the PSSC is organized and structured to ensure quality and effectiveness of PBS plans. All PBS plans reviewed (AA, AB, CG, EE, ES, JS, OR, RD, SA, TQ and ZS) had the appropriate structural and functional assessments, fidelity data, staff training to competency, and timely revision when plans were not effective.

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| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.2.a.ii | 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. | **Current findings on previous recommendations:**<br><br>**Recommendation 1 and 2, April 2009:**<br>• Ensure that all staff correctly implements the By Choice program.<br>• Implement the program per the manual.<br><br>**Findings:**<br>The following table summarizes staff training on By Choice during the review period (March-August 2009): |

| Staff Training in By Choice | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2009 | Mar | Apr | May | June | July | Aug | Mean |
| Number of staff eligible for training | 27 | 20 | 23 | 46 | 29 | 17 | 27 |
| Number of staff trained | 27 | 20 | 23 | 46 | 29 | 17 | 27 |
| Percent of eligible staff trained | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

As the table above indicates, all staff hired during this period received By Choice training.

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, ASH assessed its compliance based on a mean sample of 13% of the Level of Care staff:

| | | |
|---|---|---|
| 1. | *Staff correctly states the current point cycle.* | 98% |
| 2. | *Staff correctly states the procedures for assigning participation levels on point cards.* | 100% |
| 3. | *Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.* | 100% |
| 4. | *Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.* | 88% |
| 5. | *Staff locates the By Choice Manual.* | 97% |
| 6. | *Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.* | 99% |
| 7. | *Staff correctly states where the point reallocation documentation is located.* | 98% |
| 8. | *Staff can indicate that there is a system for orienting new individuals to the By Choice system.* | 94% |
| 9. | *There is a system to orient new individuals to the By Choice Incentive System.* | 94% |
| 10. | *Staff is able to state their unit's incentive store hours of operation.* | 92% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1-3 and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 65% | 88% |
| 5. | 85% | 97% |
| 6. | 89% | 99% |
| 7. | 79% | 98% |
| 8. | 88% | 94% |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 9. | 81% | 94% |
| 10. | 60% | 92% |
| Compliance rate in last month of period | | |
| 4. | 71% | 100% |

ASH has a new By Choice Coordinator. He has established a system to regularly and accurately track and monitor the By Choice inventory system, reporting high compliance rates in the last several months of this review period. Fidelity and reliability checks are conducted weekly. The Coordinator also receives daily inventory reports to ensure that items are stocked in a timely manner.

**Recommendations 3 and 4, April 2009:**

- By Choice point allocation should be determined by the individual at the WRPC, with facilitation by the staff.
- Report By Choice point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.

**Findings:**

Using the DMH Psychology Monitoring-By Choice Form , ASH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 2. | *The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.* | 93% |

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

A review of the records of six individuals (JHG, MLV, MTG, RD, RP and RR) found that the By Choice point allocation was reported in the Present Status section of the individual's case formulation and updated in the subsequent WRPs in all six cases.

A review of the records of eight individuals found that seven of the WRPs in the charts contained documentation that the individual was a participant in his/her By Choice point allocation (DLA, DS, EC, ECF, HWT, JLP and RGP); the documentation was not found in one chart (JM).

This monitor observed three WRPCs (JEC, JWC and RH). Two of the teams engaged the individual in the By Choice point allocation process. The individual the third WRPC left the conference after a minute saying, "I am fine, I do not need anything from you all," so the team did not have the opportunity to discuss By Choice point allocation.

**Other findings:**
Using the Fidelity of Implementation by Individuals Form, ASH also assessed fidelity of By Choice implementation based on a mean sample of 23% of individuals in the facility:

| | | |
|---|---|---|
| 1. | *The individual is holding his/her own point card.* | 76% |
| 2. | *The individual states, to the best of his/her ability how points are earned.* | 98% |
| 3. | *The individual states, to the best of his/her ability how points are spent.* | 99% |
| 4. | *The individual states, to the best of his/her ability, the expectations for earning FP (full participation), MP (moderate participation), or NP (non-participation) for the current cycle.* | 91% |
| 5. | *The individual states, to the best of his/her ability, the possible number of points that may be earned each day.* | 94% |

| | | |
|---|---|---|
| 6. | *The individual states, to the best of his/her ability, how the points are reallocated for their point card.* | 81% |
| 7. | *The individual states, to the best of his/her ability, the hours the incentive store is open.* | 89% |
| 8. | *The individual can identify, to the best of his/her ability, the cycles of "high priority" on his/her point card.* | 74% |
| 9. | *Individual understands the goal of the By Choice system* | 97% |
| 10. | *Individual can correctly state the procedure for reallocating their By Choice points.* | 73% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 3-5 and mixed changes in compliance for the remaining items as follows:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 55% | 97% |
| 2. | 98% | 76% |
| 6. | 48% | 94% |
| 7. | 68% | 81% |
| 8. | 48% | 73% |
| 9. | - | 89% |
| 10. | - | 74% |
| Compliance rate in last month of period | | |
| 2. | 99% | 96% |
| 7. | 73% | 89% |
| 8. | 45% | 92% |
| 9. | - | 99% |
| 10. | - | 98% |

Using the By Choice Monitoring Form: Satisfaction Check, ASH surveyed a mean sample of 23% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:

| | | Previous period | Current period |
|---|---|---|---|
| 1. | *Is the point system helpful to you?* | 89% | 93% |
| 2. | *Do staff explain how you earn an "FP", "MP", or "NP' for all your activities?* | 86% | 92% |
| 3. | *Do staff tell you if you earned an "FP", "MP", or "NP' for all your activities?* | 78% | 87% |
| 4. | *Are you satisfied with the numbers of points you can earn for each cycle or group?* | 88% | 88% |
| 5. | *Do you like what is offered in the incentive store?* | 71% | 75% |
| 6. | *Do you hold on to your point card during the day?* | 68% | 82% |
| 7. | *Do you discuss how you want your points allocated when you meet with your team during your conferences?* | 75% | 89% |

Using the Fidelity of Implementation by the By Choice Staff Form, ASH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:

| | | |
|---|---|---|
| 1. | *The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.* | 100% |
| 2. | *The incentive store includes a delivery system that ensures that all individuals have access to incentive items.* | 100% |
| 3. | *The incentive store is well stocked with appropriate* | 31% |

| | | |
|---|---|---|
| | *items from the incentive list.* | |
| 4. | *The incentive store has an inventory control system.* | 29% |
| 5. | *The incentive store has a system to track and remove outdated food items.* | 28% |
| 6. | *There is a By Choice Manual located in the incentive store.* | 100% |
| 7. | *The incentive store staff has completed incentive store training.* | 100% |
| 8. | *The individuals bring their point cards to the store to make a purchase.* | 100% |
| 9. | *There is a By Choice Calorie Activity Guide located in the incentive store.* | 100% |
| 10. | *There is an Alert list in the incentive store for staff reference.* | 100% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1, 2 and 7-10, and mixed changes in compliance for the remaining items as follows:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 92% | 31% |
| 4. | 17% | 29% |
| 5. | 17% | 52% |
| 6. | 100% | 28% |
| Compliance rate in last month of period | | |
| 3. | 100% | 100% |
| 4. | 0% | 100% |
| 5. | 0% | 100% |
| 6. | 100% | 67% |

<table>
<tr><td></td><td></td><td>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), ASH assessed fidelity of implementation based on average samples of 13% of the Level of Care Staff, 22% of the individuals, and 100% of the By Choice program staff. The table below is a summary of the data:<br><br><table><tr><td>Level of Care Staff</td><td>96%</td></tr><tr><td>Individuals</td><td>86%</td></tr><tr><td>By Choice Program Staff</td><td>77%</td></tr></table><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.2.b</td><td>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current practice.<br><br>Findings:<br>The Chief of Psychology continues to have the clinical and administrative responsibility for the Positive Behavior Supports team and the By Choice incentive program. However, for ease of operation, the Chief of Psychology has delegated the authority to the Coordinator of Psychology Specialty Services.<br><br>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue current practice.</td></tr>
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|---|---|---|
| F.2.c | Each State Hospital shall ensure that: | **Compliance:**<br>Substantial. |
| F.2.c.i | behavioral assessments include structural and functional assessments and, as necessary, functional analysis; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue to train new PBS team members, and with re-training of the enduring PBS team members to keep them updated with developments in the field.<br><br>**Findings:**<br>See Other Findings in F.2.a.<br><br>**Recommendation 2, April 2009:**<br>Use the PBS-PSSC pathway for all consultations.<br><br>**Findings:**<br>All consultations, reviews, and behavioral interventions are tracked, monitored, and reviewed by the PSSC<br><br>**Other findings:**<br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (March-August 2009):<br><br>1. *The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.* 100%<br>2. *The WRPT and the PSST determined the goals of the intervention.* 100%<br>3. *At least one specific behavior of concern was defined in clear, observable and measurable terms* 100%<br>4. *Baseline of maladaptive behavior was established in* 100% |

| | | |
|---|---|---|
| | *terms of objective measures (e.g., rate, frequency, duration, intensity and severity.)* | |
| 5. | *Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.* | 100% |
| 6. | *A functional assessment interview was completed for the structural assessment.* | 100% |
| 7. | *Direct observations of the challenging behavior were undertaken, as applicable* | 100% |
| 8. | *Additional structural assessments (e.g., ecological, sleep, medication effects, mall attendance) were completed. [This item is NA for BGs.]* | 100% |
| 9. | *A functional assessment rating scale was completed.* | 100% |
| 10. | *Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [his item is NA for BGs.]* | 100% |
| 11. | *Patterns of challenging behavior were recognized based on the structural and functional assessments.* | 100% |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for the indicators relevant to this cell (regarding structural and functional assessments).

A review of eight PBS plans (AM, AS, BM, KR, MM, TQ, WT and ZE) found that all eight had been developed and implemented based on data derived from structural and functional assessments. The structural and functional assessments of the PBS plans were comprehensive.

**Current recommendation**:
Continue to monitor this requirement.

<table>
<tr>
<td>F.2.c.ii</td>
<td>hypotheses of the maladaptive behavior are based on structural and functional assessments;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

**Findings:**
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (March-August 2009):

<table>
<tr><td>12.</td><td>Hypotheses of the maladaptive behavior are based on structural and functional assessments</td><td>100%</td></tr>
</table>

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

A review of eight PBS plans (AM, AS, BM, KR, MM, TQ, WT and ZE) found that the hypotheses in all eight plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments.

**Current recommendation**:
Continue to monitor this requirement.

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</tr>
<tr>
<td>F.2.c.iii</td>
<td>There is documentation of previous behavioral interventions and their effects;</td>
<td>

**Current findings on previous recommendations:**

**Recommendations 1 and 2, April 2009:**
- Document previous behavioral interventions.
- Document effectiveness of previous interventions.

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**Findings:**
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of behavioral interventions (PBS plans and Behavior Guidelines) developed during the review period (March-August 2009):

<table>
<tr><td>5.</td><td>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</td><td>100%</td></tr>
</table>

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

A review of the structural and functional assessments of eight PBS plans (AM, AS, BM, KR, MM, TQ, WT and ZE) found that all eight assessments documented previous behavioral interventions and their effects.

**Current recommendation**:
Continue to monitor this requirement.

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<tr>
<td>F.2.c.iv</td>
<td>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies.

**Findings:**
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (March-August 2009):

<table>
<tr><td>17.</td><td>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when</td><td>100%</td></tr>
</table>

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</table>

| | | |
|---|---|---|
| | | *the challenging behavioral occurs; and* |
| | | Comparative data indicated maintenance of compliance greater than 90% from the previous review period.<br><br>A review of eight PBS plans (AM, AS, BM, KR, MM, TQ, WT and ZE) found that all behavioral interventions were based on a positive behavioral support model without any use of aversive or punishment contingencies.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.2.c.v | behavioral interventions are consistently implemented across all settings, including school settings; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training.<br>• Ensure that all behavioral interventions are consistently implemented across all settings, including Mall, vocational and education settings.<br><br>**Findings:**<br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (March-August 2009):<br><br>22. *The PSSC ensures that the BG and PBS Plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings* — 100%<br><br>Comparative data indicated improvement in compliance from 87% in the previous review period. |

| | | |
|---|---|---|
| | | This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of eight individuals (AM, AS, BM, KR, MM, TQ, WT and ZE) found that ASH had conducted fidelity checks on all eight PBS plans and PBS-driven behavior guidelines.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.2.c.vi | triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control; | **Current findings on previous recommendations:**<br><br>**Recommendation 1 and 2, April 2009:**<br>• Continue to refine the trigger system.<br>• Ensure that staff is aware of the PBS-PSSC pathway.<br><br>**Findings:**<br>ASH continues to review all triggers and attend to them following the Risk Management Policy and Procedures (SO 262). Upon review, triggers deemed to involve learned behaviors are referred to the PSSC. The PSSC then reviews all referrals and conducts appropriate assessments and interventions.<br><br>The PSSC specifically tracks and monitors trigger data on aggression to self and others, with the PSSC Coordinator reviewing the data on a weekly basis and incorporating it into the PSSC meeting agenda list.<br><br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of individuals with aggression triggers during this review period (March-August 2009):<br><br>10. *Triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include Aggression to Self and Aggression to Others* — 100% |

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

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

| DMH Psychology Services Monitoring Form | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2009 | Mar | Apr | May | Jun | Jul | Aug | Mean |
| Aggression to others | 49 | 54 | 45 | 52 | 61 | 37 | 50 |
| %C | 65% | 59% | 67% | 65% | 97% | 93% | 74% |
| Aggression to self | 18 | 7 | 9 | 9 | 10 | 8 | 10 |
| %C | 83% | 100% | 100% | 100% | 100% | 100% | 97% |

The table above indicates that nearly 50% of the aggression to others triggers during this review period involved factors other than learned behaviors, whereas the triggers for aggression to self were primarily the result of learned behaviors.

**Other findings:**
Under the current Coordinator, the PSSC conducted a retrospective study on institutional violence and violence recidivism to better understand factors contributing to institutional violence, with the goal of preventing violence at ASH.

**Current recommendation**:
Continue to monitor this requirement.

| F.2.c.vii | positive behavior support teams and team | **Current findings on previous recommendation:** |
|---|---|---|

<table>
<tr>
<td></td>
<td>psychologists integrate their therapies with other treatment modalities, including drug therapy;</td>
<td>

**Recommendation, April 2009:**
Integrate all behavioral interventions with other treatment modalities including drug therapy.

**Findings:**
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (March-August 2009):

<table>
<tr><td>27.</td><td>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</td><td>99%</td></tr>
</table>

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

Review of psychiatry and psychology progress notes of eight individuals (AB, AE, AM, BG, BM, HA, SM and TG) found that positive behavior support teams and team psychologists integrated their therapies with other treatment modalities, including drug therapy, in all eight cases. Interview of the PBS psychologists found that they routinely discuss cases with staff from other disciplines at WRPCs and ETRC meetings.

**Current recommendation**:
Continue to monitor this requirement.

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<tr>
<td>F.2.c.<br>viii</td>
<td>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual.

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**Findings:**
Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of PBS plans developed during the review period (March-August 2009):

| | | |
|---|---|---|
| 19. | *The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections* | 90% |
| 19.a | *The present status of the WRP includes a statement that a BG or PBS plan is being implemented.* | 99% |
| 19.b | *The Objective section of the WRP states what the individual will learn to do.* | 97% |
| 19.c | *The Intervention section of the WRP will state that the staff will implement the BG or PBS plan as written.* | 77% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 19. | 58% | 90% |
| Compliance rate in last month of period | | |
| 19. | 40% | 94% |
| 19.a | 90% | 100% |
| 19.b | 95% | 100% |
| 19.c | 45% | 82% |

A review of the records of 10 individuals with behavioral interventions (PBS plans, PBS assessments and Behavior Guidelines) found that eight (AM, AS, BM, KR, MM, TQ, WT and ZE) of the WRPs in the charts had

| | | |
|---|---|---|
| | | properly discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP. Two of the WRPs (AF and MAR) were incomplete or did not update the data.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.2.c.ix | 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 | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>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.<br><br>**Findings:**<br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of all behavioral interventions developed during the review period (March-August 2009):<br><br>24. *The WRPT Psychologist discusses the individual's monthly outcome data for all behavioral interventions during the WRPC.* 100%<br><br>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.<br><br>This monitor's review of PBS plans, outcome data, and WRPs of 10 individuals (AB, AE, BG, BM, HA, KR, SM, TG, TQ and WT) found that PBS teams reviewed and revised all 10 PBS plans based on data trends, and that all ten WRPs contained documentation of the plan implementation data in the Present Status section of the individual's |

<table>
<tr><td></td><td></td><td>WRP.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.x</td><td>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>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.<br><br>Findings:<br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of behavior guidelines and PBS plans developed during the review period (March-August 2009):<br><br>
<table>
<tr><td>20.</td><td>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG and PBS plan.</td><td>100%</td></tr>
</table>
<br>Comparative data indicated maintenance of compliance greater than 90% from the previous review period.<br><br>A review of 25 PBS plans and related assessments and staff training data (AA, AB, AE, AG, AR, BB, BG, BM, CG, CV, DC, HA, JB, JC, JeB, JuB, MA, MG, MM, RC, SA, SB, SM, TB and ZE) found that the staff responsible for implementing the PBS plans were trained to competency in all 25 cases. The PSSC Coordinator has structured the PSSC to ensure that staff is competent in implementing behavioral interventions for which they are responsible, and has performance improvement measures for monitoring the implementation of such interventions</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.xi</td><td>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Same as F.2.a.<br><br>Findings:<br>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention services. When they had to work overtime, they were assigned to their usual PBS duties.<br><br>
<table>
<tr><td>15.a.i</td><td>All PBS team members are primarily responsible for the provision of behavioral interventions</td><td>17/17</td></tr>
<tr><td>15.a.ii</td><td>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</td><td>17/17</td></tr>
<tr><td>15.b</td><td>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</td><td>17/17</td></tr>
</table>
<br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
<tr><td>F.2.c.xii</td><td>the By CHOICE point allocation is updated monthly in the individual’s Wellness and Recovery Plan.</td><td>Current findings on previous recommendations:<br><br>Recommendation 1, April 2009:<br>Ensure that By Choice point allocation is updated monthly in the individual’s WRP.</td></tr>
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Findings:<br>
Using the By Choice Chart Audit Form, ASH assessed its compliance based on an average sample of 22% of the individuals at ASH each month during the review period (March-August 2009):<br><br>
<table>
<tr><td>16.</td><td>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</td><td>93%</td></tr>
</table>
<br>
Comparative data indicated maintenance of compliance greater than 90% since the previous review period.<br><br>
A review of the records of six individuals found that all six of the WRPs in the charts contained documentation of the individual's By Choice point allocation in the Present Status section (DS, EC, HWT, JLP, JM and RGP).<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
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<tr>
<td>F.2.d</td>
<td>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</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue current practice.<br><br>
Findings:<br>
ASH has a full DCAT team. Documentation review (PSSC Meeting minutes from May through August 2009) found that ASH conducted meetings on a regularly basis and that attendance of the standing members was high. The DCAT members received ongoing training in DCAT/PBS topics on a monthly basis covering topics such as Motivational Interviewing, graphing, assessments, and WRP.<br><br>
Compliance:<br>
Substantial.
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| | 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. | **Current recommendation**:<br>Continue current practice. |
| F.2.e | Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive 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. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly.<br><br>**Findings:**<br>Staff interview and review of PSSC meeting minutes (May through August 2009) found that the PSSC met regularly and attendance of the standing members of the Committee at these meetings was high.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.2.f | Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Make referrals, when appropriate, for neuropsychological assessments.<br><br>**Findings:**<br>Using the DMH Psychology Services Monitoring Form, ASH assessed its compliance based on a 100% sample of referrals received each month during the review period (March-August 2009). ASH reported that on average, 46 neuropsychological assessments were due for completion each month during the review period, and 42 were completed. The |

| | | |
|---|---|---|
| | | average time from referral to completion was 29 days, compared to 88 days in the previous review period.<br><br>Since the previous review period, Neuropsychology Services has experienced a substantive increase in the number of referrals received, the number of consultations provided, and the number of individuals evaluated and assigned to cognitive remediation groups.<br><br>**Recommendation 2, April 2009:**<br>Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall.<br><br>**Findings:**<br>Neuropsychologists at ASH provide seven hours of cognitive remediation groups per week.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.2.g | All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Psychologists at ASH continue to have the authority to write orders for the implementation of positive behavior support plans.<br><br>**Compliance:**<br>Substantial. |

| | | |
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| | | **Current recommendation**:<br>Continue current practice. |

| 3. Nursing Services | | |
|---|---|---|
| | Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services. | **Methodology:**<br><br>Interviewed:<br>1. Concha Silva, RN<br>2. Donna Hunt, RN, HSS<br>3. Marlene Espitia, RN, Assistant Director of Standards Compliance<br>4. Rosie Morrison, RN, HSS<br><br>Reviewed:<br>1. ASH's progress report and data<br>2. ASH's training rosters<br>3. ASH's MVR Training curriculum<br>4. Med Room Staff Survey<br>5. MTRs for Units 6, 13, 16, 18, 21 and 23<br>6. Nursing Policy 107, Controlled Medications (revised)<br>7. Nursing Procedure 309, Controlled Drugs (revised)<br>8. Medication Variance Reports for MAR and Narcotic blanks<br>9. Curriculum for General Assessment for Registered Nurses<br>10. Minutes of the Medication Management Enhancement Plan Performance Improvement meeting from March 2009 to August 2009<br>11. ASH Nursing Services Mentoring Program procedure<br>12. ASH's Plan of Hospital-Wide Unit Mentoring Program<br>13. Change of Shift Report worksheets and Kardexes for Unit 13<br>14. California Department of Public Health Deficiency Statements with Plans of Correction and Evidence of Compliance<br>15. Unit Medication Room Staff meeting minutes dated 4/23/09, 5/28/09, 6/25/09, 7/23/09 and 8/27/09<br>16. Medical records for the following 79 individuals: AC, AD, AGH, AH, AL, AM, AS, ASM, BEC, BFM, BJS, CB, CC, CS, DBC, DL, DLW, DWW, EF, EM, EMW, EO, ERA, ERG, ET, GLB, GM, GN, HA, HW, JCC, JCD, JG, JHA, JHH, JLD, JLR, JMD, JO, JR, JRR, JT, JWL, JZC, KC, LC, LDN, LEM, LG, LM, LVH, MAJ, MCM, MDC, MFM, MG, MK, MMC, |

| | | |
|---|---|---|
| | | MWV, OR, OY, PD, PJT, PPD, RAB, RF, RKH, RNR, RSD, SHS, SJB, SS, TAK, TE, TT, WEL, WL, WS and ZS<br><br>Observed:<br>1. Shift report on unit 13<br>2. Medication administration on unit 18<br>3. WRPC (Program III, unit 21) for 7-day review of AF<br>4. WRPC (Program IV, unit 6) for 14-day review of AJY<br>5. WRPC (Program V, unit 13A) for 14-day review of KW |
| F.3.a | Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure: | **Compliance:**<br>Partial. |
| F.3.a.i | safe administration of PRN medications and Stat medications; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (March-August 2009):<br><br>1. *Safe administration of PRN medications* 91%<br><br>Comparative data indicated improvement in compliance from 81% in the previous review period. |

Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on an 18% mean sample of Stat medications administered each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 2. | *Safe administration of Stat medications* | 79% |
| 2.a | *Stat medication was administered based on a complete physician's order* | 79% |
| 2.c | *The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual* | 78% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 40% | 79% |
| Compliance rate in last month of period | | |
| 2. | 55% | 91% |
| 2.a | 61% | 100% |
| 2.c | 74% | 82% |

To improve compliance, ASH implemented a mentoring program in May 2009 in which 30 RNs were taken out of the staffing numbers so that they could provided concentrated mentoring in the following areas:

- Assessments
- Communication skills
- Focus 6
- Provision of care
- Restraint/seclusion and PRN/Stat documentation
- RN monthly/PT weekly documentation

| | | |
|---|---|---|
| | | • WRP input<br>• Medication side effect monitoring<br><br>In addition, the CNS staff provide one-to-one training to nursing staff and Unit Mentors addressing shift change, WRPTs, and medication administration via random and unannounced unit visits. These strategies have increased compliance rates.<br><br>A review of 172 orders (150 PRN and 22 Stat orders) for 32 individuals (AM, ASM, CC, CS, DLW, EF, EM, EMW, EO, ERA, ET, GM, HA, JLD, JLR, JO, JR, JWL, LEM, MFM, MG, MK, MMC, OR, RNR, RSD, SHS, SS, WEL, WL, WS and ZS) found that 137 orders included specific individual behaviors. Although the review found a number of non-specific physician orders, there were many that were very specific to the individual. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications, and the sites of the injections were consistently documented.<br><br>**Other findings:**<br>Although the PRN/Stat IDN template has had a significant impact on nursing's compliance with documentation requirements, the review found a number of forms that were missing information such as whether the medication was a PRN or Stat and the indicators from the physician's orders. ASH needs to ensure that these forms are appropriately completed with the required information in order to not backslide on the progress that has been made in this area.<br><br>**Current recommendations**:<br>1. Increase sample size for Stat medication to at least 20%.<br>2. Continue to monitor this requirement. |
| F.3.a.ii | documentation of the circumstances requiring PRN and Stat administration of medications; | **Current findings on previous recommendation:** |

**Recommendation, April 2009:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 3. | *There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.* | 86% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 3. | 48% | 86% |
| Compliance rate in last month of period | | |
| 3. | 84% | 95% |

See F.3.a.i for the facility's plan of action to improve compliance.

A review of 150 incidents of PRN medications for 21 individuals (CC, CS, DLW, EF, EMW, EO, ERA, ET, GM, HA, JLD, JLR, JWL, LEM, MFM, MK, OR, RSD, SS, WEL and ZS) found adequate documentation in the IDNs of the circumstances requiring the PRN medication in 128 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on an 18% mean sample of Stat medications administered each month during the review period (March-August 2009):

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<tr><td>4.</td><td>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</td><td>81%</td></tr>
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<br>
Comparative data indicated improvement in compliance since the previous review period:
<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>37%</td><td>81%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>84%</td><td>87%</td></tr>
</table>
<br>
See F.3.a.i for the facility's plan of action to improve compliance.<br><br>
A review of 22 incidents of Stat medications for 11 individuals (AM, ASM, EM, JO, JR, MG, MMC, RNR, SHS, WL and WS) found adequate documentation in the IDNs of the circumstances requiring the Stat medication in 19 incidents<br><br>
Current recommendation:<br>
See F.3.a.i.
</td>
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<tr>
<td>F.3.a.iii</td>
<td>documentation of the individual's response to PRN and Stat medication.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Nursing Services Monitoring PRN Audit, ASH assessed
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its compliance based on a 20% mean sample of PRNs administered each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 5. | *There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.* | 87% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 57% | 87% |
| Compliance rate in last month of period | | |
| 5. | 78% | 95% |

See F.3.a.i for the facility's plan of action to improve compliance.

A review of 150 incidents of PRN medications for 21 individuals (CC, CS, DLW, EF, EMW, EO, ERA, ET, GM, HA, JLD, JLR, JWL, LEM, MFM, MK, OR, RSD, SS, WEL and ZS) found a timely and comprehensive assessment of the individual's response in the IDNs in 107 incidents.

Using the DMH Nursing Services Monitoring Stat Audit, ASH assessed its compliance based on a 18% mean sample of Stat medications administered each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 6. | *There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.* | 85% |

Comparative data indicated improvement in compliance since the previous

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<td>review period:<br><br>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>44%</td><td>85%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>77%</td><td>93%</td></tr>
</table>
<br>
See F.3.a.i for the facility's plan of action to improve compliance.<br><br>
A review of 22 incidents of Stat medications for 11 individuals (AM, ASM, EM, JO, JR, MG, MMC, RNR, SHS, WL and WS) found a timely and comprehensive assessment of the individual's response in the IDNs in 20 incidents.<br><br>
Current recommendation:<br>
See F.3.a.i.</td>
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<tr>
<td>F.3.b</td>
<td>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</td>
<td>Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Ensure the accuracy of the data for this requirement.<br><br>
Findings:<br>
ASH has a review system for medication variances that includes the Medication Management Enhancement Plan Performance Improvement (EPPI) Team. The Medication Management EPPI Team is an interdisciplinary clinical review team that meets weekly to review MVR data, performs intensive case analysis and in-depth reviews, and prepares analysis and interpretation of trended monthly and bi-annual data. The team consists of the Medical Director and members representing Psychiatry, Pharmacy, Central Nursing, Standards Compliance, Medical</td>
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| | | |
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| | | Staff, and Program Staff. In addition, the Quality Council reviews hospital-wide issues such as certain critical medication variances at an executive level. Also, ASH holds monthly Medication Room Staff Meetings, which are mandatory for Med Room Persons and representatives from Standards Compliance, Medical Staff and Central Nursing. Pharmacy chairs this committee and clinical case presentations are made to this group. During this review period, the Medical Director presented training regarding Diabetes in response to two serious and other less serious insulin-related MVRs.<br><br>ASH's process for MVRs includes the following:<br><br>1. MVR generated after variance discovered<br>2. Review by Program HSS – Maintains original MVR<br>3. Review by Program Unit Supervisor – All MVRs<br>4. Review by Program Director, as applicable (All actual MVRs)<br>5. Review by Standards Compliance MVR Team – All MVRs for review/data agreement and identification of serious potential Variances<br>6. Review by Pharmacy (All actual MVRs) – for ORYX benchmarking<br><br>Programs immediately contact Standards Compliance regarding any MVR suspected to be Serious (actual or potential). The information is forward to the Medical Director, Central Nursing Services, Medication Management EPPI Team Leader and Standards Compliance - Licensing as applicable. The Medication Management EPPI Team reviews for Intensive Case Analysis (for serious MVRs) or In-Depth Reviews (for serious potential MVRs).<br><br>**Recommendation 2, April 2009:**<br>Ensure that the medication nurses are familiar with policies addressing medication variances. |

| | | |
|---|---|---|
| | | **Findings:**<br>Training rosters indicated that the CNS provided training in June 2009 to medication room staff related to revisions to NP 310.1, Medication Variances.<br><br>**Recommendation 3, April 2009:**<br>Develop strategies to ensure that reporting of medication variances is not punitive.<br><br>**Findings:**<br>ASH's MVR training curriculum includes content regarding the facility's Blame-Free culture. ASH's progress report indicated that MVR data are provided as a tool to evaluate both management and employee awareness of pertinent trends in hospital performance and quality of care relative to medication variances. The data are trended and used mainly in identifying hospital performance issues. Medication Variance data is not solely relied upon to determine employee performance, but may be used in support of other findings as noted in NP 310.1, Medication Variance, which was revised on 6/24/09.<br><br>**Recommendation 4, April 2009:**<br>Identify and address barriers regarding medication administration that includes input from medication nurses.<br><br>**Findings:**<br>In April 2009, ASH conducted a Med Room Staff Survey to identify barriers related to safe medication administration. The results indicated that the staff felt that medication variances were a result of human error, distractions and being rushed as opposed to being unable to follow policy. ASH is currently initiating interventions to address some of the barriers identified from the Med Room Staff Survey. |

**Recommendation 5 and 6, April 2009:**

- Provide data addressing this requirement that includes appropriate supporting documentation.
- Continue to monitor this requirement.

**Findings:**

The facility reported the following data:

| Key Indicator Data on MVR Documentation Errors | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 3/09 | 4/09 | 5/09 | 6/09 | 7/09 | 8/09 | Mean |
| N | 120 | 101 | 157 | 106 | 137 | 133 | 126 |
| n | 120 | 101 | 157 | 106 | 137 | 133 | 126 |
| %S | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

N = Number of medication variances for missed signatures, titles and/or initials on MTR reported
n = Number followed up to prevent recurrence of signature variances

A review of the MTRs for Units 6, 13, 16, 18, 21 and 23 found 11 incidents of missing initials and six missing signatures for the Narcotic Logs. There were eight MVRs found for these missing initials and five for the missing signatures, which is the best data regarding MVRs from ASH thus far.

However, during the review period, ASH had discovered that a number (43) of narcotics had been taken from two units. The containers were found to be tampered with and a controlled drug sheet and a portion of the controlled drug count sheet were missing. Clearly, staff had failed to follow appropriate controlled drug counting procedures. In response to this issue, the Medication Management EPPI Team requested data related to all drug security errors. The Team recommended changes in the policy and practices by which controlled drugs are counted. As a result of the review and inquires, controlled drugs are to be taken out of the baggies and inspected for tampering as part of the count process.

| | | |
|---|---|---|
| | | Policy 107, Controlled Medication and Nursing Procedure 309, Controlled Drugs were revised to include this recommendation.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.c | Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>See C.2.l.<br><br>**Findings and Compliance:**<br>No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. Therefore, the facility is in substantial compliance with this component. The requirement regarding the integration of nursing interventions into the WRP is addressed in C.2.l.<br><br>**Current recommendation**:<br>See C.2.l. |
| F.3.d | All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• See C.2.l.<br>• Increase sample size to 20%.<br><br>**Findings:**<br>Sample size for this requirement remains below 20%. |

Using the DMH Nursing Staff Familiarity Monitoring Audit, ASH assessed its compliance based on an average sample of 13% of the nursing staff:

| | | |
|---|---|---|
| 8. | *Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.* | 93% |

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

A review of the admissions assessments, integrated assessments and/or WRPs of 40 individuals (AC, AD, AGH, AH, AS, BEC, BFM, BJS, CB, DBC, DWW, ERG, GLB, GN, HW, JCC, JCD, JG, JHA, JHH, JMD, JRR, JZC, KC, LC, LDN, LG, LVH, MAJ, MCM, MDC, MG, MMC, MWV, PJT, PPD, RAB, RF, SJB and TAK) found that there was significant overall improvement in most (34) of the nursing objectives and interventions, especially in alignment with information contained in the Nursing Admission/ Integrated Assessments. This progress needs to continue for ASH to achieve substantial compliance.

In the three WRPCs observed by this monitor, all team members were familiar with the individuals' interventions in the WRPs. However, in one WRPC, the team was not aware that one of the groups the individual was scheduled to attend had been canceled and he had not been assessed for another group addressing his objective.

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement and ensure a sample size of at least

| | | |
|---|---|---|
| | | 20%. |
| F.3.e | Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' 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. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Increase sample size for shift report data.<br><br>**Findings:**<br>ASH's progress report indicated that the sample size for shift report had increased from a mean of 67% to a mean of 92%. However, ASH's data indicated that the sample size was only 9%. In addition, ASH reported that reasons for low sample size included staffing issues such as:<br><br>1. Unit coverage weekly<br>2. WRPT mentoring<br>3. Group facilitation<br>4. The loss of one auditor who was returned to the units in order to open an additional unit<br><br>ASH is in the process of reassessing the auditing demands and reassigning shift change audits in an attempt to increase the sample size.<br><br>**Recommendation 2, April 2009:**<br>Ensure that the quality of the documentation regarding change in status is reflected in the auditing.<br><br>**Findings:**<br>ASH's Nurse Mentors continue to work directly with unit RNs to ensure quality in this area using the DMH-approved tool.<br><br>**Recommendation 3, April 2009:**<br>Continue implementing the new process for change of shift. |

**Findings:**
ASH continues to implement and monitor the new process for change of shift.

**Recommendation 4, April 2009:**
Continue to monitor this requirement.

**Findings:**
Using the DMH Medical Transfer Audit, ASH assessed its compliance based on a 84% sample of individuals transferred to community hospitals each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* | 99% |
| 7. | *The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 78% | 99% |
| 7. | 94% | 100% |

A review of the records of 11 individuals who were transferred to a community hospital/emergency room (AL, DL, EF, JG, JT, LM, OY, PD, RKH, TE and TT) found that the documentation in nine cases included appropriate and comprehensive assessments upon the onset of change of

status and when the individual returned from the ER/hospital. Documentation in this area has improved overall. However, in one case (RKH), there was no documentation at the time the individual was transferred back to the facility from the hospital. In two cases, lung sounds were not documented for acute respiratory issues. In addition, a number of the RN Change of Status forms were noted to not contain all of the information that the form required, especially in the section regarding "Changes Needed in Focus 6 of WRP."

Using the DMH Nursing Services Audit, ASH assessed its compliance based on a 9% sample of Change of Shift Reports observed during in the review months (March-August 2009):

| | | |
|---|---|---|
| 10. | *Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.* | 97% |

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

Observation of shift report on unit 13 found that ASH has made progress in the clinical content of shift report and has included a number of the individuals' Foci during the report. ASH needs to continue mentoring and monitoring this process and should be able to achieve substantial compliance by the next review.

**Compliance:**
Partial.

**Current recommendations**:
1. Increase sample size regarding shift report.
2. Continue mentoring the change of shift process.
3. Continue to monitor this requirement.

| | | |
|---|---|---|
| F.3.f | Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that: | **Compliance:**<br>Partial; improved compared to the last review. |
| F.3.f.i | nursing staff are knowledgeable regarding each individual's prescribed medications; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified:<br><br>11. *Nursing staff are knowledgeable regarding each individual's prescribed medications.* 95%<br><br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>In 8 a.m. medication administration on Unit 18 observed by this monitor, the medication nurse had a very good rapport with the individuals and provided some medication education. In addition, she was able to answer most of the questions asked by the individuals regarding their medications and side effects. Appropriate medication procedures were followed.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.f.ii | education is provided to individuals during medication administration; | **Current findings on previous recommendation:** |

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Recommendation, April 2009:<br>
Continue to monitor this requirement.<br><br>
Findings:<br>
Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>12.</td><td>Education is provided to individuals during medication administration.</td><td>91%</td></tr>
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<br>
Comparative data indicated improvement in compliance from 82% in the previous review period. See F.3.f.i for review findings.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
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<tr>
<td>F.3.f.iii</td>
<td>nursing staff are following the appropriate medication administration protocol; and</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Analyze all data regarding nursing medication practices to determine the etiology of the discrepancies between data.<br><br>
Findings:<br>
ASH's NOC shift performs an audit of all MARs each night. The HSS checks the NOC audit on the following day and spot-checks the MARS to ensure that errors are identified. When errors are found, the HSS responds to them according to policy. In addition, Standards Compliance audits 100% of the MVR data monthly. During the review period, ASH reported a 97% accuracy rate. Also, Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly, and initiate a QI process for any incipient trend. The NOC shift also compares PRN/Stat data to the data
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<td>contained in the Quick Hits database.<br><br>Recommendation 2, April 2009:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>13.</td><td>Nursing Staff are following the appropriate medication administration protocol.</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period. See F.3.f.i for review findings.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td>
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<tr>
<td>F.3.f.iv</td>
<td>medication administration is documented in accordance with the appropriate medication administration protocol.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>See F.3.b and F.3.f.iii.<br><br>Findings:<br>Using the DMH Medication Administration Monitoring Audit, ASH assessed its compliance based on an average sample of 73% of level of care nursing staff who are licensed and medication-certified:<br><br>
<table>
<tr><td>14.</td><td>Medication administration is documented in accordance with the appropriate medication administration protocol.</td><td>97%</td></tr>
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| | | |
|---|---|---|
| | | Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>Although ASH was able to produce the MVRs for all but four blanks found on the MARs and Narcotic Logs, review of ASH's data regarding medication variances and the incident regarding the missing narcotics (see F.3.b) indicate that medication administration is not being consistently documented in accordance with the appropriate medication administration protocols. ASH has put a significant amount of effort into reviewing and analyzing the medication administration system. In addition, ASH has indicated that it is aware that the current Medication Administration data was not consistently capturing accurate data in comparison to the MVR system. At the time of this review, ASH was in the process of critically reviewing the medication system to assist in determining the etiology of the discrepancies between data. By the next review, ASH should be well into the process of reviewing and analyzing the outcomes of interventions addressing medication administration.<br><br>**Current recommendation**:<br>1. Continue to monitor this requirement.<br>2. Ensure full implementation of recent corrective actions to address variances in the medication administration system. |
| F.3.g | Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons. | **Current findings on previous recommendation:**<br><br>**Recommendation 3, April 2009:**<br>Continue to monitor this requirement in the event this issue arises.<br><br>**Findings:**<br>There were no bed-bound individuals during this review period.<br><br>**Compliance:**<br>Not applicable. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue to monitor this requirement in the event this issue arises. |
| F.3.h | Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding: | **Compliance:**<br>Substantial. |
| F.3.h.i | mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>ASH's New Employee Medication Certification training rosters indicated that 76 out of 76 nursing staff attended and achieved competency (100%). New Employee Psychiatric Nursing Training rosters indicated that 44 out of 52 nursing staff attended and passed the training (85%). Also, s one new RN was hired in August and completed and passed the training in September.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.h.ii | the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Training rosters for New Employee Therapeutic Strategies and Interventions Training (TSI) indicated that 91 out of 93 nursing staff |

| | | |
|---|---|---|
| | | attended and passed the training (98%). In addition, training rosters indicated that all 89 new employees attended and passed the New Employee TSI in Recovery Training (100%).<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.3.h.iii | positive behavior support principles. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Training rosters indicated that 88 out of 89 new employees attended and passed the New Employee PBS Training (99%).<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| F.3.i | Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Training rosters indicted that for existing employees, 60 out of 869 current employees were delinquent for the Medication Re-Certification training; 93% are currently in compliance. See F3.h.i. for New Employee medication certification training data<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue to monitor this requirement. |

| 4. Rehabilitation Therapy Services | | |
|---|---|---|
| | Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Kathy Runge, Occupational Therapist<br>2. Ladonna Decou, Chief of Rehabilitation<br>3. Rachelle Rianda, Acting Senior Rehabilitation Therapist<br><br>Reviewed:<br>1. F.4 audit data for March-August 2009<br>2. ASH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review<br>3. Records for the following 15 individuals participating in observed PSR Mall groups: ADS, DEM, DH, DLT, JLS, JRL, JSN, MG, MJG, PWM, RC, RET, SJC, VA and YG<br>4. List of individuals who received direct physical therapy services from March-August 2009<br>5. List of individuals who received direct speech therapy services from March-August 2009<br>6. List of individuals who received direct occupational therapy services from March-August 2009<br>7. Records for the following 11 individuals who received direct physical, speech and occupational therapy services between March-August 2009: AT, CV, DH, DS, FFM, JJ, PSJ, SDG, TAK, TG and VP<br><br>Observed:<br>1. Painting Workshop PSR Mall group<br>2. Tai Chi PSR Mall group<br>3. Competency Through Activities PSR Mall group<br>4. Interaction Through Recreation PSR Mall group<br>5. The Sports Experience PSR Mall group<br>6. Social Skills PSR Mall group<br>7. Physical Wellness Through Basketball PSR Mall group |

| | | |
|---|---|---|
| F.4.a | Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum: | **Compliance:**<br>Please see sub-cells for compliance findings. |
| F.4.a.i | the provision of direct services by rehabilitation therapy services staff; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Provide quality direct services by occupational, physical, and speech therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services is documented in the present status section of the WRP.<br><br>**Findings:**<br>The table below presents the number of scheduled vs. actual hours/ sessions of direct services provided by OT, PT and SLP during the week of August 17, 2009:<br><br>[table below]<br><br>The facility reported that the reasons for the discrepancies between scheduled and provided hours included individual illness, scheduling conflicts, lack of escort available, and individual refusals.<br><br>**Other findings:**<br>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 23% of individuals receiving occupational, speech, |

| | Scheduled | Provided |
|---|---|---|
| PT | 24 | 21 |
| OT | 21 | 15 |
| SLP | 46 | 32 |

and/or physical therapy direct treatment during the review period of March-August 2009:

| | | |
|---|---|---|
| 1. | *The provision of direct services by rehabilitation therapy services staff* | 81% |
| 1.a | *There is an appropriate Focus of Hospitalization (typically Focus 6).* | 94% |
| 1.b | *The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.* | 71% |
| 1.c | *The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.* | 74% |
| 1.d | *There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.* | 84% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 17% | 81% |
| Compliance rate in last month of period | | |
| 1. | 36% | 100% |
| 1.a | 79% | 100% |
| 1.b | 25% | 100% |
| 1.c | 42% | 100% |
| 1.d | 46% | 100% |

| | | |
|---|---|---|
| | | The facility reported that data has shown an upward trend since May 2009, when the POST services staff were mentored and provided WaRMSS access to enter treatment information into the WRP.<br><br>A review of the records of ten individuals receiving direct occupational, physical, and/or speech therapy treatment to assess compliance with F.4.a.i criteria found seven records in substantial compliance (CV, DH, DS, FFM, JJ, TG and VP) and three records in partial compliance (PSJ, SDG and TAK).<br><br>**Other findings:**<br>POST team therapists have developed course outlines and curricula for three different PSR Mall groups that focus on physical rehabilitation skills and supports. These classes include Sports Stacking, Home Exercise Program, and Wheelchair Skills. These groups are in the process of being implemented and should be added to the Mall schedule as they are made available.<br><br>There continues to be difficulty ensuring that recommendations made by speech therapists regarding communication strategies and supports are trained and implemented.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Continue current efforts to achieve compliance.<br>2. Develop and implement a process by which recommendations made by OT, PT, and/or SLP are implemented by direct care staff. |
| F.4.a.ii | the oversight by rehabilitation therapists of individualized physical therapy programs | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | implemented by nursing staff. | **Recommendation, April 2009:**<br>Ensure that the oversight by Rehabilitation Therapists of individualized occupational or physical therapy programs implemented by nursing staff occurs as needed, and that results are documented in the present status section of the WRP.<br><br>**Findings:**<br>The facility reported that no individualized OT or PT programs were implemented by nursing staff as there was no indication of clinical need for this service during this review period.<br><br>**Compliance:**<br>Unable to determine at this time.<br><br>**Current recommendation**:<br>Continue current practice. |
| 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. | **Current findings on previous recommendation:**<br><br>**Recommendation 1, April 2009:**<br>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.<br><br>**Findings:**<br>The facility reported that 17 out of 17 nurses identified during the review period as requiring training related to the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue current practice. |
| F.4.c | Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.<br><br>**Findings:**<br>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 21% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period of March-August 2009:<br><br>4. *Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.* 94%<br><br>Comparative data indicated improvement in compliance from 46% in the previous review period.<br><br>A review of the records of 15 individuals participating in Rehabilitation Therapist-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 12 records in substantial compliance (ADS, DEM, DH, DLT, JLS, MG, MJG, PWM, RC, RET, SJC and VA), two records in partial compliance (JSN and YG) and one record not in compliance (JRL).<br><br>It was noted during the review that the number of RT PSR Mall groups utilizing specific RT modalities within a focus other than focus 10 seems to have decreased. It is essential that individuals are provided with |

groups that employ activities that are motivating and congruent with assessed preferences as well as needs in order to ensure that optimal attendance and opportunities for learning occur.

Two individuals met the criteria for 24-hour plans during the review period. One individual was discharged in May due to a resolution of a swallowing issue, and the other individual's plan was implemented in August and did not yet require reassessment.

The table below presents the average number of scheduled and actual hours of PSR Mall services provided by RT and Vocational Rehab during the month of September 2009:

| | Scheduled | Provided |
|---|---|---|
| RT | 311 | 235 |
| Voc Rehab | 48 | 48 |

The table shows a discrepancy between the scheduled and provided hours of RT services. ASH reported that it was not able to provide all scheduled groups because of furloughs. However, the individuals scheduled for groups were provided the services by redistributing them across similar groups during the same time slots.

**Recommendation 2, April 2009:**
Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions.

**Findings:**
The facility reported that 29 RTs were identified as requiring training on writing quality foci, objectives and interventions and all 29 were trained on 7/9/09.

| | | |
|---|---|---|
| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.4.d | Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment. | **Current findings on previous recommendation:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.<br>• Develop and implement a system to ensure that individuals with adaptive equipment issued by RT prior to the review period have access to equipment that meets assessed needs and promotes independence.<br><br>**Findings:**<br>Using the DMH F.4 Monitoring Tool, ASH assessed its compliance based on an average sample of 67% of individuals added to the adaptive equipment database each month during the review period March-August 2009: |

| | | |
|---|---|---|
| e. | *The individual was assessed for the appropriateness of adaptive equipment by an RT professional* | 100% |
| f. | *The individual was provided with the equipment as per the doctor's order* | 100% |
| g. | *The individual's level of functioning related to independence versus supports needed was assessed.* | 100% |
| h. | *Training for the individual on the use of adaptive equipment was provided.* | 100% |
| i. | *Reassessment of adaptive equipment, if clinically* | N/A |

| | | |
|---|---|---|
| | | *indicated* |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period (items h and i were not applicable in the previous period).

**Other findings:**
Additional training for individuals with wheelchairs is provided in individualized and group treatment, and is documented in the monthly progress notes.

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement.

| 5. Nutrition Services | | |
|---|---|---|
| | Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Dawn Hartman, Assistant Director of Dietetics<br>2. Erin Dengate, Assistant Director of Dietetics<br><br>Reviewed:<br>1. Lists of individuals with Nutrition Care Assessments due from March-August 2009 for each assessment type<br>2. Records for the following 42 individuals with type a-j.ii assessments from March-August 2009: AF, BEC, BJS, BLB, BTR, CDB, CEF, DJD, DPP, DVW, DWB, EKW, EWS, GEC, GHW, HJB, JAD, JJK, JJS, JM, JMC, JR, JRC, JRH, JWL, JWO, KWJ, LDP, LH, MG, MLN, MM, MM-2, OR, RJK, RPO, RW, SFV, SMP, TE, WL and WPB<br>3. Meal Accuracy Report audit data from March-August 2009<br>4. Nutrition Care Monitoring Tool audit data from March-August 2009 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)<br>5. Heart Health PSR Mall group lesson plan<br>6. Records for the following three individuals participating in the Heart Health PSR Mall group: GEC, IC and ROL<br><br>Observed:<br>Heart Health PSR Mall group |
| F.5.a | Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice. |

| | | |
|---|---|---|
| | 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. | **Findings:**<br>Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance based on an average sample of 34% of Nutrition Assessments (all types) due each month from March-August 2009 (total of 529 out of 1574):<br><br>7. *Nutrition education is documented* 97%<br>8 *Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified* 99%<br><br>Comparative data indicated improvement in compliance from 89% in the previous review period.<br><br>A review of the records of 42 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.<br><br>**Other findings:**<br>According to review of Meal Accuracy Report data, 96% of trays (regular and modified diets) audited from March-August 2009 (total of 1365 out of 6154, for a 22% sample) were 100% accurate. Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

<table>
<tr>
<td>F.5.b</td>
<td>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</td>
<td>

**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Continue current efforts to achieve compliance.

**Findings:**
Using the DMH Nutrition Care Monitoring Tool, ASH assessed its compliance with WRP integration based on an average sample of 34% of Nutrition Assessments (all types) due each month from March-August 2009 (529 out of 1574):

<table>
<tr><td>19.</td><td>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</td><td>95%</td></tr>
<tr><td>20.</td><td>The WRP has at least one objective and interventions linked to the Focus that pertains to the nutrition recommendation as clinically indicated</td><td>91%</td></tr>
</table>

Comparative data indicated improvement in compliance from 86% and 34% respectively in the previous review period.

A review of the records of 10 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found nine records in substantial compliance (BLB, DPP, GEC, JAD, JJS, JM, JWO, LH and SFV) and one record in partial compliance (BEC).

**Other findings:**
A review of records for three individuals participating in the Heart Health PSR Mall group to assess for compliance with provision of timely and adequate Nutrition services found two records in substantial compliance (IC and ROL) and one record in partial compliance (GEC).

Observation of the Heart Health PSR Mall group found that the
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| | | |
|---|---|---|
| | | appropriate lesson plan was in use and that the group provided activities that were in line with the individuals' assessed needs.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.5.c | Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. This procedure should be revised to align with system changes and standards of practice as they occur.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.5.d | Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice. |

| | | |
|---|---|---|
| | | **Findings:**<br>One new Dietitian was hired during the review period and was trained to competency on basic issues related to aspiration and dysphagia.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.5.e | Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| 6. Pharmacy Services | | |
|---|---|---|
| | Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require: | **Methodology:**<br><br>Interviewed:<br>Ronald O'Brien, PharmD, Acting Pharmacy Services Manager<br><br>Reviewed:<br>1. ASH self-assessment monitoring data<br>2. Outline of ASH Pharmacy Training Orientation for New Physicians and Surgeons and Psychiatrists<br>3. Pharmacists' recommendations regarding new psychotropic medication orders and physicians' responses to these recommendations during this reporting period |
| F.6.a | Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Continue current practice.<br>• Provide monitoring data by specific type of recommendations and comparisons with previous review.<br><br>**Findings:**<br>ASH presented the following data regarding the recommendations made during the current review period: |

| | | Previous period | Current period |
|---|---|---|---|
| 1. | Drug-drug interactions | 59 | 19 |
| 2. | Side effects | 20 | 30 |
| 3. | Need for laboratory testing | 67 | 43 |
| 4. | Dose adjustment | 145 | 82 |
| 5. | Indications | 8 | 17 |
| 6. | Contraindications | 0 | 4 |

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<tr><td>7.</td><td>Need for continued treatment</td><td>12</td><td>17</td></tr>
<tr><td>8.</td><td>Others</td><td>31</td><td>73</td></tr>
<tr><td colspan="2">Total number of recommendations</td><td>342</td><td>285</td></tr>
</table>
<br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
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<tr>
<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendations 1 and 2, April 2009:<br>
• Continue current practice.<br>
• Provide monitoring data by specific category of recommendations followed/not followed and comparisons with previous review<br><br>
Findings:<br>
ASH presented the following data:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td>Recommendations followed</td><td>342</td><td>285</td></tr>
<tr><td>Recommendations not followed, but rationale documented</td><td>0</td><td>0</td></tr>
<tr><td>Recommendations not followed and rationale/response not documented</td><td>0</td><td>0</td></tr>
</table>
<br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
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| 7. General Medical Services | | |
|---|---|---|
| | | **Methodology:**<br><br>Interviewed:<br>1. Ana Onglao, MD, Physician and Surgeon<br>2. Art Onglao, MD, Physician and Surgeon<br>3. Douglas Shelton, MD, Chief Physician and Surgeon<br>4. Emily Luk, MD, Physician and Surgeon<br>5. Francisco Castrejon, MD, Physician and Surgeon<br>6. Hussein Akhavan, M.D, Physician and Surgeon<br>7. John Coyle, MD, Physician and Surgeon<br>8. Phil Wichmann, MD, Physician and Surgeon<br>9. Robert Taylor, MD, Physician and Surgeon<br>10. Rosemary Morrison, RN, Acting Assistant Nurse Administrator<br>11. Thomas Cahill, MD, Physician and Surgeon<br>12. Willard Towle, MD, Physician and Surgeon<br><br>Reviewed:<br>1. The charts of the following 11 individuals: AL, DL, EF, JG, JT, LM, OY, PPD, RH, TE and TT<br>2. List of all individuals admitted to external hospitals during the review period<br>3. ASH Integration of Medical Conditions into the WRP Audit summary data (March-August 2009)<br>4. ASH Medical Transfer Audit summary data (March-August 2009)<br>5. ASH Diabetes Mellitus Audit summary data (March-August 2009)<br>6. ASH Hypertension Audit summary data (March-August 2009)<br>7. ASH Dyslipidemia Audit summary data (March-August 2009)<br>8. ASH Asthma/COPD Audit summary data (March-August 2009)<br>9. ASH Physician and Surgeon Quality Performance Profile<br>10. ASH Department of Medicine Performance Improvement/Peer Review Monitoring Tool, October 15, 2009<br>11. ASH Preventive Healthcare Audit, October 15, 2009 |

| | | |
|---|---|---|
| | | 12. ASH Secondary Prevention for Individuals with Coronary and Other Atherosclerotic Vascular Disease Auditing Form, October 14, 2009<br>13. DMH Physician Order Form (Transfer to Outside Facility) |
| F.7.a | Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care. | **Current findings on previous recommendations:**<br><br>**Recommendations 1, 2 and 3, April 2009:**<br>• Implement corrective actions to address this monitor's findings of deficiencies in this report.<br>• Ensure full and proper implementation of AD 531 regarding Provision of Medical Care to Individuals.<br>• Ensure full and proper implementation of ADs 540 through 548 regarding joint nursing and medical protocols.<br><br>**Findings:**<br>The facility reported the following corrective actions during the review period:<br><br>1. Nursing staff and physicians were retrained (March, April and May 2009) on AD 531, Provision of Medical Care to Individuals; the use of the Nursing Assessment for Change of Condition form; and requirements for physician documentation.<br>2. Each Physician and Surgeon received feedback (April 2009) on his/her compliance with the four medical conditions guidelines (Asthma/COPD, Diabetes, Hypertension and Dyslipidemia) and the Medical Progress Notes and Medical Transfers Audits.<br>3. The Chief Physician and Surgeon implemented a monthly Medical Journal Club in July 2009. The first topic focused on the assessment and treatment of delirium and altered levels of consciousness.<br><br>**Other findings:**<br>This monitor reviewed the charts of 11 individuals who were transferred to an outside medical facility during this reporting period. The following |

table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):

| Individual | Date/time of MD evaluation | Reason for transfer |
|---|---|---|
| 1. | 3/7/09 | Abdominal pain |
| 2. | 3/13/09 | Seizure, possibly recurrent |
| 3. | 5/16/09 | Seizure, recurrent |
| 4. | 5/19/09 | Cellulitis, right leg |
| 5. | 5/24/09 | R/O Pneumonia |
| 6. | 7/3/09 | Hypoglycemia |
| 7. | 7/23/09 | Congestive Heart Failure |
| 8. | 8/7/09 | Chest Pain (R/O Myocardial Infarction) |
| 9. | 8/15/09 | Seizure, possibly new onset |
| 10. | 8/21/09 | R/O Pneumonia |
| 11. | 8/26/09 | Shoulder/Arm Pain (R/O Myocardial Infarction). |

The review found that the facility has made significant progress in addressing the previous findings of deficiencies in the provision of general medical care. However, this monitor found process deficiencies related to seizure management. The following are examples:

1. One individual expired in the context of recurrent seizure activity. The mortality review included an independent external review. The facility addressed the findings and recommendations of this review. However, the final mortality review did not adequately address some important clinical contributing factors regarding the nursing and medical management of this individual.
2. One individual suffered a new onset seizure episode that appeared to be triggered by psychiatric treatment. However, there was no

| | | |
|---|---|---|
| | | documentation of a review by the psychiatrist of possible contributing factors or a plan to address these factors.<br>3. One individual was diagnosed with Mild Mental Retardation and experienced recurrent episodes of motor movements and changes in level of consciousness. He was started on a regimen of phenytoin for management of a possible seizure disorder. However, there was no documented assessment of the appropriateness and potential risks of this treatment.<br><br>**Compliance:**<br>Partial; improved compared to last review.<br><br>**Current recommendations**:<br>1. Implement corrective actions to address this monitor's findings of deficiencies related to seizure management, including findings in section C.2.c.<br>2. Provide summary outline of any changes in policies and procedures regarding medical care to individuals during the review period. |
| F.7.b | Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that: | Please see sub-cells for compliance findings. |
| F.7.b.i | require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Finalize the DMH Initial Medical Assessment standardized monitoring tool and present the data in D.1.c.i.<br><br>**Findings:**<br>ASH reported that the DMH Initial Medical Assessment monitoring tool was finalized and implemented during the April 2009 audit. |

**Recommendations 2 and 3, April 2009:**

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

**Findings:**

Using the DMH Medical Surgical Progress Notes Auditing Form, ASH assessed its compliance based on an average sample of 11% of all individuals with at least one diagnosis on Axis III during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *There is a quarterly note that documents reassessment of the individual medical status.* | 89% |
| 2. | *Significant conditions for which the individual is at risk for complications are identified.* | 99% |
| 3. | *If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.* | 100% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 63% | 89% |
| 2. | 78% | 99% |
| 3. | 77% | 100% |

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>1.</td><td>100%</td><td>98%</td></tr>
</table>
<br>
Recommendation 4, April 2009:<br>
Provide a summary outline of improvements in practice made as a result of the facility's review of internal monitoring data.<br><br>
Findings:<br>
The facility's corrective actions are summarized in F.7.a.<br><br>
Compliance:<br>
Substantial.<br><br>
Current recommendation:<br>
Continue to monitor this requirement
</td>
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<tr>
<td>F.7.b.ii</td>
<td>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</td>
<td>
Current findings on previous recommendations:<br><br>
Recommendation 1, April 2009:<br>
Finalize the monitoring tools regarding the medical emergency response system and drills for use across state facilities.<br><br>
Findings:<br>
The facility indicated that the monitoring tools for the medical emergency response system and drills (MH-C 9129, DMH Medical Emergency Response Evaluation; MH-C 9128, DMH Medical Emergency Flow Sheet and MH-C 9131, DMH Medical Emergency Response Improvement Plan), which were finalized in June 2009, were implemented at ASH in July2009. ASH indicated that it implemented AD 352, Medical Emergency Response System on August 10, 2009. The facility reported
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that it monitored quarterly drills and emergency events utilizing these tools or drafts throughout the review period.

**Recommendations 2 and 3, April 2009:**

- Monitor this requirement using the DMH Medical Transfer Auditing Form, the DMH Integration of Medical Conditions into the WRP Auditing Form and the facility's audit regarding timeliness of consultations off-site, based on at least 20% samples.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

**Findings:**

Using the DMH Medical Transfer Auditing Form, ASH assessed its compliance based on an average sample of 84% of medical transfers during the review period (March – August 2009):

| | | |
|---|---|---|
| 1. | *There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* | 99% |
| 2. | *There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.* | 99% |
| 3. | *Sufficient information is provided to the accepting facility in order to ensure continuity of care.* | 100% |
| 4. | *Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.* | 100% |
| 5. | *Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the* | 100% |

| | | |
|---|---|---|
| | *acute medical facility.* | |
| 6. | *Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.* | 100% |
| 7. | *The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.* | 100% |

Comparative data showed improvement in or maintenance of compliance since the previous review as follows:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 78% | 99% |
| 2. | 73% | 99% |
| 3. | 100% | 100% |
| 4. | 100% | 100% |
| 5. | 100% | 100% |
| 6. | 100% | 100% |
| 7. | 100% | 100% |

ASH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 18% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (March-August 2009). The following table summarizes the data:

| | | |
|---|---|---|
| 1. | *All medical conditions listed in Axis III are included on the Medical Conditions form* | 89% |
| 2. | *The WRP includes a focus statement, objective and* | 92% |

| | | |
|---|---|---|
| | *intervention for each medical condition listed on the Medical Conditions form* | |
| 3. | *There is an appropriate focus statement for each medical condition or diagnosis* | 77% |
| 4. | *There is an appropriate objective for each medical condition or diagnosis* | 88% |
| 5. | *There are appropriate intervention(s) for each objective* | 78% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 55% | 89% |
| 2. | 63% | 92% |
| 3. | 32% | 77% |
| 4. | 26% | 88% |
| 5. | 2% | 78% |
| Compliance rate in last month of period | | |
| 1. | 64% | 100% |
| 3. | 46% | 84% |
| 4. | 38% | 99% |
| 5. | 4% | 96% |

Using the same tool, the facility reviewed an 86% sample of individuals who have refused medical treatment or laboratory tests. The following summarizes the data:

| | | |
|---|---|---|
| 6. | *Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to* | 34% |

| | | |
|---|---|---|
| | *overcome individual's refusals of medical procedures* | |
| 6.a | *Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP, and* | 28% |
| 6.b | *When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.* | 44% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6. | 4% | 34% |
| Compliance rate in last month of period | | |
| 6. | 14% | 73% |
| 6.a | 17% | 38% |
| 6.b | 0% | 93% |

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

**Findings:**
The following summarizes ASH's corrective actions related to refusal of medical procedures during the review period:

1. The WRP Master Trainer facilitated the training "Present Status: Intervention and Response Section: Refusal of Medical Appointments, Tests, Labs and Vaccinations" with the WRPTs and mentors in March 2009.

| | | |
|---|---|---|
| | | 2. ASH developed templates for documentation of all refusal types in the WRP (May 2009).<br>3. General Medical Services initiated entering episodes of refusal (including initial refusals) into the Task Tracker as a prompt for the WRPTs (June 21, 2009).<br><br>**Compliance:**<br>Partial; improved compared to the last review.<br><br>**Current recommendation**:<br>Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). |
| F.7.b.iii | define the duties and responsibilities of primary care (non-psychiatric) physicians; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>ASH reported that the duties and responsibilities of primary care physicians continue to be defined in the General Medical Services Policies and Procedures and are included in each Physician and Surgeon's Duty Statement.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.7.b.iv | ensure a system of after-hours coverage by primary care physicians with formal psychiatric | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | training (i.e., privileging and proctorship) and psychiatric backup support after hours; and | **Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>ASH indicated that a Primary Care Physician and a Psychiatrist continue to provide after-hours coverage.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| F.7.b.v | endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility. | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Monitor this requirement based on a 100% sample.<br>• Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).<br><br>**Findings:**<br>The facility presented data based on a 100% sample of individuals returning from outside medical treatment during two months in the review period (March and June 2009). The facility tracked whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 98%, compared to 89% in the previous review period.<br><br>**Other findings:**<br>This monitor's chart reviews (see F.7.a) found significant improvement in the availability of discharge summaries from outside hospitals compared to the previous review period. |

<table>
<tr><td></td><td></td><td>Compliance:<br>Substantial.<br><br>Current recommendation:<br>Continue to monitor this requirement</td></tr>
<tr><td>F.7.c</td><td>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.</td><td>Current findings on previous recommendations:<br><br>Recommendations 1 and 2, April 2009:<br>• Monitor specific medical conditions including Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD using the standardized tools based on at least 20% samples.<br>• Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).<br><br>Findings:<br>ASH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 15% (diabetes mellitus), 18% (hypertension), 17% (dyslipidemia) and 15% (COPD/asthma) of individuals diagnosed with these disorders during the review months (March-August 2009). The following tables summarize the facility's data:<br><br><u>Diabetes Mellitus</u>
<table>
<tr><td>1.</td><td>The individual has been evaluated and supporting documentation is completed at least quarterly.</td><td>89%</td></tr>
<tr><td>2.</td><td>HgbA1C was ordered quarterly.</td><td>98%</td></tr>
<tr><td>3.</td><td>The HgbA1C is equal to or less than 7%.</td><td>95%</td></tr>
<tr><td>4.</td><td>Blood sugar is monitored regularly.</td><td>77%</td></tr>
<tr><td>5.</td><td>Urinary micro albumin is monitored annually.</td><td>76%</td></tr>
</table></td></tr>
</table>

| | | |
|---|---|---|
| 6. | *If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.* | 100% |
| 7. | *The lipid profile is monitored on admission or time of diagnosis and at least annually.* | 92% |
| 8. | *LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.* | 72% |
| 9. | *Blood pressure is monitored weekly.* | 96% |
| 10. | *If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.* | 81% |
| 11. | *An eye exam by an ophthalmologist/optometrist was completed at least annually.* | 93% |
| 12. | *Podiatry care was provided by a podiatrist at least annually.* | 92% |
| 13. | *A dietary consultation was considered and the recommendation followed, as applicable.* | 88% |
| 14. | *Diabetes is addressed in Focus 6 of the WRP.* | 98% |
| 15. | *Focus 6 for Diabetes has appropriate objectives and interventions for this condition.* | 95% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 3, 6, 9, 14 and 15, and general improvement in compliance since the previous review period for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 73% | 89% |
| 2. | 84% | 98% |
| 4. | 87% | 77% |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 65% | 76% |
| 7. | 58% | 92% |
| 8. | 84% | 72% |
| 10. | 49% | 81% |
| 11. | 82% | 93% |
| 12. | 89% | 92% |
| 13. | 89% | 88% |
| Compliance rate in last month of period | | |
| 1. | 70% | 100% |
| 4. | 96% | 50% |
| 5. | 74% | 100% |
| 8. | 82% | 76% |
| 10. | 57% | 87% |
| 13. | 87% | 100% |

Hypertension

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 99% |
| 2. | *Blood pressure is monitored weekly.* | 99% |
| 3. | *Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.* | 98% |
| 4. | *If the individual is 40 or older, aspirin has been ordered unless contraindicated.* | 89% |
| 5. | *Hypertension is addressed in Focus 6 of the WRP.* | 98% |
| 6. | *Focus 6 for Hypertension has appropriate objectives and interventions.* | 98% |

| | | |
|---|---|---|
| 7. | *A dietary consult was considered and the recommendation was followed, as applicable.* | 94% |
| 8. | *The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.* | 90% |
| 9. | *An exercise program has been initiated.* | 80% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 1-3 and 5-7, and improvement in compliance since the previous review period for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 81% | 89% |
| 8. | 25% | 90% |
| 9. | 18% | 80% |
| Compliance rate in last month of period | | |
| 4. | 95% | 96% |
| 9. | 30% | 94% |

Dyslipidemia

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 97% |
| 2. | *A lipid panel was ordered at least quarterly.* | 99% |
| 3. | *The HDL level is >40(M) or >50(F) or a plan of care is in place.* | 90% |
| 4. | *The LDL level is ≤ 130 or a plan of care is in place.* | 93% |
| 5. | *The Triglyceride level is ≤ 200 of a plan of care is in place.* | 92% |

| | | |
|---|---|---|
| 6. | *Dyslipidemia is addressed in focus 6 of the WRP.* | 96% |
| 7. | *Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.* | 90% |
| 8. | *A dietary consultation was considered and the recommendation followed, as applicable.* | 97% |
| 9. | *BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.* | 50% |
| 10. | *An exercise program has been initiated.* | 81% |
| 11. | *If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.* | 97% |

Comparative data indicated maintenance of compliance greater than 90% since the previous review period for items 2, 4, 8 and 11, and improvement in compliance since the previous review period for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 85% | 97% |
| 3. | 46% | 90% |
| 5. | 67% | 92% |
| 6. | 82% | 96% |
| 7. | 42% | 90% |
| 9. | 0% | 50% |
| 10. | 30% | 81% |
| Compliance rate in last month of period | | |
| 9. | 0% | 46% |
| 10. | 57% | 92% |

Asthma/COPD

| | | |
|---|---|---|
| 1. | *The individual has been evaluated and supporting documentation completed at least quarterly.* | 98% |
| 2. | *For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.* | 100% |
| 3. | *If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.* | 100% |
| 4. | *If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.* | N/A |
| 5. | *Asthma or COPD is addressed in focus 6 of the WRP.* | 97% |
| 6. | *Focus 6 for Asthma/COPD has appropriate objectives and interventions.* | 96% |
| 7. | *The individual has been assessed for a flu vaccination.* | 81% |
| 8. | *If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.* | 80% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 83% | 98% |
| 2. | 100% | 100% |
| 3. | 64% | 100% |
| 4. | 65% | N/A |
| 5. | 84% | 97% |
| 6. | 84% | 96% |

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 89% | 81% |
| 8. | 73% | 80% |
| Compliance rate in last month of period | | |
| 7. | 86% | 100% |
| 8. | 89% | 100% |

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

**Findings:**
ASH reported that when auditors reviewed August charts, direct feedback related to missing information or documentation was provided to clinicians. The facility indicated that when appropriate, the monitoring physician immediately remedied the deficiency. Additionally, charts were re-audited 2-4 weeks after feedback was given to the PCP.

**Recommendation 4, April 2009:**
Monitor preventive care and care of cardiac disease using NSH's indicators.

**Findings:**
ASH reported that it developed Cardiac Care and Preventive Health Care guidelines and tools and intends to implement them with the October audit.

**Compliance:**
Partial; improved compared to the last review.

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). |
| 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. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Utilize the Medical Services EPPI Team in the review and analysis of all the medical triggers/key indicators and establishment of any additional indicators of process and clinical outcomes.<br><br>**Findings:**<br>ASH reported that the Medical Service EPPI Team will begin to include review and analysis of the medial triggers/key indicators as well as develop any additional indicators of process and clinical outcomes in October 2009.<br><br>**Recommendation 2, April 2009:**<br>Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.<br><br>**Findings:**<br>ASH reported that it developed a physician peer review tool and intends to implement this tool in October 2009.<br><br>**Recommendation 3, April 2009:**<br>Identify trends and patterns based on clinical and process outcomes.<br><br>**Findings:**<br>The facility did not provide information specific to this recommendation. The monitoring data provided for F.7.c above partially address this |

| | | |
|---|---|---|
| | | recommendation.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendations**:<br>1. Utilize the Medical Services EPPI Team in the review and analysis of all the medical triggers/key indicators and establishment of any additional indicators of process and clinical outcomes.<br>2. Implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a.<br>3. Identify trends and patterns based on clinical and process outcomes. |

| 8. Infection Control | | |
|---|---|---|
| | Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Brandi Norico, PHN II<br>2. Gina M. Dusi, PHN II<br><br>Reviewed:<br>1. ASH's progress report and data<br>2. ASH's H1N1 Preparedness Activities list<br>3. 2009 H1N1 Information Sheet<br>4. Department of Medicine Meeting minutes dated 3/19/09, 4/28/09, 5/21/09, 6/11/09, 7/16/09 and 8/20/09<br>5. Nursing Services meeting minutes dated 3/12/09, 3/19/09, 3/26/09, 5/28/09, 7/9/09 and 8/13/09<br>6. ASH Public Health Services Infection Report for March-August 2009<br>7. Infection Control Committee meeting minutes dated 3/26/09, 4/27/09, 5/28/09, 6/25/09, 7/23/09 and 8/27/09<br>8. HSS Committee meeting minutes for March-July 2009<br>9. Medical records for the following 107 individuals: AB, ADW, AH, ALM, AM, AR, AW, BB, BBC, BEA, BEC, BJ, BP, BRT, CAP, CC, DD, DH, DJM, DL, DLA, DLW, DM, DMB, DMK, DRD, DS, DST, DW, DWA, DWB, ELF, EOD, EOG, EW, EWS, FDA, FDS, FLA, GAG, GLB, HFH, IN, ISW, IT, IU, JAE, JE, JEP, JG, JGC, JJC, JJK, JJT, JLR, JM, JN, JRB, JS, JW, JWO, JWS, KJC, LA, LEB, LF, LJL, LMR, LRH, LV, MCD, MD, MDC, MJM, MM, MMG, MO, MWT, NMR, PDN, PWM, RAA, RCB, RDS, REC, RED, RGP, RJL, RLW, RM, RMJ, RRB, RUH, RWK,SAO, SDG, SDT, SRC, SW, TAK, TC, TTG, TVP, VK, WEM, WLB, YR and ZKL |
| F.8.a | Each State hospital shall establish an effective infection control program that: | **Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| F.8.a.i | actively collects data regarding infections and communicable diseases; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue collaboration between the Infection Control Department and nursing.<br><br>**Findings:**<br>Findings from interviews and review of meeting minutes indicate that the IC Department and nursing continue to collaborate.<br><br>**Recommendation 2, April 2009:**<br>Refine the current re-auditing system so that it ensures that WRPs that were initially found to be deficient are modified to reflect appropriate clinically objectives and interventions.<br><br>**Findings:**<br>ASH has implemented a system in which WRPs found to be deficient are referred to the IC Psych Tech, who performs a retro audit the following month. The PHNs then follow up with Program Management if any of the WRPS are still deficient. These retro audits with continued deficient findings are referred to the Program Director, Nursing Coordinator and HSS for completion. ASH has set October, 1 2009 as the deadline by which all deficient WRPs are required to be completed.<br><br>**Recommendation 3, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings (by test/disease):**<br><br>**<u>Admission PPD</u>**<br>Using the DMH IC Admission PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital with a negative PPD in the review months (March-August 2009): |

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.* | 100% |
| 2. | *PPDs were ordered by the physician during the admission procedure.* | 100% |
| 3. | *PPDs were administered by the nurse within 24 hours of the physicians order.* | 100% |
| 4. | *1st step PPDs were read by the nurse within 7 days of administration.* | 100% |
| 5. | *2nd step PPDs were read by the nurse within 48-72 hours of administration.* | N/A |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for items 1-4; item 5 was not applicable in either review period as ASH does not routinely do two-step TSTs.

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires were required.

F.8.a.iv: Identifies necessary corrective action
No corrective actions were required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor for compliance.

A review of the records of 20 individuals admitted during the review period (AM, DD, DLA, DM, DS, DWB, FLA, JE, JG, JM, JN, JW, LA, LMR, MDC, MWT, PWM, RGP, RUH and TC) found that all had a physician's order for PPD upon admission and all PPDs were timely administered and

read.

**Annual PPD**
Using the DMH IC Annual PPD Audit, ASH assessed its compliance based on an average sample of 20% of individuals needing an annual PPD during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.* | 100% |
| 2. | *PPDs were ordered by the physician during the annual review procedure.* | 100% |
| 3. | *PPDs were administered by the nurse within 24 hours of the order.* | 100% |
| 4. | *PPDs were read by the nurse within 48-72 hours of administration.* | 100% |

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

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires were required.

F.8.a.iv: Identifies necessary corrective action
No corrective actions were required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor for compliance.

A review of the records of 20 individuals requiring an annual PPD during the review period (CAP, DJM, DL, DST, DW, EOD, HFH, IT, JAE, JEP,

JJC, JLR, LF, MM, MO, PDN, RLW, RMJ, SW and WEM) found that all had a physician's order and all were timely given and read.

**Hepatitis C**

Using the DMH IC Hepatitis C Audit, ASH assessed its compliance based on an average sample of 33% of individuals admitted to the hospital in the review months (March-August 2009) who were positive for Hepatitis C:

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.* | 100% |
| 3. | *Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.* | 100% |
| 4. | *The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.* | 100% |
| 5. | *A Focus 6 is opened for Hepatitis C.* | 95% |
| 6. | *Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet* | 95% |
| 7. | *Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual* | 87% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-4 and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | 89% | 95% |
| 6. | 36% | 95% |
| 7. | 0% | 87% |
| Compliance rate in last month of period | | |
| 7. | 0% | 100% |

F.8.a.ii: Assesses these data for trends

Improvement was noted in the nursing objectives and interventions in March 2009. In April, in a significant improvement, all HCV cases had a focus 6 opened with quality objectives and interventions. A slight decrease was noted in May from one case not having an opened focus 6, which also resulted in objectives and interventions not being completed. Compliance for items 6 and 7 decreased in June due to one case that had objectives and interventions, but not of appropriate quality. July and August 2009 indicated positive compliance trends.

F.8.a.iii: Initiates inquiries regarding problematic trends

In addition to the information above, in March 2009, individual education regarding transmission of Hepatitis C was found lacking in many of the WRPs.

F.8.a.iv: Identifies necessary corrective action

The name of the individual without an opened focus 6 was referred to sick call so that a focus 6 could be opened and objectives and interventions initiated. With regard to the issue of appropriate quality, the HSSs had the unit RN rewrite the WRP objective and interventions so that they were clinically appropriate. The PHN sent an e-mail requesting the HSS to address and correct the issue of the WRPs not containing the education component for HCV.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Psych Tech (ICPT) copied the objectives and interventions from the March audit and provided these to the PHNs. The HSSs assisted in correcting deficits in the WRPs.

In June 2009, the PHN found a focus 6 opened, but objectives and interventions were not completed. The PHN obtained the name of the responsible RN and she was notified to complete the objectives and interventions.

In July 2009, the ICPT copied the objectives and interventions from the June audit for the PHN to review. Any deficiencies found were corrected.

A review of the records of 18 individuals who were admitted Hepatitis C positive during the review period (BEC, DLW, DWA, EOG, GAG, GLB, JGC, JJT, JWO, MCD, MJM, PWM, RAA, RDS, RRB, SAO, SRC and TAK) found that that all had documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 problem for Hepatitis C; and 17 had adequate and appropriate objectives and interventions in the WRPs.

**HIV Positive**
Using the DMH IC HIV Positive Audit, ASH assessed its compliance based on a 100% sample (two individuals) of individuals who were positive for HIV antibody in the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.* | 100% |
| 2. | *Notification was made to the unit housing the individual that he/she has a positive HIV Antibody* | 100% |

| | | |
|---|---|---|
| | *test.* | |
| 3. | *If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.* | 100% |
| 4. | *If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.* | 100% |
| 5. | *The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.* | 100% |
| 6. | *A Focus 6 is opened for HIV (unspecified viral illness)* | 100% |
| 7. | *Appropriate objective is written to address the progression of the disease.* | 100% |
| 8. | *Appropriate interventions are written.* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-6 and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 29% | 100% |
| 8. | 14% | 100% |

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires were required.

F.8.a.iv: Identifies necessary corrective action
No corrective actions were required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor for compliance.

A review of the records of two individuals who were admitted during the review period with HIV (JWS and SRC) found that both were in compliance regarding clinic referrals and follow-up and both had appropriate objectives and/or interventions in the WRPs.

**Immunizations**
Using the DMH IC Immunization Audit, ASH assessed its compliance based on an average sample of 20% of individuals admitted to the hospital during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department of an individual's immunity status.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual of his/her immunity status.* | 100% |
| 3. | *Immunizations were ordered by the physician within 30 days of receiving notification by the lab.* | 100% |
| 4. | *Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.* | 100% |

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

F.8.a.ii: Assesses these data for trends
No problematic trends were identified.

F.8.a.iii: Initiates inquiries regarding problematic trends
No inquires were required.

F.8.a.iv: Identifies necessary corrective action
No corrective actions were required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
ASH will continue to monitor for compliance.

A review of the records of 20 individuals (ALM, AR, BBC, BEA, BJ, DMB, DMK, DWA, ELF, FDA, KJC, LJL, LV, MMG, NMR, RCB, TTG, VK, YR and ZKL) found that 19 contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all were timely administered.

**Immunization Refusals**
Using the DMH IC Immunization Refusal Audit, ASH assessed its compliance based on a 47% sample of individuals in the hospital who refused to take their immunizations during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s* | 100% |
| 2. | *There is a Focus 6 opened for the refusal of the immunization(s).* | 81% |
| 3. | *There are appropriate objective(s) developed for the refusal of immunization(s).* | 55% |
| 4. | *There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).* | 50% |
| 5. | *The unit notified the Infection Control Department when the individual consented and received the* | 100% |

| | | |
|---|---|---|
| | *immunization(s).* | |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 100% | 100% |
| 2. | 75% | 81% |
| 3. | 21% | 55% |
| 4. | 12% | 50% |
| 5. | N/A | 100% |
| Compliance rate in last month of period | | |
| 2. | 100% | 100% |
| 3. | 50% | 100% |
| 4. | 0% | 100% |

F.8.a.ii: Assesses these data for trends
The facility conducted a month-by-month analysis of changes in compliance for items 2, 3 and 4.

F.8.a.iii: Initiates inquiries regarding problematic trends
ASH's analysis identified issues with opening a Focus 6 and writing quality objectives and interventions when a Focus 6 had been opened. When inquiries were made as to why the objectives/interventions were not completed, the responses indicated a lack of time to do so. Public Health performed an audit on the Med Surg Clinic immunization refusal process for individuals with multiple refusals and found that only 38% had a focus 6 opened at time of refusal in the clinic and only 17% of refusals were documented on the immunization record.

F.8.a.iv: Identifies necessary corrective action
HSSs were enlisted to correct WRPs that did not have quality objectives and interventions. Individuals were placed back on sick call for MDs to open a Focus 6. In addition, RNs were notified to complete objectives/interventions or be more specific in their WRPs.

The PHNs met with the Med Surg Clinic RNs, Public Health MD and Medical Services Supervising RN to review and agree on processes to improve compliance with immunization refusals.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
See F.8.a.v under Hepatitis C.

A review of the records of 17 individuals who refused immunizations during the review period (AB, ADW, BRT, DRD, EW, EWS, IN, JGC, JJK, JS, JW, LEB, REC, RED, RM, RWK and TVP) found that all had an open Focus 6 and appropriate objectives and interventions. In addition, two exceptional WRPs addressing refused immunizations were found (JJK and LEB).

**MRSA**
Using the DMH IC MRSA Audit, ASH assessed its compliance based on a 100% sample (eight individuals) of individuals in the hospital who tested positive for MRSA during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained* | 100% |
| 3. | *The individual is placed on contact precaution per MRSA policy.* | 100% |

| | | |
|---|---|---|
| 4. | *The appropriate antibiotic was ordered for treatment of the infection(s).* | 100% |
| 5. | *The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.* | 100% |
| 6. | *A Focus 6 is opened for MRSA.* | 100% |
| 7. | *Appropriate objective is written to include prevention of spread of infection* | 92% |
| 8. | *Appropriate interventions are written to include contact precautions.* | 92% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-6 and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 22% | 92% |
| 8. | 22% | 92% |

F.8.a.ii: Assesses these data for trends
In the month of March, April and August 2009, there were no +MRSA cultures. In May 2009, items 7 and 8 were at 75% compliance due to one WRP not having quality objectives or interventions. June and July 2009 indicated 100% compliance rates.

F.8.a.iii: Initiates inquiries regarding problematic trends
In May 2009, one WRP was missing quality content for the objective and interventions.

F.8.a.iv: Identifies necessary corrective action
The PHN requested the HSSs to correct the one WRP needing

appropriate objectives and interventions.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The PHN reviewed the deficient WRP and found the objectives and interventions were completed on 6/15/09 and were of quality content

A review of the records of four individuals with MRSA (BP, DRD, LRH and SDT) found that all were placed on contact precautions and on the appropriate antibiotic and all had appropriate objectives and interventions in their WRPs.

**Positive PPD**
Using the DMH IC Positive PPD Audit, ASH assessed its compliance based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.* | 100% |
| 2. | *All positive PPDs received PA and Lateral Chest X-ray.* | 75% |
| 3. | *All positive PPDs received an evaluation by the Med-Surg Physician.* | 100% |
| 4. | *If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.* | N/A |
| 5. | *If LTBI is present, there is a Focus 6 opened.* | 100% |
| 6. | *If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.* | 100% |
| 7. | *If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.* | 100% |

Comparative data indicated maintenance of compliance greater than 90%

from the previous review period for items 1, 3 and 5, and improvement in compliance since the previous review period (item 4 was not applicable in either review period):

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 2. | 60% | 75% |
| 6. | 40% | 100% |
| 7. | 20% | 100% |

F.8.a.ii: Assesses these data for trends
In July 2009, one of two positive PPD cases did not have a lateral chest x-ray completed.

F.8.a.iii: Initiates inquiries regarding problematic trends
Public Health Services wrote an IDN and placed a request for a lateral chest x-ray in sick call, but the request was not completed for one individual.

F.8.a.iv: Identifies necessary corrective action
After the audit demonstrated a missed chest x-ray, the PHN wrote a second IDN and placed another request for a lateral chest in the sick call book.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The PHN confirmed that the one case without the lateral chest x-ray had the x-ray completed.

A review of the records of three individuals who had positive PPDs (CC, FDS and WLB,) found that all had the required chest x-rays; all had documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.

**Refusal of Admitting or Annual Lab Work or Diagnostic Tests**

Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, ASH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.* | 100% |
| 2. | *There is a Focus opened for the lab work or PPD refusal* | 93% |
| 3. | *There are appropriate objectives written for the lab work or PPD refusal.* | 58% |
| 4. | *There are appropriate interventions written for the lab work or PPD refusal.* | 65% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 1. | 100% | 100% |
| 2. | 69% | 93% |
| 3. | 15% | 58% |
| 4. | 8% | 52% |
| Compliance rate in last month of period | | |
| 3. | 100% | 33% |
| 4. | 100% | 33% |

| | | |
|---|---|---|
| | | F.8.a.ii: Assesses these data for trends<br>The facility conducted a month-by-month analysis of changes in compliance for items 3 and 4.<br><br>F.8.a.iii: Initiates inquiries regarding problematic trends<br>In March 2009, compliance for item 3 was 33% due to two of three charts audited not containing appropriate objectives; item 4 was at 0% compliance because none of the three charts audited contained appropriate interventions. In April, 2009, there were no refusals. In June 2009, 50% of relevant charts (two) did not have any objectives or interventions and one did not include educating the individual on the importance of having annual TST.<br><br>F.8.a.iv: Identifies necessary corrective action<br>HSSs were enlisted to correct WRPs that did not have any or quality objectives and interventions.<br><br>F.8.a.v: Monitors to ensure that appropriate remedies are achieved<br>The PHN reviewed the retro audit for March and found that the objectives and interventions were not corrected. After the PHN reviewed the retro audit for June, it was noted that only 33% of the objectives and interventions were corrected. In August, the PHN contacted the RN and program HSS to ensure that the objective and interventions were completed.<br><br>A review of the records of 12 individuals who refused admitting or annual labs/diagnostics (AH, AW, BB, DH, DST, ISW, IU, JRB, MD, REC, RJL and SDG) found that all of the refusals were adequately addressed in the WRPs.<br><br>**Sexually Transmitted Diseases**<br>Using the DMH IC Sexually Transmitted Disease (STD) Audit, ASH |

assessed its compliance based on a 100% sample of individuals (two) in the facility who tested positive for an STD during the review months (March-August 2009):

| | | |
|---|---|---|
| 1. | *Notification by the lab was made to the Infection Control Department of a positive STD.* | 100% |
| 2. | *Notification by the lab was made to the unit housing the individual that he/she has a STD.* | 100% |
| 3. | *An RPR is ordered during the admission process for each individual.* | 100% |
| 4. | *An HIV antibody test is offered to every individual upon admission.* | 100% |
| 5. | *A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals* | N/A |
| 6. | *If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.* | N/A |
| 7. | *Focus 6 is opened for an individual testing positive for an STD.* | 100% |
| 8. | *Appropriate objective(s) are written.* | 100% |
| 9. | *Appropriate interventions are written.* | 100% |

Comparative data indicated maintenance of compliance greater than 90% from the previous review period for items 1-4 and 7, and improvement in compliance for the remaining items:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 5. | N/A | N/A |
| 6. | N/A | N/A |
| 8. | 50% | 100% |
| 9. | 0% | 100% |

| | | |
|---|---|---|
| | | F.8.a.ii: Assesses these data for trends<br>No problematic trends were identified.<br><br>F.8.a.iii: Initiates inquiries regarding problematic trends<br>No inquires were required.<br><br>F.8.a.iv: Identifies necessary corrective action<br>No corrective actions were required.<br><br>F.8.a.v: Monitors to ensure that appropriate remedies are achieved<br>ASH will continue to monitor for compliance.<br><br>A review of the records of one individual with diagnosed STD (DCS) found that the appropriate lab work was obtained indicating a positive STD and it was adequately addressed in the WRP.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.ii | assesses these data for trends; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>A review of ASH's Infection Control Committee meeting minutes and reports verifies that they consistently identify trends in the IC surveillance data. See also F.8.a.i. |

| | | |
|---|---|---|
| | | **Compliance:**<br>Substantial.<br><br>**Current recommendation:**<br>Continue to monitor this requirement. |
| F.8.a.iii | initiates inquiries regarding problematic trends; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.8.a.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.iv | identifies necessary corrective action; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>See F.8.a.i.<br><br>**Findings:**<br>See F.8.a.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| | | |
|---|---|---|
| F.8.a.v | monitors to ensure that appropriate remedies are achieved; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See F.8.a.i.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| F.8.a.vi | integrates this information into each State hospital's quality assurance review. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>ASH's Infection Control Department continues to implement strategies in attempts to increase and maintain compliance, especially in the area of WRP objectives and interventions related to Infection Control. Minutes of the Infection Control Committee Meetings, Department of Medicine Meetings, HSS and Nursing Services meetings and Infection Reports verify that Infection Control issues are integrated into the facility's quality assurance reviews. In addition, the IC Department has initiated a significant number of interventions including the distribution of emergency antiviral supplies to staff and training regarding the H1N1 virus. At the time of this review, the facility was in process of administering vaccinations to the individuals and staff members. An additional unit was opened to facilitate containment of those individuals showing flu-like symptoms. Also, the IC Department has continued to |

| | | |
|---|---|---|
| | | work on the following public health issues:<br><br>• Public Health Services has maintained ongoing collaboration with IT to streamline and rectify the Public Health 2003 database conversion<br>• Initiation of a trial of a Cough Etiquette Station in ASH's Visiting Room<br>• PHN presentation to Program Director's Group regarding proper use and accessibility of Cavi-Wipe disinfecting towelettes<br>• Approval for criteria for use of QuantiFERON® Gold testing at ASH<br>• Initiation of West Nile Virus season precautions. Implementation of information to residents and staff; memoranda to Plant Operation regarding standing water and dead bird retrieval and to Pharmacy regarding soy-based and DEET repellants<br>• Completion of Unit 1 Second Auxiliary Isolation Room<br>• ASH Proposal to DMH Headquarters regarding Swine Influenza Admission/Transfer/Discharge Criteria for DMH Hospital<br>• PHN Memorandum to Med Surg Clinic RNs regarding audit findings and agreed process to follow for immunization refusals<br>• Joint Meeting with PHNs, Public Health MD and Med Surg Clinic RNs to resolve immunization refusal processing issues<br>• Correspondence to Nursing Administrator Requesting Attendance to HSS Meeting and Nurse Mentors regarding vaccination administration and documentation<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |

| 9. Dental Services | | |
|---|---|---|
| | Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. Heather Andres, Registered Dental Assistant<br>2. Jeff Shepherd, DDS<br><br>Reviewed:<br>1. ASH's progress report and data<br>2. Dental log for refusals<br>3. Medical records for the following 95 individuals: AB, AC, AF-1, AF-2, AGV, AHC, AHL, AW, AWD, BB, BC, BEC, BJS, BO, CAP, CC, CDB, CE, CKL, CKS, CMM, CP, CRG, CV, DA, DAB, DD, DEA, DH, DIT, DR, EC, EF, EHV, EM, ERJ, FBR, IK, JB, JBD, JC, JCD, JG, JGC, JJD, JJG, JLB, JLM, JLZ, JMS, JO, JW-1, JW-2, KGM, KH, LA, LC, LF, LJ, LN, LTE, MAE, MAH, MD, MDC, MDR, MG, ML, MLD, MWM, PO, PWM, REC, RKH, RM, RMJ, RON, ROS, RRR, RSD, RT, RUB, RVP, RW, SC, SJB, SK, TGM, TIS, TL, TLB, TP, TYL, WAR and WL |
| F.9.a | Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>ASH continues to have the same number of Dental staff as in the previous review period: one chief dentist, two full-time dentists and two full-time registered dental assistants.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue current practice. |
| F.9.b | Each State hospital shall develop and implement policies and procedures that require: | **Compliance:**<br>Substantial. |
| F.9.b.i | comprehensive and timely provision of dental services; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 32% mean sample of individuals scheduled for comprehensive dental exams during the review months (March-August 2009):<br><br>1.a *Comprehensive dental exam was completed* 100%<br><br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>A review of the records of 21 individuals (AC, AWD, BC, DD, EC, EM, JB, JBD, JCD, JLM, JLZ, JW-1, JW-2, LC, MDC, MG, MWM, PWM, RRR, SC and SJB) found that all had a comprehensive dental exam completed.<br><br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 20% mean sample of individuals who have been in the hospital for 90 days or less during the review period (March-August 2009):<br><br>1.b *If admission examination date was 90 days or less* 100%<br><br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period. |

A review of the records of 21 individuals (AC, AWD, BC, DD, EC, EM, JB, JCD, JJD, JLB, JLM, JW-1, JW-2, LC, MDC, MG, MWM, PWM, RRR, SC and SJB) found that all were timely seen for their admission exams.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (March-August 2009):

| | | |
|---|---|---|
| 1.c | *Annual date of examination was within anniversary month of admission* | 100% |

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

A review of the records of 18 individuals (AHL, CC, DAB, DEA, JO, LJ, LTE, MAE, MAH, MD, MDR, ML, REC, RMJ, ROS, TL, TLB and WL) found that 17 annual examinations were timely completed.

Using the DMH Dental Services Audit, ASH assessed its compliance based on a 41% mean sample of individuals with dental problems identified on admission or annual examination during the review months (March-August 2009):

| | | |
|---|---|---|
| 1.d | *Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner* | 100% |

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

A review of the records of 39 individuals (AC, AHL, AWD, BC, CC, DAB, DD, DEA, EC, EM, JB, JCD, JJD, JLB, JLM, JO, JW-1, JW-2, LC, LJ,

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<td>LTE, MAE, MAH, MD, MDC, MDR, MG, ML, MWM, PWM, REC, RMJ, ROS, RRR, SC, SJB, TL, TLB and WL) found that all were timely seen for follow-up care.<br><br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 43% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (March-August 2009):<br><br>
<table>
<tr><td>1.e</td><td>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>A review of the records of 25 individuals (AGV, AW, CKL, CKS, CMM, CP, CRG, DA, DIT, EHV, FBR, JMS, KGM, LA, LN, MLD, PO, RON, RT, RUB, SK, TGM, TIS, TYL and WAR) found that all received timely follow-up care.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.ii</td>
<td>documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 41% mean sample of individuals scheduled for follow-up dental</td>
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<td>care during the review months (March-August 2009):
<table>
<tr><td>2.</td><td>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</td><td>100%</td></tr>
</table>
Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>A review of dental documentation for 39 individuals (AC, AHL, AWD, BC, CC, DAB, DD, DEA, EC, EM, JB, JCD, JJD, JLB, JLM, JO, JW-1, JW-2, LC, LJ, LTE, MAE, MAH, MD, MDC, MDR, MG, ML, MWM, PWM, REC, RMJ, ROS, RRR, SC, SJB, TL, TLB and WL) found that all records were in compliance with the documentation requirements.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.iii</td>
<td>use of preventive and restorative care whenever possible; and</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current practice.<br><br>Findings:<br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 21% mean sample of individuals due for annual routine dental examinations during the review months (March-August 2009):
<table>
<tr><td>3.a</td><td>Preventative care was provided, including but not limited to cleaning, root planning, sealant, fluoride application</td><td>100%</td></tr>
<tr><td>3.b</td><td>Oral hygiene instruction</td><td>100%</td></tr>
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<td>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for both items.<br><br>A review of the records of 18 individuals (AHL, CC, DAB, DEA, JO, LJ, LTE, MAE, MAH, MD, MDR, ML, REC, RMJ, ROS, TL, TLB and WL) found all were provided preventative care.<br><br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (March-August 2009):<br><br>
<table>
<tr><td>3.c</td><td>Restorative care was provided including permanent or temporary restorations (fillings)</td><td>100%</td></tr>
</table>
<br>Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>A review of the records of 25 individuals (AGV, AW, CKL, CKS, CMM, CP, CRG, DA, DIT, EHV, FBR, JMS, KGM, LA, LN, MLD, PO, RON, RT, RUB, SK, TGM, TIS, TYL and WAR) found that all received restorative care.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td>
</tr>
<tr>
<td>F.9.b.iv</td>
<td>tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (March-August 2009):</td>
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<tr><td>4.</td><td>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</td><td>100%</td></tr>
</table>
<br>
Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period.<br><br>
A review of the records of 18 individuals (AF-1, AF-2, AHC, BEC, BO, CDB, CE, CV, DH, EF, IK, JG, JGC, JJD, RKH, RSD, RW and TP) found that all were in compliance with this requirement.<br><br>
Current recommendation:<br>
Continue to monitor this requirement.
</td>
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<tr>
<td>F.9.c</td>
<td>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.</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue current practice.<br><br>
Findings:<br>
Using the DMH Dental Services Audit, ASH assessed its compliance based on a 33% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (March-August 2009):<br><br>
<table>
<tr><td>5.</td><td>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health,</td><td></td></tr>
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| | | |
|---|---|---|
| | *medications, allergies, and current dental status and complaints.* | |
| 5.a | *Physical health impact on dental service* | 91% |
| 5.b | *Medications* | 91% |
| 5.c | *Allergies that impact on dental service* | 91% |
| 5.d | *General condition of current oral environment* | 91% |
| 5.e | *When individual compliant is noted within the findings, there is documentation related to exam results* | 91% |

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

A review of the records of 39 individuals (AC, AHL, AWD, BC, CC, DAB, DD, DEA, EC, EM, JB, JCD, JJD, JLB, JLM, JO, JW-1, JW-2, LC, LJ, LTE, MAE, MAH, MD, MDC, MDR, MG, ML, MWM, PWM, REC, RMJ, ROS, RRR, SC, SJB, TL, TLB and WL) found that 38 were in compliance with the documentation requirements.

**Compliance:**
Substantial.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| F.9.d | 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. | **Current findings on previous recommendations:**<br><br>**Recommendations and 2, April 2009:**<br>• Continue to implement strategies addressing this requirement.<br>• Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Dental Services Audit, ASH assessed its compliance |

based on a 100% sample of individuals scheduled for dental appointments during the review months (March-August 2009):

| | | |
|---|---|---|
| 6.a | *The individual attended the scheduled appointment* | 79% |

Comparative data indicated no significant changes in compliance since the previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 6.a | 80% | 79% |
| Compliance rate in last month of period | | |
| 6.a | 86% | 79% |

The major reason for missed dental appointments at ASH continues to be refusals. Individuals continue to have fear and dislike of dentistry. The Dental Department has been providing dental education to individuals. However, the WRPTs have not consistently addressed refusals in the WRPs. In March 2009, training that included refusals was provided by the Master Trainer. ASH added refusals to the task tracker system in June 2009, prior to then, patterns of refusals were not readily identifiable. In addition, ASH has developed a template for documentation of all refusals in the WRPs.

A review of ASH's missed dental appointments for the review period verified that the majority of missed appointments were due to refusals; not transportation or staffing issues

A review of the records of 13 individuals who have refused dental appointments (AB, BB, BJS, CAP, DR, ERJ, JC, JJG, JLB, KH, LF, RM and RVP) found that none had an open focus with interventions addressing refusals included in their WRPs, although five WRPs did mention the

<table>
<tr><td></td><td></td><td>refusal in the Present Status section.<br><br>Compliance:<br>Partial.<br><br>Current recommendations:<br>1. Implement strategies addressing this requirement.<br>2. Continue to monitor this requirement.</td></tr>
<tr><td>F.9.e</td><td>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>See F.9.d.<br><br>Findings:<br>Using the DMH Dental Services Audit, ASH assessed its compliance based on a 88% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (March-August 2009):<br><br>
<table>
<tr><td>7.</td><td>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</td><td>13%</td></tr>
<tr><td>7.a</td><td>Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP.</td><td>20%</td></tr>
<tr><td>7.b</td><td>When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.</td><td>5%</td></tr>
</table>
<br>ASH's progress reported indicated the mean for item 7 in the current</td></tr>
</table>

review period was 17%; however, the average of sub-items 7.a and 7.b is 13% (rounding up).

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 7. | 12% | 17% |
| Compliance rate in last month of period | | |
| 7. | 8% | 28% |
| 7.a | 8% | 28% |
| 7.b | N/A | 5% |

(Item 7.b was not addressed during the last review.)

SeeF.9.d for review findings, identified barriers to compliance, and the facility's plan of action to improve compliance.

**Compliance:**
Partial.

**Current recommendation**:
See F.9.d.

| **G. Documentation** | | |
|---|---|---|
| G | Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible. | **Summary of Progress:**<br>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. |

| H. Restraints, Seclusion, and PRN and Stat Medication | | |
|---|---|---|
| H | | **Summary of Progress:**<br>1. ASH continues to make progress regarding seclusion and restraint documentation requirements. With consistent efforts, they should be able to achieve substantial compliance in most if not all areas of this section by the next review.<br>2. ASH has implementing one-to-one mentoring for WRPTs who work with individuals who have reached trigger thresholds for seclusion and restraint.<br>3. ASH continues to intensely review and analyze issues related to violence on the units. |
| H | Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care. | **Methodology:**<br><br><u>Interviewed</u>:<br>1. Donna Nelson, Standards Compliance Director<br>2. Rosie Morrison, RN, HSS<br>3. Stan Wilt, RN, Central Nursing Services<br><br><u>Reviewed</u>:<br>1. ASH's progress report and data<br>2. Prone Stabilization report<br>3. Violence Risk Management Committee Six-Month Progress Report<br>4. ASH's training rosters<br>5. Medical records for the following 26 individuals: AAA, AB, AJ, AMM, BG, GM, JGC, JJC, JLN, JPW, JS, JT, JWB, KW, LMR, MA, MAS, MJC, MS, OR, PWM, RKH, RWK, TJC, WST and ZDS |
| H.1 | Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue to collect and review episodes of prone stabilization/ |

| | | |
|---|---|---|
| | 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. | transportation.<br><br>**Findings:**<br>ASH provided data regarding episodes of prone stabilization, verifying that they continue to collect and review these episodes.<br><br>**Recommendation 2, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>ASH's Standards Compliance continues to review episodes of prone stabilization. Review of documentation for 98 episodes of prone stabilization prior to seclusion and restraint found no incidents of prone restraints, prone containment or prone transportation. ASH needs to continue to monitor this issue to ensure appropriate practices are followed.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.2 | Each State hospital shall ensure that restraints and seclusion: | **Compliance:**<br>Partial. |
| H.2.a | are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance |

based on a 63% mean sample of initial seclusion orders each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *Seclusion is used in a documented manner.* | 99% |
| 2. | *Seclusion is used only when the individual posed an imminent danger to self or others.* | 98% |
| 3. | *Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.* | 93% |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for all three items.

A review of 25 episodes of seclusion for 12 individuals (AAA, AJ, GM, JJC, JLN, JPW, LMR, MA, MJC, OR, RWK and ZDS) found that the documentation for 22 episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in 20 episodes and all had orders that included specific behaviors.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 64% mean sample of initial restraint orders each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 1. | *Restraint is used in a documented manner.* | 99% |
| 2. | *Restraint is used only when the individual posed an imminent danger to self or others.* | 98% |
| 3. | *Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.* | 92% |

Comparative data indicated that ASH maintained compliance greater than 90% from the previous review period for all three items.

| | | |
|---|---|---|
| | | A review of 30 episodes of restraint for 14 individuals (AB, AMM, BG, JGC, JLN, JT, JWB, MAS, OR, PWM, RKH, TJC, WST and ZDS) found the documentation for 28 episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in all episodes and all had orders that included specific behaviors.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.2.b | are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 63% mean sample of initial seclusion orders each month during the review period (March-August 2009): |

| | | |
|---|---|---|
| 4. | *Seclusion is not used in the absence of, or as an alternative to, active treatment.* | 92% |
| 5. | *The individual has been in seclusion and the staff did not [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].* | 98% |
| 6. | *Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior* | 96% |

| | | |
|---|---|---|
| | *as provided by the individual, or there is clinical justification as to why they were not used.* | |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 90% | 92% |
| 5. | 85% | 98% |
| 6. | 85% | 96% |

A review of 25 episodes of seclusion for 12 individuals (AAA, AJ, GM, JJC, JLN, JPW, LMR, MA, MJC, OR, RWK and ZDS) found documentation in all WRPs addressing behaviors, objectives and interventions, and documentation in 21 incidents indicated that the individual was released when calm.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 64% mean sample of initial restraint orders each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 4. | *Restraint is not used in the absence of, or as an alternative to, active treatment.* | 94% |
| 5. | *The individual has been in restraint and the staff did not [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].* | 97% |
| 6. | *Staff used and documented the use of information in the Seclusion and Restraint Preference and Family* | 96% |

| | | |
|---|---|---|
| | | *Notification Form (ASH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.* |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 4. | 77% | 94% |
| 5. | 95% | 97% |
| 6. | 95% | 96% |

A review of 30 episodes of restraint for 14 individuals (AB, AMM, BG, JGC, JLN, JT, JWB, MAS, OR, PWM, RKH, TJC, WST and ZDS) found documentation in all WRPs addressing behaviors, objectives and interventions, and documentation in 26 incidents indicated that the individual was released when calm.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| H.2.c | are not used as part of a behavioral intervention; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>See F.2.c.iv.<br><br>**Findings:**<br>See F.2.c.iv. |

<table>
<tr><td></td><td></td><td>Current recommendation:<br>See F.2.c.iv.</td></tr>
<tr><td>H.2.d</td><td>are terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue to monitor this requirement.<br><br>Findings:<br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 63% mean sample of episodes of seclusion each month during the review period (March-August 2009):<br><br><table><tr><td>7.</td><td>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>92%</td></tr></table><br>Comparative data indicated improvement in compliance from 84% in the previous review period.<br><br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 64% mean sample of episodes of restraint each month during the review period (March-August 2009):<br><br><table><tr><td>7.</td><td>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</td><td>91%</td></tr></table><br>Comparative data indicated improvement in compliance from 84% in the previous review period.<br><br>See H.2.b for review findings for both seclusion and restraint.<br><br>Current recommendation:<br>Continue to monitor this requirement.</td></tr>
</table>

| H.3 | Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 63% mean sample of initial seclusion orders each month during the review period (March-August 2009): |
|---|---|---|

| 8. | *Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.* | 81% |
|---|---|---|
| 8.a | *The order was obtained within 15 minutes from the initiation of seclusion.* | 91% |
| 8.b | *The RN conducted an assessment within 15 minutes of the initiation of seclusion and documented in the IDN.* | 75% |
| 8.c | *The Physician conducted a face-to-face evaluation of the individual in seclusion within one hour from the initiation of seclusion and documented in the Physician's Progress Note.* | 78% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 60% | 81% |
| Compliance rate in last month of period | | |
| 8. | 64% | 81% |

| | Previous period | Current period |
|---|---|---|
| Compliance rate in last month of period | | |
| 8.a | 91% | 94% |
| 8.b | 81% | 61% |
| 8.c | 78% | 89% |

A barrier to compliance is that the Physician and Nursing progress notes do not contain the actual time the assessment was completed, only the time the note was written. Training has been provided to ensure that that the clock starts right after the application of restraint or seclusion.

A review of 25 episodes of seclusion for 12 individuals (AAA, AJ, GM, JJC, JLN, JPW, LMR, MA, MJC, OR, RWK and ZDS) found that the RN conducted a timely assessment in 17 episodes and the individual was seen timely by a psychiatrist in 18 episodes.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 64% mean sample of initial restraint orders each month during the review period (March-August 2009):

| | | |
|---|---|---|
| 8. | *Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in restraint within one hour.* | 83% |
| 8.a | *The order was obtained within 15 minutes from the initiation of restraint.* | 92% |
| 8.b | *The RN conducted an assessment within 15 minutes of the initiation of restraint and documented in the IDN.* | 73% |
| 8.c | *The Physician conducted a face-to-face evaluation of the individual in restraint within one hour from* | 84% |

| | | |
|---|---|---|
| | | *the initiation of restraint and documented in the Physician's Progress Note.* |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 8. | 63% | 83% |
| Compliance rate in last month of period | | |
| 8. | 66% | 91% |
| 8.a | 88% | 96% |
| 8.b | 80% | 88% |
| 8.c | 92% | 88% |

See barrier to compliance and plan of action above.

A review of 30 episodes of restraint for 14 individuals (AB, AMM, BG, JGC, JLN, JT, JWB, MAS, OR, PWM, RKH, TJC, WST and ZDS) found that the RN conducted a timely assessment in 26 episodes and the individual was seen timely by a psychiatrist in 24 episodes.

See H.7 for training data.

**Compliance:**
Partial.

**Current recommendation**:
Continue to monitor this requirement.

| | | |
|---|---|---|
| H.4 | Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, | **Current findings on previous recommendation:** |

| | | |
|---|---|---|
| | psychiatric PRN medications, or Stat medications. | **Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>ASH's Standards Compliance Department compares the ORYX and PLATO data regarding restraint and seclusion monthly to ensure accuracy. In the event a discrepancy is found, the Department notifies the specific Program and the data are checked against the Program's raw data (tally sheets). If needed, any corrected data are entered in the ORYX system. During the review period, 35 discrepancies were incorrectly tallied out of 799 episodes of seclusion and restraint for an accuracy rate of 95.6%.<br><br>In addition, the NOC shift performs an audit of all medication records nightly. The HSS check the NOC audit on the following day and spot-check the MARS to ensure that any errors are identified. Also, Standards Compliance audits 100% of the MVR data monthly. If any discrepancies are found, they are reviewed by the MED EPPI team, and the errors are forwarded to the appropriate area for correction. ASH reported a 97% accuracy rate during the review period.<br><br>Also, the Ongoing Enhancement Plan Performance Improvement teams review the PLATO results for Restraint/Seclusion and PRN/Stat medications monthly and initiate QI process for any developing trends. The NOC shift also conducts nightly audits of the MARs and compares the PRN/Stat data to the data contained in the Quick Hits database.<br><br>A review of PRN/Stat medications and seclusion and restraint incidents found no incidents that were not included in the ASH databases.<br><br>**Compliance:**<br>Substantial. |

| | | |
|---|---|---|
| | | **Current recommendation**:<br>Continue current practice. |
| H.5 | Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 93% sample of individuals who were in seclusion more than three times in 30 days during the review period (March-August 2009):<br><br>9. *Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate* — 43%<br>9.a *The review was held within three business days for any individual who had 4 or more episodes of seclusion within the last 30 days* — 30%<br>9.b *The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done* — 51%<br>9.c *If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP* — 47%<br><br>Comparative data indicated mixed changes in compliance since the |

previous review period:

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 9. | 67% | 43% |
| Compliance rate in last month of period | | |
| 9. | 60% | 100% |
| 9.a | 60% | 100% |
| 9.b | 80% | 100% |
| 9.c | 80% | 100% |

To address these items, ASH implemented one-on-one training with the WRPTs that work with individuals who met this trigger in August 2009. The training included the following elements:

1. Daily review of Trigger report is completed by the trainer.
2. The trainer checks WRP inclusion of restraint or seclusion events in Present Status section.
3. If the information is not present, the trainer provides individualized training to the team with follow-up reviews to ensure the inclusion of information in the WRP in the time frame outlined in the EP.

A review of the records of six individuals who were in seclusion more than three times in 30 days during the review period (AB, AJ, JS, KW, MS and ZDS) found documentation in the WRP within three business days in four records.

Using the DMH Seclusion/Restraint Audit, ASH assessed its compliance based on a 64% sample of individuals who were in restraint more than three times in 30 days during the review period (March-August 2009):

| | | |
|---|---|---|
| 9. | *Required to review within three business days of* | 41% |

| | | |
|---|---|---|
| | *individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate* | |
| 9.a | *The review was held within three business days for any individual who had 4 or more episodes of restraint within the last 30 days* | 37% |
| 9.b | *The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done* | 38% |
| 9.c | *If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP* | 47% |

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

| | Previous period | Current period |
|---|---|---|
| Mean compliance rate | | |
| 9. | 39% | 41% |
| Compliance rate in last month of period | | |
| 9. | 33% | 61% |
| 9.a | 33% | 67% |
| 9.b | 33% | 50% |
| 9.c | 33% | 67% |

See plan of action noted above.

A review of the records of 11 individuals who were in restraint more than

| | | |
|---|---|---|
| | | three times in 30 days during the review period (AB, AJ, AMM, BG, JLN, JT, JWB, OR, PWM, RKH and ZDS) found that documentation in the WRP within three business days in five records.<br><br>**Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.6 | Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that: | **Compliance:**<br>Partial. |
| H.6.a | such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.b.<br><br>**Findings:**<br>See F.1.b.<br><br>**Current recommendation:**<br>See F.1.b. |
| H.6.b | PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.b. |

| | | |
|---|---|---|
| | | **Findings:**<br>See F.1.b.<br><br>**Current recommendation:**<br>See F.1.b. |
| H.6.c | PRN medications are appropriately time limited. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.1.b.<br><br>**Findings:**<br>See F.1.b.<br><br>**Current recommendation:**<br>See F.1.b. |
| H.6.d | nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in F.3.a.iii.<br><br>**Findings:**<br>See F.3.a.iii.<br><br>**Current recommendation**:<br>See F.3.a.iii. |
| H.6.e | A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Same as in D.1.f, F.1.b and H.6.a. |

| | | |
|---|---|---|
| | appropriate, adjustment of current treatment and/or diagnosis. | **Findings:**<br>Same as in D.1.f, F.1.b and H.6.a<br><br>**Current recommendations**:<br>Same as in D.1.f, F.1.b and H.6.a. |
| H.7 | Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>Training rosters verified that 100% of staff that were required to attend the TSI and Medication Certification trainings during the review period received and passed the classes.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue to monitor this requirement. |
| H.8 | Each State hospital shall: | **Compliance:**<br>Not applicable. |
| H.8.a | develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>There was no use of side rails during this review period. |

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|---|---|---|
| | | **Current recommendation**:<br>Continue to monitor this requirement. |
| H.8.b | ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that 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. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to monitor this requirement.<br><br>**Findings:**<br>See H.8.a.<br><br>**Current recommendation**:<br>See H.8.a. |

| I. Protection from Harm | | |
|---|---|---|
| I | Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm. | **Summary of Progress:**<br>1. The facility's vigilance in reviewing SIRs has resulted in substantial improvement in their accuracy. Since the SIR database is the backbone of the trigger system and the source for much of the data related to violence, this is an important accomplishment.<br>2. With guidance from DMH counsel, the facility has revised its policy on consensual sexual activity to no longer consider it a reportable incident.<br>3. When presented with the lack of congruence between the SIR definition of verbal abuse and the penal law definition of dependent adult abuse used when preparing a SOC 341,the facility revised its policy to cite verbal abuse as a policy violation. This change will mean that ASH staff will be held to the same standard as staff members in the other facilities.<br>4. Nearly 90 percent of the staff members at ASH have participated in A/N training within the last 12 months.<br>5. The hospital police are responding quickly and beginning initial investigations within 24 hours receiving reports of allegations of A/N/E.<br>6. The IMRC has agreed to ensure that each member of the committee will review sufficient information about the investigation prior to the meeting to be able to make sound judgments about the quality. Similarly, SC leadership acknowledged the importance of the second investigation compliance review and will ensure it continues.<br>7. The Violence Risk Management Committee deserves accolades for the work it has done in studying inpatient violence and relating these findings to ASH data that it has gathered, presented and analyzed. This work has resulted in measures to reduce violence that range from purchasing "no throw" chairs to starting each day with a motivational meeting. This group's work has spawned consideration of a step-down unit for individuals coming from prison and of a secure |

| | | |
|---|---|---|
| | | unit for exceptionally violent individuals.<br>8. The ETRC meeting that this monitor attended evidenced active participation of the psychiatrists and psychologists presenting their cases, offering treatment suggestions and making commitments to implement recommendations.<br>9. The facility has continued to work toward ensuring a clean and safe environment. The common areas of the units visited were generally clean; "no throw" chairs and bedside stands, new doors on single bedrooms that permit greater visibility for staff and which can be locked from the inside, and fine mesh over air vents in single bedrooms have enhanced safety on the units. The facility has installed sensors in various locations in the building that provide real-time temperature monitoring.<br>10. WRPs address the problem of incontinence with appropriate objectives and interventions. More importantly, when observed, individuals with this problem were clean and well cared for. |

| 1. Incident Management | | |
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| I.1 | Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care. | **Methodology:**<br><br>Interviewed:<br>1. C. Williams, Standards Compliance<br>2. D. Karas, Program Director<br>3. D. Landrum, Hospital Administrative Resident II<br>4. D. Nelson, Standards Compliance Director<br>5. L. Persons, Hospital Administrator<br>6. Lt. D. Landrum, DPS<br>7. M. Kelly, Standards Compliance<br><br>Reviewed:<br>1. Eighteen SIRs<br>2. Thirteen DPS and OSI investigation reports<br>3. Incident Management Review Committee (IMRC) minutes<br>4. IMRC Task Tracking Form<br>5. 10 Headquarters Reportable Briefs<br>6. Incident listings from the Record Management System<br>7. Graphed incident data<br>8. Portions of 15 staff members' personnel and training records<br>9. Clinical records of six individuals to review incident follow-up activities<br>10. Twelve clinical records for notification of rights<br>11. Mortality Interdisciplinary Review Committee (MIRC) minutes and supporting documents. |
| I.1.a | Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require: | **Compliance:**<br>Substantial. |

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| I.1.a.i | that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Adopt a policy establishing a hierarchy of disciplinary actions to be imposed when a staff member does not report abuse/neglect in the manner required by facility policy.<br><br>**Findings:**<br>The facility issued a memo to managers and supervisors dated March 26, 2009 entitled "Abuse/Neglect and/or Failure/Delayed Reporting." It asserts the need to apply the principles of progressive discipline and provides a listing of actions in rank order from a letter of instruction through to dismissal.<br><br>**Other findings:**<br>Policies in place explicitly state the obligation of staff to report suspected abuse and neglect.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.ii | identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings; | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Carefully match allegations with the incident definitions.<br>• Write determination rationales citing the relevant portions of the definition of the incident type investigated.<br><br>**Findings:**<br>The facility reports that investigators began citing the portion of the incident definition that is relevant to their findings in late September 2009. |

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| | | **Recommendation 3, April 2009:**<br>As planned, DMH should provide legal counsel on defining and handling incidents of consensual sexual contact between individuals.<br><br>**Findings:**<br>DMH did provide legal counsel to the facility. ASH has a draft policy under review entitled "Condoms," which, while not condoning consensual sexual activity, no longer leaves it a matter for referral to law enforcement.<br><br>**Other findings:**<br>During this review, an incident of verbal abuse, wherein a staff member admitted using exceedingly vulgar language in responding to an individual, highlighted the need for investigators to identify the portion of the incident definition upon which he/she is basing the determination. Specifically, although the incident clearly was verbal abuse applying the SIR definition, the allegation was determined not substantiated because the investigator was applying, but not identifying, the penal law definition of abuse. When this problem was identified, the facility amended its Duty to Report Abuse/Neglect policy to include the SIR definition of verbal abuse and noted that verbal abuse is a policy violation. This should correct the problem, and ASH staff will be held to the same standard applied in the other facilities.<br><br>**Current recommendation**:<br>Implement the corrective action taken in ensuring that verbal abuse is recognized as a policy violation and the staff member is held accountable for his/her actions. |
| I.1.a.iii | mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Document the review of the decision to remove or not remove a staff |

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| | the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation; | member in the IMRC minutes.<br><br>**Findings:**<br>This recommendation has been implemented; beginning in August 2009, the IMRC minutes identify whether or not the named staff member has been removed. In addition, a Consideration of Removal slip provides the same information and is part of the investigation case file.<br><br>**Other findings:**<br>In none of the investigations reviewed was the named staff member removed from contact with individuals, although the review of HQ briefs revealed that several staff members involved in these incidents had been removed. The criteria for consideration of removal as stated in the Duty to Report Abuse and Neglect policy is "reasonable suspicion that continued contact between the alleged suspect and victim may pose a risk to the safety or quality treatment of the victim." Review of the IMRC minutes for the period April 30-September 10, 2009 found that the recording of whether the staff member was removed began in the August 4, 2009 minutes. The minutes state that two staff members were removed from this date through the September 10 meeting.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.iv | adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue providing annual A/N training to all staff members.<br><br>**Findings:**<br>The facility reports that as of August, 2102 staff members were current in annual A/N training and only 89 were not current. This is consistent with the findings of the small sample of 15 cited below. |

**Other findings:**
As demonstrated below, all 15 staff members reviewed had completed annual A/N training within the past 12 months:

| | Date of: | | | |
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| Staff member* | Hire | Background clearance | Signing of Mandatory Reporter | Most recent A/N training |
| _O | 8/3/81 | 7/10/81 | 10/31/86 | 9/15/09 |
| _L | 12/3/07 | 10/8/07 | 10/2/07 | 8/25/09 |
| _L | 7/7/03 | 3/29/02<br>10/13/05 | 7/7/03 | 8/8/09 |
| _A | 5/5/08 | 12/1/06 | 5/5/08 | 6/15/09 |
| _P | 5/29/07 | 3/19/07 | 3/19/07 | 6/15/09 |
| _M | 12/9/02 | 7/2/02 | 12/9/02 | 6/8/09 |
| _S | 6/23/93 | 6/23/93 | 6/23/93 | 4/6/09 |
| _Y | 5/14/07 | 12/6/06 | 5/14/07 | 4/6/09 |
| _M | 2/19/08 | 8/16/07 | 2/19/08 | 3/15/09 |
| _D | 7/17/06 | 3/15/05 | 7/17/06 | 3/5/09 |
| _L | 6/7/99 | 5/6/99 | 6/7/99 | 3/5/09 |
| _R | 7/26/99 | 2/26/98<br>9/10/04 | 7/26/99 | 3/5/09 |
| _A | 11/13/07 | 1/13/06 | 11/13/07 | 2/15/09 |
| _A | 11/29/06 | 7/29/05 | 11/27/06 | 2/9/09 |
| _G | 11/8/93 | 11/8/93 | 11/8/93 | 1/15/09 |

*Only last initials are provided to protect confidentiality.

**Current recommendation**:
Continue current practice.

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<td>I.1.a.v</td>
<td>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current practice.<br><br>Findings:<br>As demonstrated in the table above, all staff members signed the mandatory reporter acknowledgement prior to or on the date of hire except for the staff member hired in 1981 (likely prior to the requirement), who signed five years later.<br><br>Current recommendation:<br>Continue current practice.</td>
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<td>I.1.a.vi</td>
<td>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current practice.<br><br>Findings:<br>As shown in the table below, all individuals reviewed have signed (or refused to sign) the statement of rights within the last year.
<table>
<tr><th>Individual</th><th>Date of most recent signing</th></tr>
<tr><td>RR</td><td>9/24/09</td></tr>
<tr><td>MC</td><td>9/23/09 (refused)</td></tr>
<tr><td>EM</td><td>9/14/09</td></tr>
<tr><td>RH</td><td>8/25/09</td></tr>
<tr><td>JM</td><td>8/19/09</td></tr>
<tr><td>RJ</td><td>8/19/09</td></tr>
<tr><td>MK</td><td>8/5/09</td></tr>
<tr><td>RG</td><td>7/8/09</td></tr>
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| | | GH 5/5/09<br>RR 3/16/09<br>KR 12/11/08<br>DS 12/4/08<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.vii | posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>In each of the units inspected, the Rights poster was on a wall in a common area and included the names of the Patient Rights Advocates. Staff reported that an internal phone line accessible to individuals on each unit rings directly in the PRA's office.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.a.viii | procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue to review SIRs and make necessary changes in the SIR database to ensure its accuracy.<br><br>**Findings:**<br>The review of 18 SIRs found no errors. This represents substantial improvement over the findings from the previous review. A Standards Compliance staff member completes a comprehensive review of A/N SIRs that includes the quality of the responses in the narrative portions, as |

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| | | well as the accuracy and completeness of the coding. When there is insufficient information, the unit is asked to supply that which is lacking.<br><br>**Recommendation 2, April 2009:**<br>Follow the advice of DMH counsel in defining and handling incidents of sexual contact among individuals.<br><br>**Findings:**<br>As noted earlier, an Administrative Directive related to handling incidents of consensual sexual activity is under review.<br><br>**Other findings:**<br>Three of the investigations reviewed included notice that the case had been forwarded to the District Attorney (and in each case rejected): the investigation of the allegation by EC of physical abuse (7/14/09), the allegation by RH of the use of excessive force (7/24/09) and the investigation of the allegation of sexual assault of MC (6/22/09).<br><br>**Current recommendation**:<br>Continue current practice, including self-monitoring and data analysis, as warranted. |
| I.1.a.ix | mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice of questioning individuals about why they have changed the particulars of their complaint or why they have withdrawn the complaint, cognizant that this could be the result of intimidation.<br><br>**Findings:**<br>In two investigations reviewed, the investigator questioned the individual, asking if he had been threatened in any way to withdraw his complaint. These were the investigation of the 6/23/09 allegation of neglect made |

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| | | by LR and the 7/27/09 allegation of sexual assault made by WP.<br><br>**Other findings:**<br>Four staff members were identified in the investigations reviewed as having failed to report allegations of A/N as required by agency policy. No action was taken or is pending for one staff member (related to the 3/11/09 allegation of physical abuse). A letter of instruction was presented to a second staff member, and an official reprimand is pending for a third. The fourth staff member figured in several allegations and was dismissed while on probation.<br><br>**Current recommendation**:<br>Ensure HR is tracking all findings of violation of statute and policy to ensure appropriate action is taken. |
| I.1.b | Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall: | **Compliance:**<br>Substantial—assuming effective implementation of corrective actions written into policies and procedures by the facility during this review. |
| I.1.b.i | require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Document progress (perhaps using a task tracker) in implementing the recommendations resulting from both internal and external death reviews. Pay particular attention to the recommendations of the 2/24/09 MIRC recommendations based on the Independent Reviewer's recommendations related to the death of DM and the MIRC recommendations related to the death of LA [discussed in this cell in the previous report]. |

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| | | **Findings:**<br>The facility provided no response to this recommendation.<br><br>**Other findings:**<br>Review of documents related to the death of TT (5/16/09) revealed that all were completed within the timeframes specified in SO 205.05: Mortality Review. The final MIRC review (6/26/09) addressed all of the issues raised by the External Independent Review except the finding that the WRPT did not consider whether the change in seizure medication might be a factor in the re-emergence of TT's seizures after a 15-year seizure-free period. The MIRC minutes state that the revised SO 136: Provision of Medical Care to Individuals addresses the topic of seizures.<br><br>**Current recommendation**:<br>During the maintenance phase, ensure that SO 136 and other relevant policies address the issues raised by TT's death (factors affecting the re-emergence of an active seizure disorder). |
| I.1.b.ii | ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>All investigations are completed by members of the hospital police force or the Office of Special Investigations who have had training in the conduct of investigations.<br><br>**Other findings:**<br>Lt. Landrum reported that ASH presently has two full-time Special Investigators and nine retired annuitants working in OSI. |

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| | | **Current recommendation**:<br>Continue current practice. |
| I.1.b.iii | investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>One investigation reviewed (allegation of sexual assault of WP on 7/24/09) specifically documented taking custody of physical evidence, bagging and recording it, and placing it in an evidence storage locker.<br><br>**Current recommendation**:<br>Continue current practice. |
| I.1.b.iv | 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: | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue working on the timely completion of investigations.<br><br>**Findings:**<br>Please see I.1.b.iv.2.<br><br>**Other findings:**<br>Sections I.1.b.iv.3(ii) and I.1.b.iv.3(ix) identify problems in two of the investigations reviewed.<br><br>**Current recommendation**:<br>Continue working toward compliance with this section of the EP, through the close review of the quality and timeliness of investigations. |

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<td>I.1.b.iv.1</td>
<td>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</td>
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**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Continue taking measures to improve the timeliness of OSI investigations.

**Findings:**
The facility reports that all investigations closed during the review period met this EP requirement.

**Other findings:**
All investigations reviewed commenced within 24 hours of the report of the incident.

**Current recommendation**:
Continue current practice.
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<td>I.1.b.iv.2</td>
<td>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</td>
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**Current findings on previous recommendation:**

**Recommendation, April 2009:**
Implement actions to ensure that investigations commence as quickly as possible once the incident is turned over to OSI.

**Findings:**
As indicated in the table below, of the 11 relevant investigations, seven were completed within 30 business days.

<table>
<tr><th>Incident type</th><th>Date incident reported</th><th>Date of first OSI interview</th><th>Date investigation closed</th></tr>
<tr><td>Physical abuse allegation</td><td>3/16/09</td><td>4/9/09</td><td>5/21/09</td></tr>
<tr><td>Physical abuse allegation</td><td>3/16/09</td><td>Begun after close of the criminal inv.</td><td>7/8/09</td></tr>
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<tr><td>Verbal abuse allegation</td><td>5/19/09</td><td>5/26/09</td><td>6/22/09</td></tr>
<tr><td>Neglect allegation</td><td>5/28/09</td><td>6/10/09</td><td>6/23/09</td></tr>
<tr><td>Verbal abuse allegation</td><td>6/5/09</td><td>6/9/09</td><td>6/24/09</td></tr>
<tr><td>Sexual assault allegation</td><td>6/22/09</td><td>Criminal inv.</td><td>6/25/09</td></tr>
<tr><td>Neglect allegation</td><td>6/23/09</td><td>7/7/09</td><td>8/7/09</td></tr>
<tr><td>Neglect allegation</td><td>7/12/09</td><td>8/5/09</td><td>8/10/09</td></tr>
<tr><td>Physical abuse allegation</td><td>7/14/09</td><td>7/20/09</td><td>8/19/09</td></tr>
<tr><td>Sexual assault allegation</td><td>7/27/09</td><td>Criminal inv.</td><td>7/31/09</td></tr>
<tr><td>Excessive force alleg.</td><td>8/13/09</td><td>8/13/09</td><td>10/2/09</td></tr>
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<br>
Other findings:<br>
The facility reports during the period March-August 2009, 68% of the investigations were completed within 30 business days. As of October 21, the OSI had six open investigations, none of which were overdue.<br><br>
Current recommendation:<br>
Continue to work to close investigations during the timeframe specified in the EP.
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<td>I.1.b.iv.<br>3</td>
<td>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</td>
<td>
Current findings on previous recommendation:<br><br>
Recommendation, April 2009:<br>
Continue the practice of tracking IMRC recommendations using the Task Tracker.<br><br>
Findings:<br>
The IMRC has continued to use the Task Tracker to document recommendations and their implementation.<br><br>
Other findings:<br>
The investigations reviewed each resulted in a written investigation report. The report was forwarded to HR or other bodies as appropriate for identification of corrective action recommendations.
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| | | **Current recommendation**:<br>Continue current practice of forwarding investigations to appropriate bodies for review and implementation of recommendations. |
| I.1.b.iv. 3(i) | each allegation of wrongdoing investigated; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Be alert to incidents of failure to report allegations as prescribed in policy. Include these findings in investigations and make recommendations that the appropriate body review them and take action in accordance with established guidelines.<br><br>**Findings:**<br>As described previously, in three investigations reviewed a total of four staff members were identified as having failed to report A/N allegations.<br><br>**Recommendation 2, April 2009:**<br>Identify the type of each incident under review in the IMRC minutes.<br><br>**Findings:**<br>The IMRC minutes beginning on July 23, 2009 identify the type of incident being reviewed.<br><br>**Other findings:**<br>The investigations reviewed clearly identified the wrongdoing under investigation—citing penal law in the criminal investigations.<br><br>**Current recommendation**:<br>Continue current practice, including self-monitoring and data analysis, as indicated. |

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| I.1.b.iv. 3(ii) | the name(s) of all witnesses; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Investigation supervisors and the IMRC should ensure that all investigations of incidents that occur in a location where individuals are likely to have been present question staff and individuals in an effort to identify all witnesses—both staff and individuals.<br><br>**Findings:**<br>The 3/16/09 allegation of physical abuse made by a staff member alleges that another staff member encourages individuals to fight and refuses to give them medication. According to this monitor's review and notes, four staff members were interviewed, but no individuals.<br><br>**Other findings:**<br>Members of the IMRC review the SIR, HQ brief and an Executive Summary of each incident under review. The complete investigation is available at the meeting, should any member request additional information. The content of the Executive Summaries varied widely. Some gave a succinct synopsis of the findings; others were only a recitation of the allegation and the determination (sustained or not sustained). In order for the IMRC to consider the quality of an investigation, the members need to review either the entire investigation or set minimum standards regarding what information should be included in the Executive Summary. The dearth of information regarding the conduct of the investigation may have contributed to the IMRC's not identifying the problem in the investigation discussed above. The Committee leadership agreed to ensure that each member reviews sufficient information upon which to make judgments about the quality of the investigation.<br><br>**Current recommendation:**<br>Ensure, as agreed, that the IMRC reviews sufficient information to form |

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| | | a sound judgment regarding the quality of investigations. |
| I.1.b.iv. 3(iii) | the name(s) of all alleged victims and perpetrators; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Identify the source of the discrepancies between the Query Case List and the listing of closed cases (sorted by complainant) and take steps to correct it.<br><br>**Findings:**<br>Several investigations reviewed did not appear on the A/N Activity Listing produced by the RMS. In response to this finding, staff identified the source of the problem: the RMS system sometimes fails to assign a disposition date to a case, leaving the case "in suspension." ASH will work with the vendor to have this corrected. In a memo dated 10/20/09, the facility further identified back-up procedures to identify and correct any problems until RMS is reliable. These call for the monthly review of the A/N Case Activity Listing, checking the status of any case without a disposition or without a disposition date.<br><br>**Recommendation 2, April 2009:**<br>Reference the review of the incident history of both the named staff members and the alleged victims in A/N/E investigations.<br><br>**Findings:**<br>ASH has determined that investigators will not review the incident history of persons involved in incidents under investigation. Rather, the IMRC will review this information for the named staff member when it reviews the case. Beginning with the April 30 meeting, the IMRC minutes consistently identify any prior cases in which the staff member has been the named subject and the determination made in the case. |

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| | | **Current recommendation**:<br>Implement the plan described in the 10/20/09 memo to ensure that all closed A/N cases are listed on the A/N Activity Listings. |
| I.1.b.iv. 3(iv) | the names of all persons interviewed during the investigation; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Supervise investigations to ensure that all likely persons who may have witnessed an incident are identified and questioned.<br><br>**Findings:**<br>In several of the investigations reviewed, the investigator asked if anyone else could have witnessed the incident. Examples include the 5/19/09 verbal abuse and the 6/23/09 neglect investigations. In contrast, as described in I.1.b.iv.3(ii), no individuals who might have witnessed the incident under investigation were interviewed.<br><br>**Current recommendation**:<br>Ensure that all persons who may have witnessed an incident are identified and questioned. |
| I.1.b.iv. 3(v) | a summary of each interview; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Ensure that all likely witnesses are questioned about their knowledge of the incident under investigation.<br><br>**Findings:**<br>See findings in I.1.b.iv.3(iv).<br><br>**Recommendation 2, April 2009:**<br>Conduct interviews as proximate to the incident as possible. |

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| | | **Findings:**<br>See findings in the chart in I.1.b.iv.2. In the eight relevant investigations reviewed, the first OSI interviews were conducted as near to the report of the incident as the very same day and as remote as 23 days after the report of the incident.<br><br>**Other findings:**<br>In all of the investigations reviewed, the investigator provided the date, time and location of interviews conducted, along with a summary of the contents.<br><br>**Current recommendation**:<br>Continue current practice of providing the date, time, location and summary of interviews in the investigation reports. |
| I.1.b.iv. 3(vi) | a list of all documents reviewed during the investigation; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>When documents are reviewed and they contain (or fail to contain when expected) information relevant to the case, either attach them or quote them in the report.<br><br>**Findings:**<br>Two investigations reviewed yielded findings regarding the review of relevant documents to complete an investigation. In the investigation of the 7/12/09 allegation of neglect (failure to give a medication when requested), the investigator reviewed and documented the content of the physician's order and the MAR. The use of a photo to identify the named staff member in the investigation of the use of excessive force (7/24/09) similarly moved the investigation forward. In contrast, during that same investigation, the investigator failed to review and document the physician's evaluation of the individual's injuries. |

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| | | **Current recommendation**:<br>During the maintenance phase, continue current practice of providing a second-level thorough review of all OSI investigations. Ensure this review is completed prior to review by the IMRC. |
| I.1.b.iv. 3(vii) | all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s); | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Cite in the investigations the review of the incident history of the individual making the allegation and the named staff member. The IMRC should be looking for this information in the investigations and noting its absence.<br><br>**Findings:**<br>As reported, ASH has determined that it will not review the incident history of the staff members or individuals involved in incidents during an investigation. Instead, the incident history of the staff member is reviewed by the IMRC and documented in the minutes. This practice began with the April 30 meeting. There is no documented formal review of the individual's incident history.<br><br>**Current recommendation**:<br>Review the relevant history of the individual (victim) during the review of investigations of abuse/neglect. |
| I.1.b.iv. 3(viii) | the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Cite the relevant section of the incident definition when writing rationales for determinations.<br><br>**Findings:**<br>This recommendation had not yet been implemented and would have likely |

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| | | identified the lack of congruence between the SIR definition of verbal abuse and the penal law definitions of dependent adult abuse that are used in completing the SOC 341. As reported in I.1.b.iv.3(vi), this has been corrected.<br><br>**Other findings:**<br>Several of the investigations reviewed included violations of policy among the findings. These included violations of the policy regarding seclusion (5/25/09 neglect allegation), violation of AD 103 regarding discourteous treatment and violations of AD 518 for dishonesty (6/23/09 neglect allegation).<br><br>**Current recommendation**:<br>Continue current practice, including self-monitoring. |
| I.1.b.iv. 3(ix) | the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that all persons who may have witnessed an incident are interviewed and the reconciliation of their statements, to the degree possible, is documented in the investigation report.<br><br>**Findings:**<br>In the investigation of the allegation of physical abuse (7/14/09), the named staff member was interviewed initially and said, "I put my hand up to his neck and I pushed [victim] back toward the wall." In the second interview, the staff member said he put his right hand out at chest level to create some space between them. The investigator did not confront the staff member with the inconsistencies in an effort to clarify the circumstances of this incident.<br><br>**Current recommendation**:<br>Ensure that what appear to be irreconcilable accounts of an incident do |

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| | | not go unaddressed. |
| I.1.b.iv.4 | staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Match allegations with incident definitions and match rationales for determinations with incident definitions. Supervisors should return investigations that do not adopt this procedure.<br><br>**Findings:**<br>This recommendation had not yet been implemented. The facility reports that investigators began citing the portion of the incident definition that is relevant to their findings in late September 2009.<br><br>**Other findings:**<br>See I.1.b.iv.3(vi) for a discussion of the importance of the second review of investigations to ensure that they comply with the requirements of the EP.<br><br>**Current recommendations**:<br>1. Continue current practice of conducting a second review of completed investigations to ensure their compliance with the EP standards.<br>2. Match rationales for determinations with the relevant elements of the incident definitions. |
| I.1.c | Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes. | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Remind WRPTs of the need to document the review of all incidents that occurred since the last treatment conference and address them as necessary. |

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| | | **Findings:**<br>Please see I.2.b.iv.<br><br>**Recommendation 2, April 2009:**<br>Move forward with disciplinary actions and training recommended following incidents as quickly as possible.<br><br>**Findings:**<br>Corrective actions were implemented or are in process in several investigations reviewed. These include:<br><br>• An adverse action has been requested for the staff member found to have neglected the individual in the 6/23/09 incident.<br>• Memorialization of verbal counseling has been proposed for the staff member who falsified a record in the 6/23/09 incident.<br>• A request for adverse action has been submitted for the named staff member determined to have failed to report an A/N/E allegation (6/5/09).<br>• Following verbal counseling, a letter of instruction will be given to the named staff members in the sustained case of neglect (7/12/09).<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendations**:<br>1. Continue current practice, ensuring that HR addresses and records all corrective actions related to the actions of staff members.<br>2. Continue the IMRC's current practice of tracking programmatic corrective actions. |
| 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 | **Compliance:**<br>Substantial. |

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| | categories: | |
| I.1.d.i | type of incident; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue efforts to reduce the number of aggressive incidents.<br><br>**Findings:**<br>Please see I.2.a.iii, which describes the facility's work in identifying factors that contribute to violence and discerning patterns in incidents of aggression.<br><br>**Recommendation 2, April 2009:**<br>Continue to share data on incidents involving violence with the IMRC and other appropriate bodies.<br><br>**Findings:**<br>Data and analysis of incidents of violence are presented in the Violence Risk Management Committee reports, which are prepared for review by the Quality Council.<br><br>**Other findings:**<br>See I.2.a.iii for data showing a decrease in incidents of violence in August and September. Facility data related to allegations of abuse (all types) show the following frequency: |

| Allegation type | December 2009 – February 2009 | March-May 2009 | June-August 2009 |
|---|---|---|---|
| Physical abuse | 13 | 13 | 17 |
| Verbal abuse | 18 | 16 | 11 |
| Psychological abuse | 4 | 3 | 1 |
| Neglect | 7 | 13 | 6 |

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| | | **Current recommendation**:<br>Continue current practice, including self-monitoring and data analysis. |
| I.1.d.ii | staff involved and staff present; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Provide analysis of the listings produced by the RMS, so that the receiving bodies are presented with usable information.<br><br>**Findings:**<br>This recommendation has not yet been implemented.<br><br>**Other findings:**<br>The facility produced a listing of all staff members identified as subjects in A/N/E investigations for the period March through August 2009 that included the date and type of allegation and the disposition. The current document identifies 88 staff members named as subjects in A/N/E investigations, compared with 133 in the report for the prior six months. One staff member was listed as the subject of more than one A/N/E investigation in the current report.<br><br>The facility also produced a monthly report through August 2009 that listed each A/N/E investigation and all of the persons involved along with the code identifying their involvement—witness, victim, subject, etc.<br><br>The facility's own analysis of its data indicates that in the period August 1, 2008 - May 31, 2009, two staff members were named as the subjects in more than one (in each case, two) sustained allegation. There were no instances in which an individual was found to have been abused or neglected by the same staff person. During the same period, one single individual was found to have been abused/neglected twice by different staff members. Nine individuals were listed as complainants in more than one incident. |

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| | | Covering a more recent period (August 1, 2008 -August 30, 2009), the number of individuals listed as a complainant in more than one incident jumped from nine to 17, indicating that in the period June—August, eight individuals were complainants in more than one incident. The other figures remained largely unchanged.<br><br>**Current recommendation**:<br>Continue current practice, including self-monitoring and data analysis. |
| I.1.d.iii | individuals directly and indirectly involved; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Take necessary measures to ensure that all A/N/E incidents reported in either the SIR or RMS database also appears in the other database.<br><br>**Findings:**<br>There is some evidence that problems still exist in reconciling the SIR and RMS databases. For example, the RMS victim report (3/1/09-8/31/09) identifies seven individuals as complainants in A/N/E incidents reported in March 2009. The trigger report (based on the SIR database) shows 10 individuals as having made A/N/E allegations during the month. Similarly, the same RMS report shows 16 individuals as complainants in July, but the trigger report shows 20.<br><br>**Recommendation 2, April 2009:**<br>Continue the practice of identifying individuals who are highly aggressive and begin identifying individuals who are repeat victims.<br><br>**Findings:**<br>The facility has produced a list of individuals who have been repeat victims and a list of individuals who have been involved in incidents of aggression. This latter listing is in rank order with the individuals with |

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| | | the most aggressive incidents heading the list.<br><br>**Other findings:**<br>Review of the RMS report covering March 1 through August 2009 reveals that 49 individuals reported allegations of A/N/E. Eight of the 49 individuals made more than one allegation. An additional RMS report for the period August 2008 through August 2009 identifies 114 individuals as having alleged A/N/E.<br><br>**Current recommendation:**<br>During the maintenance phase, identify and take the necessary steps to ensure that the RMS and SIR databases reconcile. |
| I.1.d.iv | location of incident; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Determine the source of the discrepancy between the SIR and RMS databases and take appropriate corrective actions.<br><br>**Findings:**<br>See findings in the cell above.<br><br>**Recommendation 2, April 2009:**<br>Continue the facility's work in studying patterns of violence and initiating measures to stem it.<br><br>**Findings:**<br>See the findings in the Performance Improvement section of this report. The facility's work in this area has continued and expanded.<br><br>**Other findings:**<br>The facility's graphed data shows that in the period March 2009—August 2009, Program VII was the site of the highest number of assaults with |

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| | | approximately 176. The next highest was Program VI with approximately 144. Program V with approximately 52 had the fewest number of assaults.<br><br>**Current recommendation**:<br>Continue current practice, including self-monitoring and data analysis. |
| I.1.d.v | date and time of incident; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue collecting data on the time of day of incidents and implement plans for reducing violence in hopes that data in succeeding months will show a positive outcome in violence reduction.<br><br>**Findings:**<br>This work has continued. Recent data produced and analyzed by the facility indicates that there is no statistical difference in the frequency of assaults among the days of the week, although most recently (March-August 2009) Sunday was the calmest day and Wednesday the day with the highest number of aggressive incidents.<br><br>The facility's data and analysis clearly show that more assaults occur on evenings, with many occurring as individuals are going to and from the dining room. The facility's analysis came to the conclusion that about one third of the assaults during peak hours occurred when individuals were not engaged in a specific activity or were being asked to start or stop an activity. The facility additionally identified numerous recommendations for reducing assaults based on its review of violence data.<br><br>**Recommendation 2, April 2009:**<br>Continue to reconcile the SIR and the DPS information systems. |

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| | | **Findings:**<br>See findings in I.1.d.iii.<br><br>**Current recommendation:**<br>Continue current practice of presenting data in an attractive and informative format accompanied by analysis as in the reports by the Violence Risk Management Committee. |
| I.1.d.vi | cause(s) of incident; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue current practice of completing HQ briefs with relevant information in each section.<br><br>**Findings:**<br>Review of ten HQ briefs revealed that they addressed pertinent issues such as the reassignment of staff while the incidents were investigated, forwarding allegations to the DA, WRPT discussion of the incident, transfer of an assailant or other measures to protect a victim from further harm, and counseling or discipline for staff members.<br><br>**Recommendation 2, April 2009:**<br>Improve the timeliness of the briefs.<br><br>**Findings:**<br>In each case the HQ brief was reviewed by the IMRC. The briefs were completed within a reasonable time after completion of the investigation. |

| Incident date | Date of Final HQ Brief | Meets 60 business day timetable? |
|---|---|---|
| 7/2/09 | 8/27/09 | Yes |
| 7/4/09 | 8/20/09 | Yes |
| 7/10/09 | 8/10/09 | Yes |

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<tr><td></td><td></td><td>
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<tr><td>7/12/09</td><td>10/16/09</td><td>No</td></tr>
<tr><td>7/14/09</td><td>9/2/09</td><td>Yes</td></tr>
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<br>In several of the briefs, the closure date was not recorded.<br><br>Other findings:<br>See also the cell above describing the facility's identification of factors contributing to assaults and recommendations for addressing the behavior.<br><br>Current recommendation:<br>Continue current practice.</td></tr>
<tr><td>I.1.d.vii</td><td>outcome of investigation.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Make RMS investigation data available to the IMRC and other appropriate bodies, for example executive leadership, that may review incident trends.<br><br>Findings:<br>See the Performance Improvement section of the report for a description of incident data collected and presented to leadership.<br><br>Other findings:<br>The RMS reports described in I.1.d.i-iii all include the outcome/disposition of the investigation.<br><br>Current recommendation:<br>Continue current practice, including analysis of the data.</td></tr>
<tr><td>I.1.e</td><td>Each State hospital shall ensure that before permitting a staff person to work directly with any</td><td>Current findings on previous recommendation:</td></tr>
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| | 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. | **Recommendation, April 2009:**<br>Continue current practice of reviewing staff member's personnel files to ensure background clearance checks have been completed.<br><br>**Findings:**<br>The facility continues to be diligent in ensuring that staff members' background clearance has been completed prior to hire. See the table in I.1.a.iv, showing that all 15 staff members reviewed had cleared the background check on or before their hire date.<br><br>**Other findings:**<br>The facility is using the "risk to the safety or quality treatment of the victim" standard in determining when a staff member should be reassigned during an investigation of an allegation of misconduct. This decision is now documented in the IMRC minutes and reviewed by the committee members.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |

| 2. Performance Improvement | | |
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| I.2 | Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include: | **Methodology:**<br><br><u>Interviewed</u>:<br>1. A. Dehod, PsyD, Unit 20 psychologist<br>2. A. Powers, Unit 1 psychiatric technician<br>3. C. Innis, Unit 1 office technician<br>4. D. Karas, Program Director<br>5. D. Nelson, Standards Compliance Director<br>6. E. Bischof, PhD, PBS psychologist<br>7. G. Paladino, MD, Unit 1 psychiatrist<br>8. G. Vega, MD, Unit 20 psychiatrist<br>9. J. DeMorales, Executive Director<br>10. M Heinze, PhD, Unit 1 psychologist<br>11. M. Hughes, PD and Co-chair Violence Risk Management Committee<br>12. M. Mongin, RN, Unit 1 nurse<br>13. R. Banks, Unit 1 clinical social worker<br>14. R. Spurgeon, Program VII Director<br>15. S. Smith, RN, Unit 1 mentor<br>16. S. Warming, Unit 20 art therapist<br>17. T. Leung, Unit 20 clinical social worker<br>18. T. Wilson, RN, Unit 20 nurse<br><br><u>Reviewed</u>:<br>1. Violence Risk Management Committee Progress Report (October 13, 2009)<br>2. ETRC minutes and recommendations, 3/25/09, 4/8/09,4/15/09, 4/22/09, 5/6/09, 5/13/09, 6/3/09, 8/05/09 and 9/16/09<br>3. MRMC minutes, June-September 2009<br>4. Clinical records of 13 individuals for WRP follow-up of incidents and high-risk status<br>5. Data dashboard reports for eight individuals<br>6. Aggregate trigger data |

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| | | 7. The charts of two individuals (OR and RC) to review implementation of the process and clinical application of Special Order 262<br>8. ASH Trigger Report for OR and RC<br>9. PSSC Individual Summary Report and Recommendations for OR and RC<br>10. PBS Behavioral Assessment for OR<br>11. PBS Plan for OR, 10/13/09<br><br><u>Observed</u>:<br>ETRC meeting |
| I.2.a | Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to: | **Compliance:**<br>Substantial. |
| I.2.a.i | data collection tools and centralized databases to capture and provide information on various categories of high-risk situations; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue development of the information system and expand its use, providing any training users may require.<br><br>**Findings:**<br>In collecting information for each individual on incidents, triggers and the use of restraint and seclusion, the Data Dashboard provides teams with information necessary to identify individuals' risk factors. SIR data has been used by the facility to identify high-risk situations, such as lining up and walking to and from the dining room.<br><br>**Current recommendation**:<br>Continue current practice. |

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| I.2.a.ii | establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1-3, April 2009:**<br>• Continue refining the committee reviews of individuals as their behaviors and medical conditions warrant, as specified in the Risk Management Special Order.<br>• Ensure that reviews at the second level (ETRC, PSCC, and MRMC) include adequate clinical review and rationale for each recommendation.<br>• Ensure that the second level review generates a clinical document that is filed within the individual's record.<br><br>**Findings:**<br>This monitor and his experts interviewed two WRPTs who supported individuals who had crossed established risk management triggers. The following summarizes these episodes:<br><br>Individual \| Unit \| Indicator \| Trigger \| Date(s)<br>OR \| 20 \| Aggressive Act to Others \| 4 or more within 30 days \| Fourth episode occurred on 9/27/09<br>RC \| 1 \| Suicide \| Suicide attempt \| 8/17/09<br><br>The second level reviews included adequate clinical review and rationale for each recommendation.<br><br>**Recommendation 4, April 2009:**<br>Utilize the Task Tracker to integrate second-level recommendations into WRPs.<br><br>**Findings:**<br>The ETRC minutes identify numerous instances in which the second-level recommendations have been integrated into the WRP. The minutes |

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| | | specifically address whether any changes to the WRP are necessary for each individual being reviewed.<br><br>**Recommendation 5, April 2009:**<br>Ensure that all behavior guidelines meet generally accepted guidelines.<br><br>**Findings:**<br>See findings in Section F.2 of this report relating to the quality of behavioral guidelines.<br><br>**Current recommendation**:<br>Continue to implement the Risk Management Special Order. |
| I.2.a.iii | identification of systemic trends and patterns of high risk situations. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue studying the factors related to violence and identifying interventions to decrease its prevalence.<br><br>**Findings:**<br>ASH has studied and analyzed data on violence with the objective of identifying contributing factors and implementing measures to reduce its frequency and intensity. This work began with a study of the literature related to inpatient violence and coupled this with data specific to ASH. Findings included:<br><br>• In the period September 2008-July 2009, there was a nearly steady increase in incidents of assault. This trend has recently reversed and shows a decrease in August and September.<br>• The increase in violence has occurred as the number of individuals admitted on MDO status has increased. These individuals are often unstable when paroled to ASH.<br>• Once identified, high-risk individuals can be effectively treated |

through Behavior Guidelines and Positive Behavior Support Plans. Identification of high-risk individuals is facilitated by the Data Dashboard. This intranet-based application provides aggressor and victimization data on individuals, a rank order listing of individuals engaging in violent behavior, a count of violent incidents by unit and hospital-wide frequency of assault incidents by month.

- The rate of assaults on admission units is more than double the rate on ICF units. Earlier data showed that the majority of assaults occur within the first 90 days of admission.
- The violence risk assessment tool currently in use does not predict acts of inpatient aggression (per SIR data), but some items within the tool were found to be predictive.

**Other findings:**
Trigger data shows a decrease in overall aggression in the last two months of the review period. Staff and individuals both hope this is the beginning of a downward trend.

| Trigger | Jun-Jul | Aug-Sep |
|---|---|---|
| Aggression to self resulting in major injury | 9 | 10 |
| Individuals with two or more aggressive acts to self in seven consecutive days | 9 | 6 |
| Individuals with four or more aggressive acts to self in 30 consecutive days | 3 | 4 |
| Peer-to-peer aggression resulting in major injury | 36 | 22 |
| Aggression to staff resulting in major injury | 19 | 16 |
| Individuals with two or more aggressive acts to others in seven consecutive days | 76 | 50 |
| Individuals with four or more aggressive acts to others in 30 consecutive days | 18 | 13 |

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| | | Any suicide attempts: 2, 5<br>Total: 172, 126<br><br>**Current recommendation:**<br>Continue current practice, including data analysis and review of outcomes. |
| I.2.b | Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to: | **Compliance:**<br>Substantial. |
| I.2.b.i | a hierarchy of interventions by clinical teams that correspond to triggers and thresholds; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue to refine the implementation of the Risk Management Special Order.<br><br>**Findings:**<br>All review committees required under the Risk Management Special Order are meeting regularly. The ETRC minutes use a format that addresses psychiatry, psychology, Program/WRP and PBS/DCAT issues for each individual reviewed and provide a summary of the reason the individual is under review and the review recommendations. The subsequent ETRC reviews of several "Individuals Still Triggering" revealed that the recommendations had been implemented and their effectiveness evaluated. The individuals reviewed included JB, JC, RJ, TN and ZS.<br><br>Review of the MRMC minutes revealed that in the period June-September, the committee reviewed eight individuals, several of them more than once for follow-up. For those individuals reviewed more than once, the committee reviewed the WRP to determine if previous recommendations had been incorporated. Assuming WaRMSS is reliable |

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| | | by January 2010, it will alert the team to review individuals who have been on the High Risk List for six months to determine whether they should remain on the list. If yes, they should be referred to the MRMC.<br><br>**Current recommendation**:<br>Continue current practice, including analysis of outcomes. |
| I.2.b.ii | timely corrective actions by teams and/or disciplines to address systemic trends and patterns; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue identifying and implementing initiatives to reduce aggressive incidents.<br><br>**Findings:**<br>The facility has undertaken a number of initiatives to reduce violence. These include but are not limited to the following:<br><br>• Convening staff from units that have been most successful in maintaining less violence to identify factors that they believe contribute to lower rates of violence. These staff identified reasons including seasoned staff who have worked together for a long time; good communication; "hands-on" Unit Supervisors; therapeutic communication with individuals (Be Respectful); clean and comfortable units; and vigilance with regard to medication regimens. These and other suggestions garnered through dialogue with a lower-violence admission unit were compiled into a flyer by the Health and Safety Department, distributed to the units and published in the weekly staff newspaper.<br>• In response to the finding that the weapon of choice (per review of SIRs) was chairs, the facility has replaced all dayroom chairs with "no throw" chairs.<br>• All doors to single rooms are being replaced to provide a vertical window that will improve staff's ability to see individuals when |

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| | | conducting rounds. The new doors have a lock that allows individuals to lock them from the inside to prevent peers from entering. Staff keys will unlock the door from the outside. ASH expects to complete the door replacement project by May 2010.<br>• The facility is considering the establishment of a Step-Down Unit for individuals coming from prisons. This unit would have enriched clinical and security staffing.<br>• The facility is also considering the establishment of a Security Unit for individual at exceptionally high risk for violence.<br>• The Peaceful Resolution Committee reviews data on violence and undertakes projects to further its objectives. The Committee is planning a "Peace Week" in December.<br>• Units with three or fewer aggressive incidents earn $25 a month. Points earned and spent are tracked on the Data Dashboard.<br>• Two individuals have been appointed to the Quality Council.<br>• Morning motivational meetings are conducted on all units.<br>• ASH has provided additional structured activities in the evening on and off the unit to keep individuals occupied.<br>• Fifteen individuals are currently engaged in Narrative Restructuring Therapy in hopes of enabling them to engage in regular Mall groups at a later date.<br>• Mindfulness training was provided to 17 staff members who will serve as trainers. All staff who have contact with individuals are being trained in Motivational Interviewing.<br>• Revisions in the R/S debriefing form are being considered that would permit staff to quantify triggers, warning signs and suggestions for handling the situation differently.<br><br>**Other findings:**<br>This monitor and his experts interviewed WRPTs who supported individuals who had crossed established risk management triggers (see I.2.a.ii for summary). In regards to process, the interviews revealed that the WRPTs were knowledgeable in regards to the first, second and third |

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| | | levels of the risk management procedures, including how to access these interventions.<br><br>In regards to clinical care, some areas of progress were noted:<br><br>1. Timely review of the incident by a psychiatrist was documented consistently;<br>2. The Present Status section of the case formulation was updated to reflect the trigger event; and<br>3. Behavior guidelines/PBS plans were implemented and modified as clinically appropriate.<br><br>However, for one individual (OR), neither modification of treatment nor justification for maintaining current treatment was documented within 24 hours of the incident.<br><br>**Current recommendation**:<br>Continue current practice of identifying and implementing initiatives to reduce violence at the facility. |
| I.2.b.iii | formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>The facility, through the Data Dashboard, provides teams with listings of incidents in which the individual has been involved, restraint and seclusion use, and triggers.<br><br>**Current recommendation**:<br>Continue current practice. |

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| I.2.b.iv | formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>When possible, return to the practice of projecting the WRP under consideration during Enhanced Trigger Review Committee meeting to ensure the availability of current and accurate information.<br><br>**Findings:**<br>This recommendation has been implemented. During the meeting attended, the availability of the WRP was particularly useful to the discussion in several cases.<br><br>**Recommendation 2, April 2009:**<br>At the ETRC, encourage the active participation of all physicians present in the discussion and formulation of recommendations.<br><br>**Findings:**<br>During the ETRC meeting attended, physicians and psychiatrists were prepared to present the issues under review, offer recommendations and make commitments to accomplish certain tasks.<br><br>**Recommendation 3, April 2009:**<br>Implement plans for Standards Compliance to monitor implementation of trigger-related treatment interventions on a sample basis.<br><br>**Findings:**<br>The facility reports that Standards Compliance monitors WRPs on a sample basis for evidence of implementation of trigger responses. Facility data reports the following:<br><br>Trigger: Implementation rate per WRP review (sample size not specified)<br>Aggressive act to self: 100% |

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|---|---|
| Aggressive act to others | 79% |
| Alleged A/N/E | 80% |
| Restraint | 60% |
| Seclusion | 87% |
| Stat meds | 84% |
| Suicide attempts/threats | 65% |

**Other findings:**
Review of the records of 13 individuals who were involved in incidents or were listed as multiple aggressors or victims on the High Risk lists revealed that of the 15 issues reviewed, 11 were reflected in the individual's WRP. In some instances, objectives and interventions (abbreviated as O and I in the table below) were directed at the behavior. In other instances, this was not the case.

| Individual | Issue | WRP documentation |
|---|---|---|
| AM | 8/17 and 8/27/09 triggers for 1:1 for suicide prevention | WRP dated 10/7/09 includes a long narrative on suicidal risk factors. |
| EM | 6/1/09 suicide attempt | WRP dated 6/3/09 says "no recent history of suicide." Risk factors cite high risk for suicide and provide a description of the 6/1/09 incident. WRP dated 7/2/09 added O and I directed at depression. |
| JC | On High Risk list for victimization | WRP dated 10/28/09 (draft) lists victimization as a risk factor. |
| JR | 7/09 sexual assault aggressor | No mention of incident. |
| JT | 8/19/09 suicide attempt and 8/19 sexual incident | WRP dated 9/28/09 mentions suicide attempt in Present Status. Focus 3.3 addresses sexual |

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| | | | | incident behavior. |
| | | JW | 8/29/09 allegation of sexual abuse | 8/29/09 IDN describes the allegation. JW was discharged back to corrections on 9/3/09. |
| | | KW | Among the 17 individuals who account for 25% of incidents of aggression | WRP dated 10/24/09 (draft) lists violence and aggression as risk factors. |
| | | LB | On High Risk list for victimization | WRP dated 10/28/09 (draft) references his being on the high risk list for victimization at one time. "No incidents of victimization in the last month." |
| | | RC | 8/17/09 SIB leading to hospitalization | WRP dated 9/25/09 cites the incident and subsequent surgeries in Present Status. No O or I are directed at SIB. Focus 6.7 addresses managing resulting colostomy. |
| | | RH | 6/25/09 suicide attempt | WRP dated 9/1/09 notes this incident under triggers in Present Status. Focus 3.1 addresses self-calming skills to minimize self-harm. |
| | | RH | 7/6/09 allegation of sexual abuse | Incident is mentioned in WRP dated 9/1/09. |
| | | RH | 7/18/09 allegation of sexual abuse | WRPs dated 8/13 and 8/28/09 make no mention of incident. |
| | | RH | 8/19/09 allegation of physical abuse | WRP dated 8/28/09 mentions incident in trigger response section of Present Status. |
| | | SJ | 7/28/09 allegation | WRPs dated 8/11 and 9/10/09 |

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<tr><td></td><td>of sexual assault</td><td>make no mention of the incident.</td></tr>
<tr><td>WP</td><td>7/27/09 allegation of sexual assault</td><td>WRPs dated 8/20 and 9/23/09 make no mention of the incident.</td></tr>
</table>
<br>The Data Dashboard provides a listing of all incidents (including date, type, location and SIR number) for each individual, making it easier for WRPTs to ensure that each incident is mentioned in the WRP and addressed as appropriate.<br><br>Current recommendation:<br>Ensure that the WRP cites all incidents that occurred since the last review and addresses them with treatment objectives and interventions as warranted.
</td></tr>
<tr><td>I.2.b.v</td><td>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Proceed with plans to audit implementation of interventions in response to triggers.<br><br>Findings:<br>See findings in I.2.a.ii which describe the follow-up provided by the ETRC for individuals who continue to trigger.<br><br>Current recommendation:<br>Continue current practice, including analysis of outcomes.</td></tr>
<tr><td>I.2.c</td><td>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</td><td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue current practice of studying violence in the facility and identifying and implementing measures aimed at making the environment safer.</td></tr>
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| | | **Findings:**<br>See the findings in I.2.a.iii and I.2.b.ii.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice, including analysis of outcomes. |

| 3. Environmental Conditions | | |
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| I.3 | Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that: | **Methodology:**<br><br>Interviewed:<br>1. E. Dawson, Assistant Hospital Administrator<br>2. L. Euler, Chief of Plant Operations<br>3. S. Everett, Health and Safety Officer<br><br>These staff members and supervisory unit staff led the environmental tour, offered information, and answered questions.<br><br>Reviewed:<br>1. September staff injury report<br>2. Suicide Prevention Compliance Reports for March-August 2009<br>3. October 14 memo from Clinical Administrator re Housekeeping and General Cleanliness of Units<br>4. AD 610.7: Housekeeping of Bed/Dorm Rooms<br>5. AD 610.3: Storage of Patient Property on Units<br>6. Clinical records of seven individuals with the problem of incontinence<br>7. Clinical records of seven individuals involved in sexual incidents<br>8. AD under review re Condoms<br><br>Toured:<br>Three units: 14, 18 and 31 |
| I.3.a | Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible; | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue with plans to provide additional storage space for individuals in their bedrooms.<br><br>**Findings:**<br>The facility reports that 555 solid-state "no throw" bedside tables that |

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| | | provide storage space have been distributed to individuals and an additional 375 are on order. These tables were in use on Unit 31.<br><br>**Recommendation 2, April 2009:**<br>Continue with plans to install the small mesh vents [described by the facility as stainless steel vent covers with 5/32" perforations] and to replace the bedroom doors with ones that lock from the inside and have a vertical window.<br><br>**Findings:**<br>This work has continued and these safety improvements were observed: stainless steel covers with 5/32" perforations have been placed over the vents in single bedrooms. This work is done at the same time as the doors are replaced with ones with vertical windows and locks that can be locked from the inside (opened from the outside by key).<br><br>**Recommendation 3, April 2009:**<br>Continue with plans to submit a budget proposal for remodeling the bedrooms.<br><br>**Findings:**<br>This recommendation should have read "bathrooms" rather than bedrooms. The facility reports that the bathroom remodeling project (removing the suicide hazard related to stall uprights) is estimated to begin in February 2010 and be completed in June 2010, as budget approval and funds have been awarded.<br><br>**Recommendation 4, April 2009:**<br>Inform all staff on Unit 6 about the incident and the suicide hazard presented by the stall uprights.<br><br>**Findings:**<br>The facility reports that immediately following the last review and |

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| | | additional times thereafter, staff have been made aware of the circumstances of the incident and the suicide hazard presented by the stall uprights.<br><br>**Recommendation 5, April 2009:**<br>Remind sponsors of individuals who require assistance in keeping their person and/or personal space clean to write illustrative notes.<br><br>**Findings:**<br>The inspections this tour found individuals' personal spaces to be reasonably clean for the most part. This may be due, in part, to a memo from the Clinical Administrator (10/14/08) requiring all program management and nursing staff to review AD 610.7. This policy requires a daily "walk through" review of the unit by the AM and PM shift, the establishment of ADL Mall groups, and sponsor assistance in cleaning an individual's personal space when he is unable to keep the space clean, among other measures.<br><br>Collections of used Styrofoam cups (sometimes containing juice or coffee) were present in a number of bedrooms and could lead to an infestation problem. The facility agreed to review this issue and determine how to reduce the quantity of used cups, while ensuring that individuals have a drinking cup available.<br><br>**Recommendation 6, April 2009:**<br>Inform all inspectors of the suicide hazards in the bathrooms and review the inspection reports to ensure they reflect this understanding. Direct inspectors to discuss these hazards with unit staff at the conclusion of the unit inspection.<br><br>**Findings:**<br>There is evidence in the Suicide Prevention Compliance Reports that inspectors are cognizant of the suicide hazards in the bathrooms, as |

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<td>cited below. These reports address 25 suicide hazards and cover such issues as "cut down" instruments, break-away shower hooks and curtain rods, surface-mounted shower heads, and light fixtures that pose no hanging risk.

<table>
<tr><th></th><th>Number of relevant bathrooms inspected</th><th>Number of bathrooms found noncompliant with suicide prevention</th></tr>
<tr><td>March</td><td>4</td><td>4</td></tr>
<tr><td>April</td><td>9</td><td>7</td></tr>
<tr><td>May</td><td>5</td><td>3</td></tr>
<tr><td>June</td><td>6</td><td>2</td></tr>
<tr><td>July</td><td>9</td><td>6</td></tr>
<tr><td>August</td><td>4</td><td>4</td></tr>
</table>

Other findings:<br>
Review of the September staff injury report found that 11 staff members suffered physical injuries related to assaults by individuals or during containments. These 11 staff members lost 38 work days.

Compliance:<br>
Substantial.

Current recommendation:<br>
Continue current practice.</td>
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<td>I.3.b</td>
<td>All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;</td>
<td>Current findings on previous recommendation:<br><br>Recommendation, April 2009:<br>Continue the practice of monitoring unit temperatures, including a sample of bedrooms, when it is very warm outside.</td>
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| | | **Findings:**<br>Temperature monitoring has been ongoing during the warm weather.<br><br>**Other findings:**<br>The Health and Safety Officer reported that the facility has installed new sensors in various areas of the building that monitor temperatures electronically. Review of temperature graphs produced by this system indicates that the temperature has been maintained nearly consistently between 68 and73 degrees. There were no extreme outliers.<br><br>**Compliance:**<br>Substantial.<br><br>**Current recommendation**:<br>Continue current practice. |
| 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; | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Continue current practice.<br><br>**Findings:**<br>See below.<br><br>**Other findings:**<br>As presented in the table below, the WRPs of each of the individuals randomly selected for review addressed the problem of incontinence. In most instances, the nursing notes addressed the outcome of the nursing teaching listed as one of the treatment interventions. These positive findings are consistent with the facility's audit findings. In all instances, the facility audit found that nurses were able to describe how they attempted to assist the individual to prevent episodes of incontinence and how they assist him with this problem. |

| Individual | Mentioned/ addressed in WRP | Contents |
|---|---|---|
| JR | WRP 10/6/09 Focus 6.16 | Explain bladder training. 9/29 RN weekly note addresses training. |
| PC | WRP 10/9/09 Focus 6.25 | Teach reducing fluid intake, void before bed. RN weekly notes 9/2-10/16 make no mention of training. |
| OP | WRP 9/15/09 Focus 6.6 | RN to provide training to reduce the problem. RN monthly note (8/6/09) addresses response to teaching. |
| SO | WRP 9/8/09 Focus 6.33 | Monthly meeting with RN to discuss self-care. Monthly RN notes (8/12 and 9/8) cite substantial improvement in condition. |
| ES | WRP 9/24/09 Focus 6.2 | RN to teach methods for handling the problem monthly. RN monthly note reports progress. |
| MW | WRP 9/22/09 Focus 6.5 | RN to meet with individual once a week. [WRP viewed electronically. Outcome not reviewed; notes not available electronically.] |
| AF | WRP 9/28/09 Focus 6.10 | RN to discuss ways to decrease problem. [WRP viewed electronically. Outcome not reviewed; notes not available electronically.] |

**Compliance:**
Substantial.

**Current recommendation**:
Continue current practice.

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| I.3.d | Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and | **Current findings on previous recommendations:**<br><br>**Recommendations 1 and 2, April 2009:**<br>• Provide guidance to individuals on sexual conduct so that they can protect themselves against referral to outside law enforcement.<br>• Proceed with plans for counsel from DMH attorneys regarding sexual incidents at the facility.<br><br>**Findings:**<br>The facility has written and is reviewing a new AD addressing sexual activity among individuals at ASH. The AD clearly states that ASH does not sanction sexual activity among individuals and recommends that they not engage in sexual activity "as there is a strong likelihood that sexual relationships can divert energy and attention away from the Recovery process." The facility will provide condoms to individuals who chose to have protected sex with one another, however.<br><br>**Other findings:**<br>A review of the records of seven individuals involved in sexual incidents found that each of the incidents was described in an IDN. The psychiatrist, psychologist or WRPT documented actions in three of the six relevant incidents. |

| Individual | Incident date | Addressed in IDN? | Addressed by WRPT, psychologist or psychiatrist? |
|---|---|---|---|
| MC | 6/24/09 | Yes | Yes |
| RH | 7/18/09 | Yes | No |
| RH | 7/25/09 | Yes | Yes |
| JR | 7/28/09 | Yes | No |
| SJ | 7/28/09 | Yes | No |
| WP | 7/29/09 | Yes | Yes |
| JW | 8/29/09 | Yes | Discharged following incident |

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| | | **Compliance:**<br>Partial.<br><br>**Current recommendation**:<br>Continue to advise staff of the requirements of the EP related to sexual incidents. |
| I.3.e | Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns. | **Current findings on previous recommendation:**<br><br>**Recommendation, April 2009:**<br>Ensure that all Mall providers are current on annual A/N training.<br><br>**Findings:**<br>The facility reports that all non-clinical Mall providers are current with all required trainings as well as annual A/N training.<br><br>**Compliance:**<br>Substantial based on the facility's information.<br><br>**Current recommendation**:<br>Continue current practice. |

| J. First Amendment and Due Process | | |
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| J | | **Summary of Progress:**<br>1. HAC participants acknowledged the efforts the facility is making to reduce violence and identified several of these measures such as the incentive program, increased evening activities and expanded library hours as enriching the quality of their lives.<br>2. Participants at the HAC meeting spoke in terms of teaming up with administration to make life better at the facility. Improvements in environmental cleanliness and in Mall groups and scheduling and an increase in job opportunities received particular mention.<br>3. Two individuals have been appointed to the Quality Council. |
| J | Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process. | **Methodology:**<br><br>Reviewed:<br>1. HAC Requests and Accomplishments list<br>2. Individuals Survey results<br><br>Participated:<br>Hospital Advisory Council Chairmen's meeting (via phone) |
| J | | **Current findings on previous recommendations:**<br><br>**Recommendation 1, April 2009:**<br>Continue to remain responsive to the concerns brought to the facility's attention through the leadership of the HAC.<br><br>**Findings:**<br>The HAC listing of Requests and Accomplishments describes 10 accomplishments that the facility has made at the request of and/or cooperation of the HAC. These include: |

- Unblocking one cable TV station and installing a second TV on some units;
- Expanding library and gym hours;
- Adding music to the PEN station when information is scrolling;
- Holding make-up days in the canteen when computers go down;
- Increasing vocational opportunities for men with 1026 commitments;
- Improving the canteen rotation schedule to allow individuals to visit more often; and
- Increasing discharges.

**Recommendation 2, April 2009:**
Continue to support the Peaceful Resolution Committee.

**Findings:**
The Peaceful Resolution Committee meets twice a month, reviews violence data and identifies initiatives to reduce the level of violence in the facility. Current projects include plans for a Peace Week in December and exploring the possibility of bringing representatives from "Gangs Anonymous" to the facility.

**Other findings:**
The following table contains cumulative survey results for selected items on the ASH Individuals Survey for the period March, April, July and August 2009:

| Item | % positive response |
|---|---|
| Feel safe? | 76% |
| Treated with respect? | 85% |
| Environment clean and safe? | 83% |
| Helped to meet W&R goals? | 84% |
| Your rights have been explained to you? | 77% |
| Grievance process works? | 62% |

| | | |
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| If you see A/N, can you report it? | 82% |
| Able to communicate freely with family, attorney or advocate? | 74% |

During the HAC meeting, individuals expressed appreciation for the increased library hours and evening activities, even as they requested additional board games. Additionally, individuals praised the incentive program (paying for peace) as a powerful tool in reducing violence.

**Compliance:**
Substantial.

**Current recommendation**:
Continue current practice.